this week

PREGNANCY AND EXERCISE p3 • **ISOLATION DAYS** p4 • **WHISTLEBLOWER "VICTIMISED"** p6

VICTORIA JONES/PA/ALAMY

Staff absences spark "critical incidents"

Trusts are reporting absentee rates as high as 10% as staff self-isolate or are ill with covid

A number of NHS trusts in England have declared "critical incidents" because of staff shortages caused by covid-19.

Health leaders said the "rapidly increasing" absences were exacerbating the already severe pressure on hospitals from increasing covid admissions and wider pressure on urgent and emergency services.

Chris Hopson, chief executive of NHS Providers, said he understood that around six trusts had declared critical incidents. Among these is United Lincolnshire Hospitals NHS Trust (ULHT), which provides care at four hospitals in the county. In an internal memo leaked to the *Sunday Times* the trust said it was "unable to maintain safe staffing levels," leading to "compromised care" across its sites. On 2 January it asked clinical and non-clinical staff to come forward and offer extra hours to support colleagues over the next 72 hours.

In a statement ULHT medical director Colin Farquharson said, "As a result of staffing pressures we are having to take additional steps to maintain services. Our staff continue to work hard, and we would like to reassure our patients and the public that essential services remain fully open for anyone who needs them."

Two trusts in Lancashire, University Hospitals of Morecambe Bay and Blackpool Teaching Hospitals, have also declared critical incidents. Morecambe Bay said it had cancelled non-urgent operations and outpatient appointments while redeploying staff to areas of greatest need, while Natalie Hudson, Blackpool's chief operating officer, said the trust was "stepping down activity which is not critical" as its staff sickness absence levels were above 10%.

Vishal Sharma, chair of the BMA's Consultants Committee, said the declarations underlined how serious trusts think the situation has become. Describing the situation as "completely unsustainable," he said, "Priority access to testing, protecting staff with improved personal protective equipment, and bringing the infection rate down in the community are paramount right now, and the Westminster government must take urgent action."

Hopson noted it was a positive that hospitals were not admitting large numbers of seriously ill older people with covid. He said, "The issue for the NHS is not the very ill older people covid caseload but the number of staff absences and general admissions with covid on top of existing pressures."

Gareth Iacobucci, *The BMJ*

Cite this as: *BMJ* 2022;376:o3

LATEST ONLINE

- Omicron: NHS is on "war footing" as Nightingale hubs are announced in England
- Can absorbing medical education into NHS England deliver a suitable workforce?
- Aducanumab: European agency rejects Alzheimer's drug over efficacy and safety concerns

SEVEN DAYS IN

"Women's health ambassador" aims to help close gender gap in England

The views of more than 100 000 women and 400 organisations will help to set an agenda to improve the health of women and their experiences in the NHS, the government has said in its *Vision for the Women's Health Strategy for England*.

The consultation that generated the views, which was launched last March, highlighted problems entrenched in a system that often fails to keep women safe and to listen to them. Similar concerns were chronicled in recent inquiries into the rogue breast surgeon Ian Paterson and the use of Primodos, sodium valproate, and pelvic mesh.

A strategy, to be based on the consultation's findings, will be launched in the spring and a "women's health ambassador" appointed, said the government. More immediately, it said it would introduce legislation to ban hymenoplasty at the earliest opportunity, which an expert panel said was linked to virginity testing and stemmed from similar repressive attitudes towards women's sexuality and the concept of virginity.

Problems identified by the consultation included taboos and stigmas that prevent women seeking help and reinforce beliefs that debilitating symptoms were "normal." Eight in 10 women said they thought healthcare professionals didn't listen to them, and many called for compulsory training of GPs in women's health, including menopause.

Zosia Kmietowicz, *The BMJ* **Cite this as: *BMJ* 2021;375:n3142**

Covid-19

Jabs are advised for vulnerable 5-11 year olds

The UK's Joint Committee on Vaccination and Immunisation recommended that 5-11 year olds who are clinically vulnerable should get two doses of the Pfizer-BioNTech vaccine, eight weeks apart. This would cover around 330 000 children and includes those who live in a household with someone who is immunosuppressed. The Medicines and Healthcare Products Regulatory Agency has approved a new, age appropriate formulation of the Pfizer-BioNTech vaccine for 5-11 year olds. Each UK nation can decide whether to accept the JCVI's advice.

Lawyers demand assurance on public inquiry

The law firm Bindmans wrote to the prime minister to demand assurances on the public inquiry into the handling of the pandemic. The letter, written on behalf of lawyers from 10 law firms that represent covid patients and stakeholders, including bereavement groups, medical organisations, charities, and trade unions, demands assurances that the inquiry panel will be selected in a transparent way and will represent the diversity of the UK population, that there will be a public consultation on the terms of reference, and that a start date will be no later than April 2022.

Antibody is made available in community

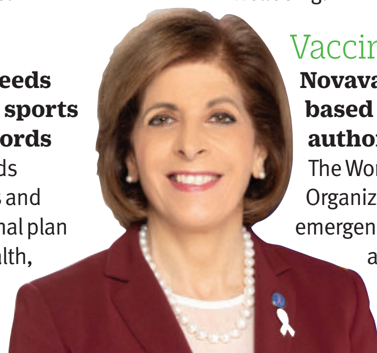
The monoclonal antibody sotrovimab is now available on the NHS to non-admitted patients with covid-19. Research indicates that sotrovimab—administered intravenously to patients with mild to moderate disease and at least one risk factor for disease progression—decreases the risk of hospital admission or death by 85%. The government has said that the treatment will be especially important in areas where omicron has become the prevalent variant, as early data suggest that Ronapreve (the other covid-19 antibody treatment) has a reduced efficacy against omicron. The UK has ordered around 100 000 doses of sotrovimab.

Sport

England needs ambitious sports plan, say lords

England needs an ambitious and radical national plan for sport, health, and wellbeing to help tackle stagnant activity levels around the country, said the House of Lords committee on sport and recreation. The percentage of people classed as "inactive" has increased from 25.6% in 2016 to

27.5% currently. The committee said that delivery of sport and recreation was "uncoordinated and fragmented," with funding structures that were "not fit for purpose." It recommended that sport policy should be moved from the Department for Digital, Culture, Media and Sport to the Department of Health and Social Care, under a new minister for sport, health, and wellbeing.



Vaccines

Novavax's protein based vaccine is authorised

The World Health Organization issued emergency use listing for a 10th vaccine against covid, Novavax's protein based Nuvaxovid, two days after its authorisation by the European Medicines Agency. Novavax is expected to deliver as many as 100 million doses of the vaccine to the EU, starting in the first quarter of 2022. The EMA's Stella Kyriakides (below) said, "Vaccination and boosting to increase protection against covid-19 is more important than ever if we are to stem the wave of infections and counter the emergence and spread of new variants."

CDC backs Moderna and Pfizer over Janssen

The US Centers for Disease Control and Prevention gave a preferential recommendation to the Moderna and Pfizer-BioNTech covid vaccines over the Janssen (Johnson & Johnson) single dose vaccine because of concerns over a rare but serious side effect associated with Janssen's. All 15 members of the Advisory Committee on Immunization Practices supported the decision, which was accepted by the CDC's director within just a few hours. Of 17 million doses of the Janssen vaccine administered in the US, 54 cases of thrombosis with thrombocytopenia syndrome, and two deaths, are suspected to be linked to it.

