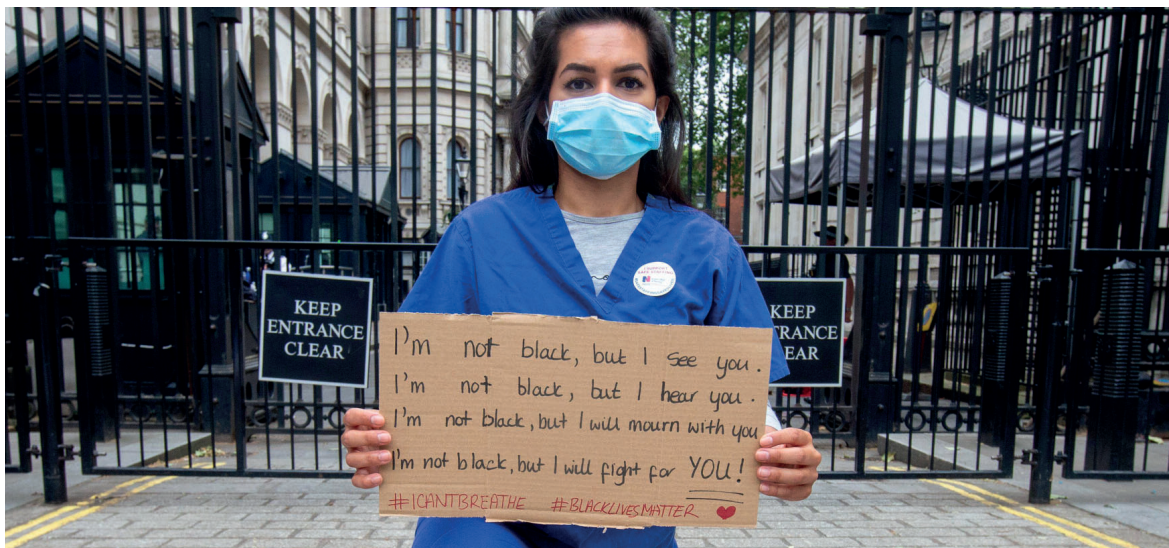


# this week

**MONKEYPOX** page 380 • **WORKFORCE PLANNING** page 382 • **LEADERSHIP REVIEW** page 384



## “Racism in NHS is forcing doctors to quit”

Widespread racism in the medical workforce is “wrecking the lives of many doctors” and forcing some to quit the profession, a hard hitting report from the BMA has warned. The report surveyed 2030 UK doctors and medical students on their experience of racism in the medical profession and the workplace.

The survey results and testimonies led the BMA to conclude that widespread racism exists on a personal and institutional level, from doctors, other NHS staff, and patients.

Three quarters (76%) of 1464 respondents who answered a question about how often they experienced racism at work said they had experienced it at least once in the past two years, and 17% reported regularly experiencing incidents.

Just under a quarter (23% of 1239 who answered the question) said they had considered leaving their NHS job because of racial discrimination, and 9% said they had already left in the past two years. Staff from black, Asian, and “other” backgrounds were most likely to have considered leaving or left.

Chaand Nagpaul, BMA chair of council, said, “The NHS was built on the principle of equality of care for patients whoever they are, but this report shows that the NHS is shamefully failing in this principle

for its own doctors, with those from ethnic minorities reporting alarming levels of unfair treatment and racial inequality at work.

“Racism is wrecking the lives of many doctors, affecting patient care and threatening services. The time for talk on this is over. Our report makes a range of clear recommendation for change which demand action across the health system, from government to NHS organisations, leaders, and other institutions.”

In other findings, 1047 doctors (52%) reported bullying in their workplace related to their ethnicity, and this was most often (68% of cases) perpetrated by senior doctors.

The report’s key recommendations include making centralised guidance on HR processes available across all organisations; mandatory training in equality, diversity, and inclusion in medical school curriculums; the introduction of mandatory reporting on the ethnic pay gap; better access to independent routes to raise concerns, such as “freedom to speak up” guardians; and requiring all organisations responsible for progression of doctors to publish their outcomes by ethnicity.