MEDICINE

Drugs

NICE backs treatment to increase peanut tolerance

Draft guidance from NICE recommended Palforzia, a new treatment that can help build up a person's tolerance of peanuts, after the manufacturer, Aimmune Therapeutics UK, agreed a deal with the NHS, although the price remains confidential. Palforzia has been shown to increase the proportion of children who can tolerate at least 1000 mg of peanut protein (equal to around three peanuts) by 50% and can help reduce the severity of allergic reactions. The drug contains precise and gradually increasing amounts of peanut protein and must be administered at a clinic.

Allergic reaction to peanuts can be reduced by treatment with Palforzia

Injection treatment for episodic migraine

Fremanezumab, a migraine drug given as an injection every three months has been recommended by NICE for episodic patients who have four or more migraine days a month and have not responded to at least three preventive drugs. Last year NICE recommended the drug for chronic migraine of five or more headache days a month. The Scottish Medicines Consortium's accepted the drug in January 2020 for both chronic and episodic migraine.

Drug to be available to all phenylketonuria patients

The NHS is set to make sapropterin dihydrochloride, a drug for the rare and debilitating disorder phenylketonuria, available to patients of all ages for the first time. It has struck a deal to secure a generic version for people with the inherited condition, which prevents them from digesting protein. NHS England said the manufacturer of the original branded drug had consistently refused to offer the drug at a fair price, so it could not be widely used. With the new generics deal, the NHS will offer the drug to more than 2300 people in England.

Registration

Oncologist with "cavalier attitude" is suspended

Justin Stebbing (below), an oncologist at Imperial College London who also practised privately, has been suspended from the medical register for nine months for his "cavalier approach" to consent, treatment, and prognosis. A medical practitioners tribunal found that Stebbing had overtreated patients at the end of their lives and was dishonest on four occasions over a 10 day period. But the tribunal accepted t the incidents had happened when he was mentally unwell, were out of character, and took place more than four years ago. Testimonials from colleagues and patients helped prevent erasure.

Urologist is struck off for financial motivations

Paul Miller, a consultant urologist at East Surrey Hospital, has been struck off the medical register for acting dishonestly in not disclosing his interest when referring patients for treatment by a high intensity focused ultrasound machine belonging to a company he part owned. He has 28 days to appeal.

Cite this as: *BMJ* 2022;376:n3145

CANCER TRIALS

The number of patients with cancer entering clinical trials fell to 27 734 in 2020-21, a drop of 60% from an average of 67 057 over the past three years

[Institute of Cancer Research]

SIXTY SECONDS ON . . . PREGNANCY AND EXERCISE

A GOOD WORKOUT?

There's plenty of evidence that being active during pregnancy and later can support the physical and mental health of mothers. Regular activity has been shown to reduce depression and hypertensive disorders and the risk of developing gestational diabetes.

SO, IT'S AN EASY WIN?

Not at all. New research from Sport England has found that almost two thirds of pregnant women and new mothers have been nervous or anxious about what is safe exercise. This, coupled with fatigue and existing childcare responsibilities, can make it challenging.

CAN CLINICIANS HELP?

Sport England thinks so. Active Mums Start with You, a new phase of the This Girl Can campaign, aims to support GPs, midwives, and health visitors in advising pregnant women and new mothers to build up their confidence about physical activity.

SPINNING CLASSES ON PRESCRIPTION?

The advice needn't be prescriptive, but brief, supportive interventions are recommended. Sport England pointed to a survey of healthcare professionals that showed that a third rarely or never gave advice on physical activity to pregnant women, and 27% rarely or never gave such advice to new mothers.

HOW WILL THE CAMPAIGN HELP?

By offering training and resources to help professionals start the conversation, and by providing guidance on activities that can be participated in without judgment, whether it's resistance training, dance, or yoga.

SIGN US UP!

Sport England's survey found that 74% of women either had been, or would have been, more active as a result of receiving safety advice or encouragement from a healthcare professional, suggesting that a simple conversation can make a big difference.

WHO ELSE IS EXERCISED BY THIS?

The Royal College of GPs and the Institute for Health Visiting are actively supporting it. "We want to help ensure our colleagues have all the information and advice needed to instigate brief, appropriate conversations about pregnancy and postpartum physical activity," said the college's Zoe Williams.

Gareth Iacobucci, *The BMJ*

Cite this as: *BMJ* 2021;375:n3099

Government commits to public repository of consultant details "in principle"

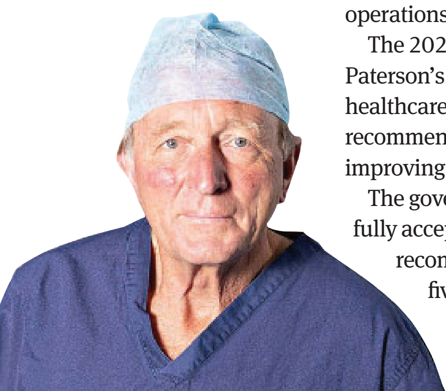
The proposals are designed to improve patient safety and prevent such criminal actions from happening again
Neil Mortensen (below)

The government has committed itself "in principle" to creating a public repository of consultants' practice details that sets out their practising privileges and key performance data, including how many times they've done a procedure and how recently.

The commitment was part of the response to an independent national inquiry, launched in 2017, after the malpractice of the rogue surgeon Ian Paterson, who is serving a 20 year prison sentence for harming hundreds of patients with unnecessary breast operations.

The 2020 inquiry blamed Paterson's crimes on a "dysfunctional" healthcare system and made 17 recommendations, mainly focusing on improving oversight and governance.

The government has now fully accepted nine of the recommendations, accepted five more "in principle," and rejected two (one will be kept under review), while one recommendation is still pending a decision.



In response to the first recommendation, for the creation of a public and easily accessible "single repository of the whole practice of consultants across England," the government pointed to NHS Digital's acute data alignment programme (ADAPt). It said this project had already started to develop a set of standards for data collection, performance measurement, and reporting systems across the NHS and the independent sector. The government said the ADAPt had the "potential" to be fully implemented by 2023. It will decide in the next year "what information can be published" and "whether further action will be needed" to achieve this recommendation.

Neil Mortensen, president of the Royal College of Surgeons of England, welcomed the decision. He said, "The independent inquiry exposed how patients were let down at every level by the system. The inquiry's recommendations are designed to improve patient safety and prevent such criminal actions from happening again."

GMC role

The recommendation is similar to one made last year by Julia Cumberlege in her review of Primodos, sodium valproate, and pelvic mesh, which recommended that the GMC register be expanded to include a list of doctors' financial and non-pecuniary interests, as well as their clinical interests and recognised specialties.

Cyril Chantler, vice chair of the safety review panel that conducted that review and a non-executive director of the Private Healthcare Information Network, told *The BMJ* that the government's response was a "step in the right direction" but that he would like to see commercial and other interests also reported.

Although the inquiry didn't mention the GMC, Chantler believes it should oversee the interests register, which could be added to the appraisal

Is it safe to reduce the covid self-isolation period?

As governments cut isolation times, **Elisabeth Mahase** looks at the evidence behind the strategies

What are the rules in different countries?

In the US people have to isolate for only five days, while in the UK they have to isolate for 10 days unless they have negative lateral flow tests on days 6 and 7, at which point they can stop isolating.

In France and Japan it is 10 days, while in New Zealand it is 10 days if the person is fully vaccinated (including 72 hours free of symptoms) but 14 days if they are unvaccinated (again including 72 hours free of symptoms). Germany, Jordan, and Brazil are following WHO's recommended 14 day isolation period.

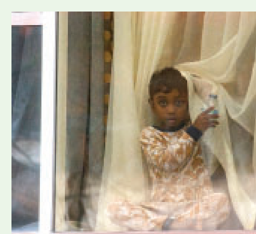
Could the UK follow the US's five day rule?

The prime minister is reportedly resisting calls for a cut to five days, at least until more evidence becomes available about the effects of the recent move from 10 days to seven days.

NHS Providers' chief executive, Chris Hopson, said, "Trust leaders are grappling with the need to keep vulnerable patients safe from catching covid-19 in a healthcare setting and ensuring staff who are having to isolate can safely return to work as quickly as possible. The key concept here is safe return . . . We must follow the science on what is safe and what is not."

Is it safe to cut the period from 14 days?

While most countries started out with WHO's



recommended 14 days, many have reduced this. Michael Ryan, executive director of the WHO Health Emergencies Programme, called the changes "judgment calls" made to deal with cases while minimising the impact on social, economic, and educational lives.

Speaking at a press conference on 29 December, he said that most people would incubate and show symptoms or be positive within the first six days of becoming infected. The chances of transmitting the disease after that were lower, although still a risk.

"There are trade-offs," said Ryan. "If people shorten the quarantine period, there will be a small number of cases that will develop disease and potentially go on to transmit. But that will be a relatively small number."

Has omicron changed anything?

The US Centers for Disease Control and Prevention

DAILY EXPRESS
THE DUCHESS OF CAMBRIDGE HER LIFE STORY
NOW 20p
FREE PLANTS
£3.50
Breast surgeon may have wounded thousands
EVIL CANCER DOCTOR PLAYED GOD

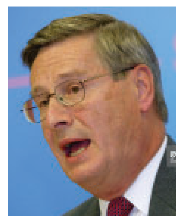
PUZZLE SPECIAL
Daily Mail
FREE JIGSAW OF YOUR FAVOURITE PHOTO!
Doctor who played God' could have maimed as many as 1,000 women, so...
WHY DID NHS FAIL TO STOP BUTCHER SURGEON?
EXCLUSIVE
SGT BLACKMAN'S WIFE: I'VE GOT MY HERO BACK

process, making it easy for doctors to update. "All the bricks are there: the appraisal system, the revalidation, the collection of data," he said. "Now somebody needs to build the house, and somebody needs to make sure the house is built to specifications, and that is the GMC. We are asking them to validate the process and to guarantee the outcomes, in the sense that patients have a right to be able to access information and to make sure the information is accurate."

Chantler added that the system could start with consultants and then be extended to other doctors, and later other healthcare workers and clinicians.

When asked by *The BMJ* whether the GMC would be involved in the repository, a spokesperson pointed to the ADAPt as the way forward. The GMC has rejected calls for it to set up a central register of doctors' declared interests, arguing it lacked the legal power.

We're not asking the GMC to do it; we are asking them to validate the process and to guarantee the outcomes
Cyril Chantler



Elisabeth Mahase, *The BMJ*

Cite this as: ***BMJ*** **2021;375:n3115**

certainly thinks so. In its five day isolation announcement it said that the change was motivated by evidence that most omicron transmission occurred one to two days before the onset of symptoms and in the two to three days thereafter.

However, Ryan warned against changing rules on the basis of early data. He said, "The data is not certain because we're dealing with a very limited number of studies and a limited number of individuals. We're also talking mainly about younger people. Maybe younger people have a shorter duration than older, but we just don't know. So, we need to be very careful with interpreting these data."

? Are people still following the rules?

In the UK the Office for National Statistics looked at the behaviour of 895 people required to self-isolate after testing positive between 29 November and 4 December. This showed 74% fully adhered to the requirements throughout their self-isolation—a similar level to that reported in July (79%) and September (78%).

However, one in four people (25%) reported having carried out at least one unauthorised activity.

Elisabeth Mahase, *The BMJ*

Cite this as: ***BMJ*** **2021;375:n3164**

Hospital admission less likely with omicron than delta, but transmission a major concern

Someone infected with the omicron variant of SARS-CoV-2 is estimated to be between 31% and 45% less likely to attend emergency care than if they had been infected with the delta variant and 50-70% less likely to be admitted to hospital, analysis by the UK Health Security Agency has shown.

But the agency said the findings, which exclude people with previous infection, are preliminary and highly uncertain because of the small numbers of hospital cases of omicron, an inability to effectively measure all previous infections, and the limited spread of omicron into older age groups. It also emphasised that, although a smaller proportion of people with omicron could end up in hospital than with previous variants, the actual number becoming seriously ill and needing hospital care could be huge, because of the variant's increased transmissibility.

Very high case numbers

Jenny Harries, the agency's chief executive, said, "Cases are currently very high in the UK, and even a relatively low proportion requiring hospitalisation could result in a significant number of people becoming seriously ill. The best way that you can protect yourself is to come forward for your first two doses of vaccine, or your booster jab, and do everything you can to stop onward transmission of the infection."

As at 20 December 132 people with confirmed omicron had been admitted to or transferred from emergency departments. Notably, over 40% of admissions were in London. Of the 132 patients, 17 had received a booster vaccine, 74 had received two doses, and 27 were not vaccinated. The vaccination status of six people was unknown, while eight had received a single dose. Within 28 days of an omicron diagnosis, 14 people were reported to have died, ranging in age from 52 to 96 years old.

Reinfection

The analysis, published on 23 December, also found that omicron was more likely than previous variants to reinfect people who have previously had covid-19, with 9.5% of those infected having a history of past infection. This is likely to be an underestimate because of some people being unaware they had had asymptomatic prior infections.

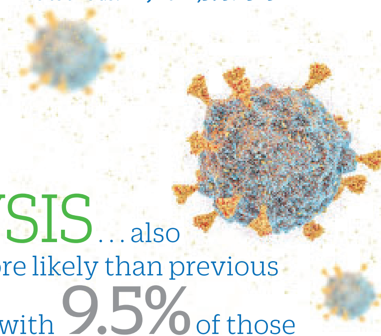
Looking at vaccine efficacy, the report said the data were continuing to show lower effectiveness against symptomatic omicron. Evidence indicates that although two doses of vaccine are less effective against omicron than against delta, a booster dose improves protection. But this may wane more rapidly against omicron, being about 15-25% lower from 10 weeks after the booster.

It's still too early to estimate vaccine effectiveness against hospital admissions, but the agency said this was more likely to be sustained, particularly after a booster.

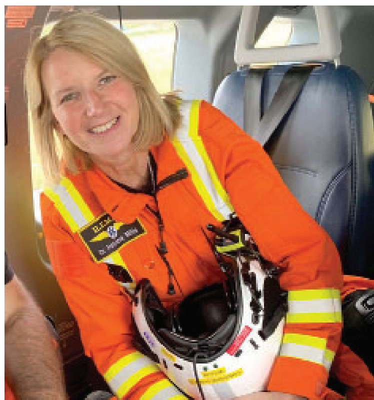
The findings were consistent with three recent studies, not yet peer reviewed, from researchers in England, Scotland, and South Africa, which all concluded that omicron carried a lower risk of hospital admission than delta.

Elisabeth Mahase, *The BMJ*

Cite this as: ***BMJ*** **2021;375:n3151**



THE ANALYSIS ... also found that omicron was more likely than previous variants to reinfect people, with 9.5% of those infected having a history of past infection



Managers victimised whistleblower for raising concerns, review finds

The harrowing experience of anaesthetist Patricia Mills's attempt to improve patient safety at her trust raises questions about the national scheme set up to protect those who report fears about colleagues or systems, find **Adele Waters** and **Elisabeth Mahase**

"It sounds bizarre but, looking back, I felt safer working inside the covid intensive treatment unit than any other location in the hospital. Once I was inside the doors of ITU, I knew I wouldn't have to run into any of the management team who seemed hell bent on ending my career."

So said Patricia Mills, an NHS anaesthetist at West Suffolk NHS Foundation Trust, who spoke to *The BMJ* after the publication last month of a damning review into how her employers handled concerns she raised about patient safety almost four years ago.