Gareth Iacobucci, *The BMJ*  
Cite this as: *BMJ* 2022;377:o1456

**Nurse Ameera Sheikh shows her support for her ethnic minority colleagues with a protest outside Downing Street earlier this month**

### LATEST ONLINE

- Experts criticise government over watered-down food strategy
- Doctor who sold hydroxychloroquine as “magic bullet” treatment for covid-19 is jailed
- NICE endorses new drug to prevent myocardial infarctions and strokes

VASCEPA

# SEVEN DAYS IN

## Doctors will have to notify local agencies of all suspected monkeypox cases



The government has amended the law to list monkeypox as a notifiable disease from 8 June. As a result, doctors in England will be required to notify their local council or local health protection team if they suspect a patient has the disease. Laboratories must also notify the UK Health Security Agency if the virus is identified in a sample.

Wendi Shepherd, monkeypox incident director at UKHSA, said, “Rapid diagnosis and reporting is the key to interrupting transmission and containing any further spread of monkeypox. This new legislation will support us and our health partners to swiftly identify, treat, and control the disease.”

The revised legislation will make monkeypox a notifiable infectious disease under the Health Protection (Notification) Regulations 2010. The government has also amended the NHS (Charges to Overseas Visitors) Regulations 2022 to make the diagnosis and treatment of monkeypox and suspected monkeypox exempt from charges for all overseas visitors.

The agency also announced it had bought more than 20 000 doses of smallpox vaccine, which will be offered to identified close contacts of people who have monkeypox diagnosed, health workers who care for patients with monkeypox, and staff working in sexual health services who may have assessed suspected cases.

Gareth Iacobucci, *The BMJ* Cite this as: *BMJ* 2022;377:o1413

### Covid-19

#### Vaccine targeting omicron shows promise

A bivalent covid booster vaccine designed to protect against the omicron variant produced a greater antibody response against omicron than boosting with the ancestral strain vaccine alone, preliminary data from Moderna showed. Antibodies were sustained at higher levels



and covered more strains for at least six months, suggesting that boosting with a bivalent vaccine may protect against breakthrough infection caused by multiple strains. However, the trial had only 437 participants, and the findings have not yet been published in a scientific paper.

#### EMA adopts first critical medicines list

The European Medicines Agency’s steering group on medicine shortages published a list of all approved vaccines and therapeutics to prevent

or treat covid-19. The list of critical medicines will be closely monitored to identify and manage potential or actual shortages. Manufacturers of medicines on the list are required to provide regular updates on available stocks and forecasts of supply and demand. EU member states must also provide regular reports on estimated demand for critical medicines at a national level.

### Maternity care

#### Migrant women and babies face inequalities in UK

A report examining inequalities in maternity care among migrant pregnant women and babies found that mental health issues occurred in over a third of 257 women surveyed. The report by Doctors of the World said the issues affecting undocumented, refugee, and asylum seeking women were “potentially exacerbated by the fact that over a third received a bill for their maternity care of up to £14 000.” The report found women had experienced challenges in accessing care, sometimes being wrongly charged (asylum seekers are exempt) or refused registration by a GP.

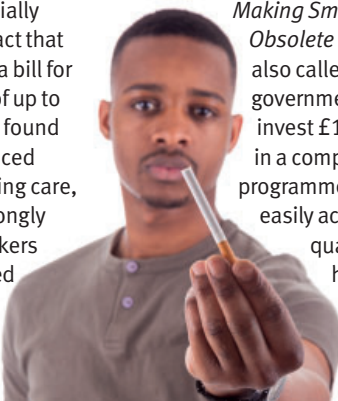
### Tobacco

#### Smoking cessation access lags in hospitals

The proportion of UK hospital patients who were offered a referral to tobacco dependence services fell from 44% in 2019 to 40% in 2021, an audit found. The British Thoracic Society’s national audit of 120 acute care hospitals in the UK from July to August 2021 found that 45% of hospital patients who smoked were given very brief advice on quitting, while only 9% were seen by a tobacco dependence practitioner while in hospital.

#### Legal smoking age “should rise every year”

England should increase the minimum age for buying tobacco products, currently age 18, by one year annually to slowly phase out smoking, said a government commissioned review. The *Making Smoking Obsolete* review also called for the government to urgently invest £125m a year in a comprehensive programme to fund easily accessible, high quality support to help smokers quit.



### Research

#### Diabetes drug produces weight loss in obesity study

A weekly injection of the antidiabetes drug tirzepatide produced “substantial and sustained weight reduction” in obese adults without diabetes, a study found. The trial participants lost as much as a fifth of their body weight on average, compared with 3% in the placebo group. Tirzepatide works by mimicking two hormones that help people feel full after eating. The randomised controlled trial, published in the *New England Journal of Medicine*, involved 2539 adults in nine countries.