In March 2018 Mills reported concerns about a fellow doctor (referred to as Dr A in the review) who injected himself with pain relief while looking after a patient. She subsequently became the focus of the trust's attention and found herself the subject of scrutiny and, in March 2019, a disciplinary investigation that lasted till September 2021.

The review, conducted by Christine Outram, chair of the Christie NHS Foundation Trust in Manchester, found "serious flaws" in how the trust handled the matter. It said that it was wrong for the trust to have dismissed Mills's warnings, alongside those from other senior staff, and it was also regrettable that Mills had come under "detailed scrutiny" over her conduct as a direct result of whistleblowing.

"Staff should be free to challenge without fear," Outram concluded. "The need for an open culture in which staff understand the importance of incident reporting, confident that all will be dealt with fairly, is one that applies to all NHS organisations. A culture where staff feel the need to keep their heads down has to be addressed."

Commenting on her nearly four year ordeal Mills said, "It was truly, truly awful . . . I've been a doctor for 30 years, and I've never had any trouble in my career ever, with anything. But suddenly I found myself accused of all manner of conduct issues."

To be subjected to that level of malevolence by your employer can't be without sequelae. It's been three years of my children's lives that I feel have been blighted
Patricia Mills

Systems not fit for purpose

Mills, who has worked in ITU throughout the covid pandemic, said the current mechanisms to support safe whistleblowing in the NHS weren't fit for purpose. "If I hadn't been so tenacious, this would just have never been exposed—that's my real concern. I think if I'd been in a different situation, if I'd been a single parent or had a one salary income, I just couldn't have risked carrying on, so at the point they offered to pay me off with an agreed reference I would have gone, and I don't think any of this would have been revealed. And that's a real worry."

Outram's review was ordered in February 2020, after staff contacted NHS England and NHS Improvement in 2019 saying that their trust was conducting a "witch hunt" in response to an anonymous letter sent in October 2018 to the widower of a patient who had died while in the trust's care. Signed "from operating theatre staff," the letter said that the consultant anaesthetist (Dr A) responsible for the patient's care should not have been at work, because of errors caused by being under the influence of drugs.

Shortly afterwards, the executive team became aware of the letter and requested handwriting samples and fingerprints from some staff, who were told that refusal could be considered as evidence that they were involved in writing the letter. These actions, Outram found, were "highly unusual and without doubt extremely ill judged."

Her 226 page review outlined how trust staff had tried to raise concerns about Dr A after he gave himself intravenous magnesium and parecoxib while being responsible for an anaesthetised patient as far back as November 2017. After this incident Dr A was permitted to remain on unrestricted duties, but Outram found there was "inadequate consideration and consultation" before allowing this and that concerns raised by senior clinical colleagues were "effectively ignored." Dr A was not disciplined and has since moved to another trust.

Trust acted against policy

The review found that by investigating Mills (referred to as Dr C in the report) as a result of her speaking up the trust acted in direct contravention of its freedom to speak up (FTSU) policy, which states that staff who raise genuine concerns will not face any form of reprisals or disciplinary action.

A request made under freedom

THE TRUST'S ACTIONS were "highly unusual and without doubt extremely ill judged." Outram's 226 page review outlined how trust staff tried to raise concerns about Dr A after he self-administered intravenous drugs while being responsible for an anaesthetised patient

of information legislation has since confirmed the trust paid £57 338 to Vista Investigations, an external investigations service for employers, to investigate the anonymous letter and Mills's conduct. As part of that investigation the trust's chief executive said the board had lost confidence in Mills, and one of the non-executive directors even said the trust had a "terrorist in our midst," with the context suggesting referred to Mills.

"Dr C's exercise in speaking up led directly to an investigation into concerns held about her conduct. That derailment was wholly contrary to the FTSU policy (particularly its requirement that no one is victimised for speaking up)," Outram wrote, adding that Mills's concerns were "well founded and shared by several of her colleagues."

Her review also found that the investigation concerning the anonymous letter was "intimidating" and "distressed and damaged individual staff members." The trust had concluded that Mills wrote the anonymous letter, a decision that, Outram's report said, was based on a "flawed internal investigation" and was at least partly the result of her having spoken up about concerns. Outram added, on the basis of all the evidence she had seen, "Dr C did not write the anonymous letter."

"I'll never be the same again, and I don't say that lightly," Mills told *The BMJ*. "To be subjected to that level of malevolence by your employer can't be without sequelae. For me, the really awful thing about this was that it's been three years of my children's lives that I feel have been blighted. Several family holidays were absolutely destroyed by receiving an awful communication, either just before I went away or while I was away. That's the uncounted cost of this."

Lessons for leaders

The BMA has called for Outram's review to be heeded not just by the new trust management but leaders nationally. "At a time when the health service is operating on the edge, we need a culture of openness, transparency, and support—away from blame, bullying, and fear," said David Wrigley, deputy chair of the BMA council. "The events described in this report are completely at odds with the NHS's commitments to protect those who speak up, and we are grateful to Ms Outram for so comprehensively investigating and exposing the numerous failures and unacceptable behaviours of the trust management between 2018 and 2020."

Wrigley said that the BMA had been supporting and working closely with its members at the trust and had raised "deep concerns" about the situation ever since it came to light.

He added, "The trust's focus should have been on patient safety and developing a supportive culture for staff, not launching an appalling investigation which intimidated staff and was at great expense to the taxpayer.

"Working in such a toxic culture can have a tragic impact on staff's morale, health, and wellbeing—as we have heard from Dr Mills—as well as compromising the quality of care that patients receive."

The board of the West Suffolk NHS Foundation Trust said it would now consider Outram's review. Its interim chief executive, Craig Black, replacing Steve Dunn, who was in post throughout Mills's ordeal, said, "We take full responsibility for failings and shortcomings around the handling of events leading up to and surrounding the whistleblowing and are truly sorry to the staff and families affected."

He said that staff should be confident in speaking up without fear of retribution and that the trust had taken up several actions to improve its human resources, culture, and leadership practices, including appointing two new "freedom to speak up guardians."

The trust's chair, Sheila Childerhouse, has also apologised for her part in the trust's failings and has stepped down.

The need for an open culture applies across the NHS. A culture where staff feel the need to keep their heads down has to be addressed
Christine Outram

Such a toxic culture can have a tragic impact on staff's morale and wellbeing, as well as compromising the quality of care patients receive
David Wrigley

We take full responsibility for failings and shortcomings around the handling of the whistleblowing and are truly sorry to staff and families
Craig Black

National guardian "hopeless"

During her ordeal Mills contacted the National Guardian's Office several times for help. The body was set up in the wake of Robert Francis's report on NHS staff's freedom to speak up. However, she was unimpressed.

"I found them absolutely, utterly hopeless, and, worse, they actively wasted my time. They would ask for excruciating eye watering detail about what's happened and then just come back and refer you to a website or information on speaking up," she said. "Absolutely hopeless, I really have no idea what their function is."

A spokesperson for the office said, "We are sorry to hear of Dr Mills's terrible experience. The findings of the review illustrate what happens when leadership views speaking up as a threat rather than an opportunity to learn and improve and when the person who speaks up becomes the focus, rather than the matters raised."

The spokesperson added that the office had no remit or powers to intervene in or investigate individual cases.

Adele Waters, Elisabeth Mahase, *The BMJ*

Cite this as: *BMJ* 2021;375:n3147

THE BIG PICTURE

Vaccines wasted as Africa waits

A truck dumps expired AstraZeneca covid vaccines at the Gosa dump site in Abuja, Nigeria, on 22 December. The same day, the UK government announced 30 million of its people had received a booster jab.

Up to a million covid vaccines are estimated to have expired in Nigeria, where less than 4% of adults have been fully vaccinated, according to WHO. The lack of infrastructure for delivering vaccines—donated through the Covax system—within the shelf life of four to six weeks is one of the continent's most pressing problems. Across Africa only 102 million people, or 7.5% of its population, are fully vaccinated. In the UK 80% of adults have received at least two doses, while in the US the proportion is 61% and in the EU 69%.

Alison Shepherd, *The BMJ*

Cite this as: *BMJ* 2022;376:n3163

AFOLABI SOTUNDE/REUTERS/ ALAMY

EDITORIAL

Neglect of FASD must end

A government report on fetal alcohol spectrum disorder details the challenge ahead

In September, the government published its long awaited report on health needs assessment for fetal alcohol spectrum disorder (FASD).[1] The document covers many of the challenges associated with the condition caused by exposure to alcohol before birth. It affects brain development and results in neurodevelopmental, physical and sometimes mental health problems that persist throughout life. Many of the difficulties experienced by affected individuals and families are compounded by lack of access to diagnostic services and support, which affects daily life and future outcomes.[1]

Why has it taken so long to get even to this stage—the dawning realisation that a substantial problem exists? Reasons include the complex relation we have with alcohol in the UK,[2] lack of professional training,[3] concern about maternal guilt, worries about erosion of maternal rights,[4] arguments about levels of alcohol consumption associated with harm,[5] the long delay between exposure and later neurodevelopmental difficulties, the complexities of making a diagnosis, and pervasive myths—including that little can be done for those affected.

Not rare

The first UK FASD prevalence study,[6] which used active case ascertainment to identify the condition among 8-9 year-olds in three primary schools in Greater Manchester, found that 1.8% (4/220; 95% confidence interval 1.0 to 3.4) had FASD, with another 1.8% possibly affected, giving a total prevalence of possible FASD of 3.6% (2.1 to 6.3). This is broadly consistent with previous estimates.[7] The condition is not rare, just rarely diagnosed.[6] It is likely to be more common than, for example, autism, where progress has been made developing diagnostic pathways. Many children with FASD may also have autism and attention deficit disorder as comorbidities.[8]

NICE is developing quality standards for FASD, reflecting Scottish evidence based guidelines.[9] These will provide a UK-wide approach and will cover advice and information provided in pregnancy, assessment and diagnosis in children with neurodevelopmental problems, and help and support with management. NICE guidance will assist clinical commissioning and outline service standards.

SPL

Knowing that one child in a class of 25-30 is affected by a potentially preventable problem should impel us to take action

Perhaps we are getting better at listening to the voices of those affected. Patient and public involvement in the government report is commendable[1] and highlights the paucity of provision: only 22% of clinical commissioning groups commission services for diagnosis in children and 8.4% for adults. Effective support is available in some areas of the country,[1] and best practice from these beacons must be shared and developed.

The report's conclusions are sound and robustly argued. They highlight an urgent need for greater understanding, awareness, and training and for improved services to support diagnosis and management. They also add considerable weight to a previous report calling for further research.[10] The latest report emphasises the life long needs of individuals and looks for closer collaboration between departments of health and social care, education, and justice. The cost effectiveness of investment in this area is strongly emphasised: effective diagnostic and support services improve outcomes[11] and primary prevention reduces future costs to individuals and wider society.[12] Although the report identifies what needs to be done, it stops short of suggesting how. We could learn from countries such as Canada,[13] Australia,[14] and Scotland,[15] where government recognition of the problem led to a central organisation for FASD at modest cost. This has created societal as well as service change thanks to increased partnership between organisations and the fostering of policy development, built on a sound research base.

Umbrella body for England

An English umbrella body for FASD would encourage partnerships between professions and professional organisations, ensure the voices of those affected are heard, support the clinical service and network development, and encourage appropriate research commissioning. It might also advise on coordinated policy initiatives, facilitate the sharing of information, and monitor progress.

In the meantime, we must ensure that diagnosis of FASD is embedded within existing pathways for those referred with neurodevelopmental difficulties. The knowledge that, on average, one child in a class of 25-30 is affected by a potentially preventable neurodevelopmental problem should impel us to take action. This report is a wake-up call to a wide range of health professionals: problems relating to the identification, diagnosis, management, and support of people affected by FASD and its underlying causes are relevant to professionals in midwifery, obstetrics, nursing, child growth and development, safeguarding, adoption, community care, mental health, and public health. The royal colleges have an important role in supporting professionals to provide timely, effective, multidisciplinary support to those affected—while working towards the ultimate goal of prevention.

Neil Aiton, consultant neonatologist with specialist interest in perinatal substance misuse, Royal Sussex County Hospital, Brighton
neil.aiton@nhs.net

Cite this as: *BMJ* 2021;375:n2969

Find the full version with references at http://dx.doi.org/10.1136/bmj.n2969

EDITORIAL

Another drug strategy for the UK

New promises, old contradictions

In 2017, we described the previous UK drug strategy as full of "false claims and empty promises."[1] The new 10 year strategy,[2] announced in early December, brings much needed money to rebuild drug treatment services but lacks any real reform. Despite repeated calls from experts and politicians to adopt a new approach,[3-6] the plan does not mention drug consumption rooms or heroin assisted treatment, and the only reference to decriminalisation of drug possession is an unfounded statement that it would lead to increased drug use.[7]

The strategy comes after a decade of defunding that has led to loss of a skilled and dedicated workforce, followed by substantial increases in drug related deaths.[8 9] Although enforcement and abstinence seemed to take centre stage in the government's announcement, most of the new money is to be spent on a "wide range" of treatment options and implementing recommendations in Carol Black's report on delivering evidence based treatment.[10] This offers the opportunity to improve outcomes for those who are dependent on drugs, with £780m of new funding for treatment over the next three years in England. The treatment sector will have to deliver on reducing crime and deaths or risk losing this funding at the end of three years. But this will take more than money.

With its cross-governmental approach, the strategy is reminiscent of the first drug strategy in 1995, which also promised to combine law enforcement to reduce supply and demand with efforts to prevent and treat drug use through interdepartmental collaboration.[11] Subsequent strategies added attention to crime reduction and the promotion of recovery,[12] which carry through into this new document. A more robust, evidence informed, well resourced treatment sector delivering better health outcomes will partly achieve the strategy's aims. While many will be disappointed by the government's unwillingness to accept that current drug laws compound social disadvantage, erect barriers to people seeking help, and worsen health outcomes, we must make the most of the funding provided.

MEHDI CHEBIL/POLARIS/EYEVINE

We must change how drugs are viewed, not simply add to police, prison, and treatment service budgets

Adam Winstock, honorary clinical professor, University College London, a.winstock@ucl.ac.uk

Niamh Eastwood, executive director, Release, London

Alex Stevens, professor in criminal justice, School of Social Policy, Sociology, and Social Research, University of Kent

For too long, many services have taken a paternalistic approach, placing onerous conditions on opioid substitution therapy and viewing people who are dependent as untrustworthy and inately criminal. Treatment must be easier to access and more attractive to stay in. Over half of people who die from opiate related causes have not been in contact with treatment services in the previous five years.[13] Services must radically change their approach, embracing harm reduction, involving people who use drugs in their design, and treating them with dignity and respect.

Unhelpful ideologies

Unhelpful ideologies, pervasive throughout the strategy, may severely limit the effect of investment, however generous. Stigmatising language and the exaggeration of the role of drugs in criminality, for example, are especially visible in the prime minister's foreword. The strategy promises to expand drug testing on arrest and to create "tough consequences" for people who refuse to engage with treatment.[14] Treatment providers will find this ethically difficult to reconcile with the principle of informed consent.[15]

The attention given to deprived areas, vulnerable families, and children, recognising the links between poverty and drug dependence and the complex interplay between drug use and both mental and physical health, is welcome. Where services will recruit the required trained workforce from is unclear, however, given the shortages identified in the Black report.

Investment in care within prisons is important, though spending £4bn to expand the prison system is highly questionable, given the lack of evidence that sending more people to prison reduces crime. Prison treatment services should not follow ministers' preferences (again unsupported by evidence) for early weaning from opioid substitution therapy. Access to opioid substitution therapy in prison reduces the odds of dying from drug related causes after release by about 85%.[16] Promised investment to reduce homelessness and offer education and employment opportunities will be crucial.

The new strategy is rooted "unashamedly" in the belief that "illegal drug use is wrong and unlawful possession of controlled drugs is a crime." The idea that such moral judgments and punishment reduce drug use and related harms has often been challenged[17] and is currently being investigated through the Global Drug Survey.[18] The strategy promises to use evidence but ignores multiple studies showing that criminalising people reduces access to vital opportunities in employment and education,[19] continuing the contradictions embedded in previous drug strategies.[20]

To get beyond repeated cycles of self-contradictory plans, we must change how drugs are viewed, not simply add to police, prison, and treatment service budgets. This strategy once again misses the chance to change the conversation fundamentally. In the meantime, we must strive to ensure the opportunities to reduce deaths and other harms provided by the new funding are fulfilled ethically and effectively.

Cite this as: *BMJ* 2021;375:n3097

Find the full version with references at http://dx.doi.org/10.1136/bmj.n3097

THE BMJ APPEAL 2021-22

“Without this team there would have been many more deaths”

The BMJ’s annual appeal is this year supporting the work of MSF in Afghanistan. **Jane Feinmann** looks at how the charity helps care teams boost survival after a major influx of injured patients

SANDRA CALLIGARO/MSF

“If you do a good triage, you ensure that limited hospital resources are focused on the most urgent cases,” says Yves Wailly, an emergency department nurse and medical adviser to Médecins Sans Frontières in Afghanistan. “If you don’t, you’ll overburden the emergency room and put lives at risk.”

Triage clinicians work against the clock, with around 30 seconds to assess each patient and decide who receives priority. “You do a clinical examination often with projectiles sticking out of the patient and them suffering considerable blood loss,” James Lee, a UK trained emergency care doctor and adviser to MSF, says.

“There’s no time for an x ray or even getting the patient’s name,” he says. “Those with internal bleeding need to be stabilised—and that means the doctor making a lightning decision, using a stethoscope and an examination of the belly, and then moving on to next patient.”

When a suicide bomb killed and injured hundreds of worshippers inside a packed mosque in Kunduz, northern Afghanistan, in October, there was media speculation worldwide about the fragile security

Support Médecins Sans Frontières’ Afghan Crisis Appeal

DONATE ONLINE:
msf.org.uk/bmj
or call
0800 055 79 81
(lines open 8 am–10 pm 7 days a week)

HEAR FROM US BY EMAIL

Sign up to our monthly email, Frontline, which provides first-hand accounts of our work. You will receive Frontline, event invitations and occasional emergency appeals with requests for donations.

Opt me in to email: ☐ Yes ☐ No

Email address: ____________________

RESPECTING YOU AND YOUR PERSONAL DATA

Your support is vital to our work and we would like to keep you informed with first-hand accounts from our staff and patients about the lifesaving impact your support is having, from combating epidemics to providing emergency surgery. We won’t allow other organisations to have access to your personal data for marketing purposes and we won’t bombard you with appeals.

By supporting MSF, you will receive our quarterly magazine Dispatches, event invitations, and occasional emergency appeals with requests for donations by post.

You can change how you hear from MSF UK by emailing uk.fundraising@london.msf.org or calling 020 7404 6600. Visit our privacy notice for more: msf.org.uk/privacy.

Please return to: *FREEPOST RUBA-GYZY-YXST, Médecins Sans Frontières, Bumpers Way, Bumpers Farm, Chippenham SN14 6NG.*

Title ______ Forename ____________ Surname ____________

Address ____________________

Postcode ____________ Telephone number ____________

☐ £50 – can pay for vaccinations to protect 60 pregnant women and their babies against tetanus.

☐ £100 – can provide sterile dressings for 36 wounded patients.

☐ £250 – can provide a month of lifesaving therapeutic food to treat 13 severely malnourished children.

☐ I’d like to donate £ ________

I enclose a cheque /charity voucher made payable to *Médecins Sans Frontières*

OR I authorise MSF to debit my Visa / Mastercard / Maestro / CAF charity card below:

Cardholder name ____________________

Card number ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐
(Shaded boxes Maestro only)

Expiry date ☐☐ / ☐☐   Start date (if shown on card) ☐☐ / ☐☐

Signature ____________________ Date ________

100953

ARE YOU A UK TAXPAYER?

IF SO, YOU CAN MAKE YOUR GIFT WORTH 25% MORE AT NO EXTRA COST. PLEASE TICK THE BOX BELOW.

☐ I wish Médecins Sans Frontières (MSF) to treat all gifts in the last 4 years, this gift and all future gifts as Gift Aid donations. I am a UK taxpayer and understand that if I pay less Income Tax and/or Capital Gains Tax than the amount of Gift Aid claimed on all my donations in that tax year it is my responsibility to pay any difference.

Date / /

NB: Please let MSF know if your name, address or tax status changes, or if you would like to cancel this declaration, so that we can update our records.

Charity Registration Number 1026588

WASEEM MUHAMMADI/MSF

19 lifesaving operations were carried out that day; 60 over the next 36 hours, and just five patients died

of the new Taliban government. For the MSF team based at its newly opened trauma centre, the blast triggered a well rehearsed response to the management of multiple serious casualties best described as reverse triage.

When dealing with mass casualty incidents healthcare teams organise themselves in the best possible way to increase survival rates. "We had more than 100 major casualties arrive at the hospital within two hours," recalls Lee, who had been in Kunduz to train the team there to deal with mass casualties and was on duty that day. Within two hours of the blast the hospital had admitted 74 patients and received 20 people who were dead on arrival.

"Almost all the patients had severe shrapnel injuries similar to a high velocity gunshot wound," says Lee. In such cases "rapid intervention to stop internal bleeding is critical." It means turning triage on its head and prioritising patients who are most likely to survive, ahead of those who are more seriously injured.

MSF has refined the standard protocol for a mass casualty incident over years of experience. Wailly tells *The BMJ* that it's always specific to each individual hospital, "matching its capacity, the health context in which it is embedded, the volatility of the situation, and the risk of being confronted with further disasters."

MSF's work in Afghanistan is supported entirely by private donations, and the charity operates alongside a depleted government healthcare system to offer healthcare in Afghanistan to anyone in need. MSF built its hospital in Kunduz through private donations, and it is this support from individuals that also finances the salaries of MSF's largely Afghan healthcare team, which includes surgeons, anaesthetists, nurses, and others.

In developed countries pre-hospital triage often aims to ensure that cases are spread across several hospitals. But the MSF hospital is one of just two facilities in Kunduz able to offer trauma surgery. This makes hospital triage ever more crucial.

In Kunduz in October it went well: 19 lifesaving operations were carried out the same day, a further 60 over the next 36 hours, and just five patients died. A debrief followed two weeks later, and Lee spoke to *The BMJ* in mid-November, a couple of days after a simulation exercise to take on the lessons learnt from the incident.

The review is perhaps more timely than ever, this being the first multiple casualty incident in a hospital that had only recently opened. It replaced the original MSF hospital in Kunduz, which was destroyed, with 42 people killed, by US airstrikes in 2015.

Lee and his team focus on the details. The hospital's response to multiple casualty incidents needs to become "less ER-focused," the debrief concluded—so staff need to resist their tendency to move towards the emergency room in response to the arrival of large numbers of patients. "We all now understand that doctors and nurses need to stay in the ward, that blood bank staff remain in place, and pharmacists continue to do their routine job," he says.

With bystanders bringing patients to the hospital in a "scoop and run" way, there's also a need for more non-medical staff, including stretcher bearers. And getting patients' names as quickly as possible, so that family members at the hospital gates can be given news about their relatives, is both humane and a contribution to crowd control. "People need certainty, whatever it is," Lee says.

Overall, however, the team has developed confidence in its ability to manage this worst case scenario. "Without this hospital, and a team of clinicians able to make such difficult decisions, there would have been many more deaths that day," says Lee. "It's individual donors who keep MSF going, so that when there's a need we can be as well prepared for scores of casualties as it's possible to be."

Jane Feinmann, freelance journalist, London jane@janefeinmann.com

Cite this as: *BMJ* 2022;376:n3101

The BMJ Appeal 2021-22 is being supported by the Green Room Charitable Trust, which will match fund up to £50 000 donations received before 31 January, enabling your support to go even further. MSF's Afghan Crisis Appeal will fund work in Afghanistan and support work in neighbouring countries

ESSAY

Why asylum seekers deserve better healthcare, and how we can give it to them

A byzantine level of paperwork leaves people who have fled to the UK without healthcare, but **Olivia Farrant and colleagues** explain how, in the depths of the pandemic, a model response was born

In August 2020, Kirsteen McDonagh met a young family staying at an address that seemed strange. The family had only recently migrated to the UK and had been housed in student accommodation in central London. It was, the family explained, "contingency accommodation" in which they had been placed by the Home Office while they waited for their asylum claim to be processed.

This was the first case of hundreds that McDonagh, a specialist health visitor for homeless families, employed by Central and North West London NHS Foundation Trust, would encounter.

The crisis in Afghanistan has again brought migration into the international spotlight. Refugee migration to the UK shows little sign of diminishing, and the problem of how best to look after asylum seekers is becoming acute. Many new arrivals have complex health needs for which current NHS healthcare systems struggle to offer appropriate care, exacerbating the trauma already experienced by many of these vulnerable people and families.

In June 2021, key recommendations were published by the Safeguarding Adults National Network in relation to the health and wellbeing of people seeking asylum. The current ability of local health services to meet the complex needs of asylum seekers is variable; many pockets of good practice exist, but many areas have struggled to respond to the demands of meeting these complex healthcare responsibilities.
An asylum seeker is a person who seeks protection from persecution and serious human rights violations in another country, but who hasn't yet been legally recognised as a refugee and is waiting to receive a decision on their asylum claim. In 2020, most asylum seekers in the UK came from Albania, Eritrea, Iran, Iraq, Sudan, and Syria.

Many have complex health needs for which NHS healthcare systems struggle to offer appropriate care, exacerbating trauma

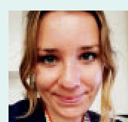
When a person claims asylum in the UK—and if they are destitute—they are provided with "initial accommodation." There are approximately 13 initial accommodation hostels around the UK; they are designed to be short term and often have commissioned health and social services allocated to them. The Home Office's target is for people to remain in initial accommodation for 35 days, before being rehoused in longer term "dispersal accommodation"—generally a house or flat in a residential area, often shared with others—to wait for their asylum claim to be processed. The Home Office's target is for 98% of claims to be processed within six months.

After a claim is processed, the asylum seeker is either granted permission to stay under humanitarian protection, including as a refugee, or the claim is refused, and they are deported. Contingency accommodation is used when all places in both initial and dispersal accommodation are filled. It comprises hotels in often non-residential areas with no allocated health, education, or schooling services. Its use has skyrocketed in the pandemic.

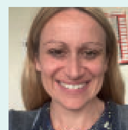
At the end of March 2021, 66 185 people were waiting for an initial decision from the Home Office, the highest number in over a decade. Around 50 000 of these people had waited for over six months, and asylum claims are currently taking between one and three years to be processed. Asylum seekers are not permitted to work during this processing period and are provided with a subsistence allowance of £39.63 a week.

Studies have shown that the uncertainty of this long process can have a major negative effect on asylum seekers' mental health.

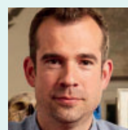
BIOGRAPHIES



Olivia Farrant is a research fellow at the Hospital for Tropical Diseases, UCLH. She is working on the Respond project while completing her medical training. Before this, she worked on the covid-19 response in Sierra Leone and on clinical research in tuberculosis and malaria.



Sarah Eisen is a co-lead for Respond and a consultant paediatrician at the Hospital for Tropical Diseases, UCLH, with a special interest in infectious diseases, tropical medicine, and migrant health. She has been running services for asylum seeking populations in North Central London for several years.



Chris van Tulleken is a doctor at the Hospital for Tropical Diseases, UCLH, where he works with Respond, and an associate professor at UCL. His academic work focuses on conflicts of interest and research integrity. He is also a broadcaster for children and adults on the BBC.

Allison Ward is a co-lead for Respond and a consultant community paediatrician working as a named doctor for safeguarding and looked after children in the London borough of Camden. She works across the Royal Free London, Central and North West, and UCLH NHS Foundation Trusts. She leads the North Central London Integrated Health Network for unaccompanied asylum seeking children.

Nicky Longley is one of the co-leads for Respond, a consultant in infectious diseases and travel medicine at the Hospital for Tropical Diseases, UCLH, and associate professor of travel medicine at London School of HTM. Nicky has a particular interest in refugee health and prevention of infection in the immunosuppressed traveller.

PETER NICHOLLS/REUTERS/ALAMY

Why the system is broken

In the UK, all asylum seekers have the right to access primary and secondary NHS services without charge. But the barriers to access can be so high these rights are very challenging to realise. GP registration is often wrongly denied if someone does not have appropriate identification or proof of address, transport costs can be prohibitively expensive, negotiating complex NHS procedures can be difficult for non-English speakers, and existing complexities in the healthcare system are amplified by repeated relocation.

At our clinic in central London, nurse practitioner Anna Burnley phoned a refugee patient who had missed an appointment. The patient explained that they had been moved to new accommodation. "The patient very kindly offered to come to another appointment but said she didn't know how far it was," Burnley said. It transpired that they were in Scotland. This type of occurrence is far from unusual.

The recent shift to remote consultations has presented additional challenges for people with limited access to technology and the internet. This has led to a huge reduction in primary care interactions, even among UK permanent residents. These barriers extend to secondary care, where there is often confusion among patients and NHS staff regarding the legal entitlements of this group. Asylum seekers may not know where to find a doctor or that care is free of charge. Even if they successfully navigate all these barriers, the strictly time limited structure of a typical NHS consultation can be inadequate for the complex and interconnected problems of most asylum seeking families: appointments in primary or secondary care are brief and usually have a narrow focus.

Respond

In the London borough of Camden, a team of primary and secondary healthcare providers have initiated a pragmatic, joined up approach that could be applicable around the country. It started in December 2020, as the UK entered another lockdown, and covid-19 case numbers were rising dramatically. Health and safeguarding professionals in Camden became increasingly concerned about the needs of patients seeking asylum.

McDonagh had spoken with her NHS safeguarding colleagues about the vulnerability of babies and young children placed in contingency accommodation. The safeguarding team recognised a similar profile of needs to those they had seen in unaccompanied asylum seeking children. In 2016, a specialised service had been set up for these children, and infection and paediatric consultants at University College London Hospital (UCLH) had wanted to adapt this model into a family focused migrant health screening service for some time. Here, amid a global crisis, was an opportunity—Respond was born. Respond is an integrated model of care, designed to meet the complex needs of asylum seekers in contingency accommodation. The service is hosted by UCLH but is delivered either directly in the contingency or initial accommodation or in primary care practices.

After GP registration, asylum seekers are given an appointment with an infection and inclusion health practitioner who assesses

The Respond model—comprehensive screening and action in primary care

Health and wellbeing domain	Screening activity	Associated Respond actions
Physical health including infectious diseases	Physical health symptom survey. Medical, drug, and vaccination history. Screening for HIV, tuberculosis, viral hepatitis, schistosomiasis, strongyloidiasis, and other relevant gut parasites and infections	Referral for catch-up immunisations. Specialist review of positive ID screening results. Signposting to accessible vision and hearing screening. Booking of targeted GP appointments
Emotional and psychological wellbeing	Mental health symptom survey. RHS-15 screening completion[12]	Referral to local primary and secondary care mental health services. Signposting to community support groups and useful wellbeing resources
Sexual and reproductive health	Sexual health screening, STI testing and access contraception	Referral to antenatal services. Referral to sexual health services. Booking of targeted primary care input for contraception
Child development and family functioning	Key developmental domain screening and observation, exploring current access to local play and education resources	Referral to local child development services, allocation of a family support worker with local authority early help services. Engagement with specialist health visitor and school nursing teams
Trauma and safeguarding	Targeted screening questions to uncover history of trafficking, sexual exploitation, torture, FGM, modern slavery, and domestic violence. Consideration of impact of parental trauma on parenting capacity	Referral to early help and safeguarding services. Referral to third sector organisations for victims of trauma and torture
Oral and dental health	Dental pain, access to toothbrushes and toothpaste, referral to urgent and non-urgent dental services	Oral health promotion packs, facilitation of access to emergency dental care, signposting to accessible local dental services, referral for specialist

FGM=female genital mutilation; RHS=refugee health screener; STI=sexually transmitted disease.

Nurses in the UCL hospital Respond team who offer a family focused migrant health screening service

CASE STUDY: AYANA

Ayana* arrived in Camden, north London, in the summer of 2020. The widowed pregnant mother of a five year old girl, had fled Eritrea a year earlier after an attack on her village by government forces. On arriving in the UK, Ayana was increasingly worried about her daughter's speech delay. Ayana had also received no antenatal care for her new pregnancy, now in its second trimester. Troubled by persistent pain in her left leg after falling from a lorry in northern France and kept awake by flashbacks and nightmares, Ayana was barely sleeping.

It took six weeks for Ayana to register with a GP surgery and make an appointment to see a doctor. Half her allocated appointment time was spent trying to find a translator who spoke her language, and she struggled to articulate the persistent concerns she has regarding her daughter's health and development. Displaced and powerless, she didn't feel able to talk about the violence and trauma leading to this pregnancy, nor how she would feel about the baby when it arrived. These thoughts were now crowded out by worries about her daughter's future and the pain from her leg injury. In Ayana's case the complexity of her family's physical, emotional, and wellbeing needs required an appointment length far longer than the allotted 10 minute slot.

Ayana and her daughter were assessed by an infection and inclusion health practitioner from Respond, alongside a family support worker who was able to distract Ayana's daughter with play so that Ayana could talk about the trauma they had both endured. Ayana was then promptly referred to antenatal care services, investigated for asymptomatic infections, scheduled for immunisations, and supported to register for a school. The family's case was discussed at the local care planning meeting, and referrals to a community paediatrician and speech therapist were made, as well as a referral to family mental health services.

After 98 days in initial accommodation, Ayana and her daughter were moved to more permanent housing 200 miles away. Ayana's integrated migrant health plan assisted health professionals there to plan her care and ensured Ayana did not need to undergo the trauma of repeating her background history, including her history of sexual violence, at every new health encounter.

*Ayana is an example drawn from the combined experiences of many of the asylum seekers presenting to Respond

the family holistically, using a trauma informed approach. They start investigations according to a protocol and refer or signpost to relevant services such as antenatal care, opticians, and dentists (see table, p 15). Families are screened together, parents with their children, and appointments are longer to allow time for comprehensive assessment.

As well as referrals within the NHS, partnerships with the local authority "early help" services and non-governmental organisations allow for extra support with housing, schooling, and welfare services. After the appointment, further decisions are made at a dedicated care planning meeting in the community, or a tertiary level multidisciplinary team meeting for complex cases. The cornerstone of these meetings—and the Respond model as a whole—is the formulation of an integrated migrant health plan, an electronic document that outlines the key issues for each family member. This document stays with the family as they move around the country thus avoiding having to start again after each short notice relocation.

To deliver an efficient, effective, and scalable service, staff must have adequate training, be empowered, feel supported, and have a safe space to debrief. Alongside the clinical work, staff who work directly with patients receive a weekly training series in collaboration with the Helen Bamber Foundation, the United Nations High Commissioner for Refugees, and Forrest Medicolegal Service. Respond has also started peer support groups with the clinical psychology service for providers to be able to reflect on this emotionally challenging work.

During one month this year, for example, Respond screened 38 patients, from 10 families, in a London based general practice. Almost all these patients (91%) were found to have an acute or chronic medical issue and were appropriately triaged, often without needing a GP appointment. Screenings have picked up advanced presentations of common conditions because of lack of access to healthcare and interruptions in medication—for example, an urgent prescription for a patient with epilepsy whose seizure medication was thrown overboard on the crossing from Calais, a same day review for a patient with unexplained weight loss, and an expedited speech and language therapy appointment for a child with a debilitating stammer.

Respond has encountered disease and injury related to shrapnel wounds and torture and the first disclosures of sexual violence

Respond has encountered disease and injury related to shrapnel wounds and torture and has provided a space for the first disclosures of sexual violence. Nine of every 10 families seen needed onward referral after a careful assessment of their mental health. Respond has provided universal screening for infectious diseases and detected infections in 30% of those screened, including latent tuberculosis, strongyloidiasis, and schistosomiasis.

For the asylum seeking families that have overcome the multiple barriers to accessing healthcare, we calculate this clinic saves approximately 10 GP appointments per family, a total of approximately 100 a month. Issues are often interconnected within a family, so if each person had their problems looked at in isolation, they would take far longer to address. Providing information to patients about NHS services, as well as documenting important negative findings in the patient record (such as the absence of safeguarding concerns), will also save time in primary care.

Many of these patients have not been accessing healthcare, which is why their presentation is so complex. Engaging with the Respond team might initially lead to more planned encounters with healthcare professionals in this previously marginalised population with unmet health and social care needs. A key benefit of the model is its flexibility and potential to extend to general practices across the country. It will be relevant long after the contingency hotels stop being used and could be adapted for other underserved populations that are commonly unable to navigate the health system and have poorer health outcomes as a result.

This is a critical time for such an intervention, with a wealth of research showing the deepening of health inequalities caused by the covid-19 pandemic. As Respond continues to expand, we hope to objectively show its success in ensuring access to quality healthcare for an underserved population who, frankly, have been through enough.

Olivia Farrant, centenary research fellow
olivia.farrant1@nhs.net

Sarah Eisen

Chris van Tulleken, honorary associate professor

Allison Ward, consultant community paediatrician

Nicky Longley, consultant in infectious diseases and travel medicine, University College London Hospitals NHS Foundation Trust

Cite this as: *BMJ* 2022;376:n3069