### Litigation

#### MDU warns of rising clinical negligence liabilities

The Medical Defence Union said it was extremely worrying that the amount earmarked to cover the cost of clinical negligence claims against the NHS in the UK had risen to £86bn. This is a fourfold increase in the past decade, according to government accounts. Michael Devlin, the MDU’s head of standards and liaison, said, “The scale of the burden that the cost of clinical negligence has on the public purse cannot be overstated.”

# MEDICINE

## General practice

### Patients no longer need masks in GP surgeries

People who enter general practices in England no longer have to wear a face mask unless they have respiratory symptoms, said updated guidance from NHS England. But a letter sent to clinical commissioning groups and trusts underlined the importance of local risk assessments and said that increased measures could be used where necessary. It said that health and care staff should continue to wear face masks as part of personal protective equipment when working with patients with suspected or confirmed covid-19, including untriaged patients in primary care and emergency departments.

### GPs criticise decision to extend Capita contract

NHS England and NHS Improvement was criticised for extending Capita's contract to provide support services to England's primary care practitioners for an extra three years, in a move worth £94m. Krishan Aggarwal, GP and deputy chair of the BMA's Pensions Committee, said Capita had "presided over a litany of failures." He added, "With thousands of GPs' pension records missing data, the handling of pensions administration nearly seven years on from Capita winning the contract continues to be appalling."

### Remote child consultations doubled in pandemic

During the pandemic young people's contacts with GPs fell by 41%, equivalent to 2.8 million contacts, during the first lockdown from March to June 2020, when compared with previous years. However, this was mitigated by a more than twofold increase in phone and video contacts. The study authors wrote



Mask coverings are no longer mandatory for people visiting their GP

in the *British Journal of General Practice* this showed GPs largely continued to provide accessible acute care for young people.

## Pay

### Junior doctors in England threaten to strike

The BMA has said that it will prepare to ballot for industrial action unless the government commits to its demand for "full restoration" of junior doctors' pay to levels equivalent to 2008-09, adjusted for inflation, by the end of the year. The association calculates that the estimated take home pay for the average junior doctor in England has fallen by 22% in real terms from 2008-09 to 2020-21 and says that "these losses are accelerating now with inflation continuing to rise."

## Cancer care

### Private treatment provider enters liquidation

Rutherford Health, a private cancer treatment provider that last year opened a community diagnostic hub in partnership with Somerset NHS Foundation Trust, has gone into liquidation. Rutherford built a network of oncology centres but failed to strike further deals despite the NHS's catch-up drive. The company blamed the collapse on reduced patient volumes because of the covid pandemic and heavy investment in building up the network.



Cite this as: *BMJ* 2022;377:o1448

## SIXTY SECONDS ON... POWER NAPS



**YES! I HAVEN'T SLEPT WELL SINCE 2019**  
Nancy Redfern, a consultant anaesthetist from Newcastle Hospitals NHS Foundation Trust, has called for all doctors and nurses to be allowed to take a 20 minute power nap during night shifts to keep patients safe.

**SOUNDS SENSIBLE. ANY OTHER IDEAS?**  
No doctor or nurse should work more than three night shifts in a row, Redfern told the Euroanaesthesia congress in Milan last week. She also called for healthcare to have formal risk management systems like those required by law in every other safety critical industry.

**WHAT ABOUT POWERING THROUGH?**  
Not so sensible. A "sleep debt" begins building after two or more nights of restricted sleep, and it takes at least two nights of good sleep to recover from this, says Redfern. Cognitive function is impaired after 16-18 hours awake, leading to a deterioration in the medical worker's ability to interact effectively with patients and colleagues.

**OK, THAT DOESN'T SOUND GOOD**  
"When fatigue sets in, we are less empathic with patients and colleagues, vigilance becomes more variable, and logical reasoning is affected, making it hard to calculate, for example, the correct doses of drugs a patient needs," says Redfern.

**I JUST WANT TO GET HOME TO BED**  
Driving home tired is the most dangerous thing a healthcare practitioner does, Redfern warns. A survey of consultants in anaesthesia



and paediatric intensive care found that almost half have had a car crash or near miss on their commute because of fatigue. Driving after being awake for 20 hours or more and at the body's circadian low point is as dangerous as driving with blood alcohol levels above the legal limit, says Redfern. And workers who drive home after 12 hour shifts are twice as likely to crash as those working eight hour shifts.

**NIGHT NIGHT TO OVERWORK CULTURE?**  
The Association of Anaesthetists, the Faculty of Intensive Care Medicine, and the Royal College of Anaesthetists launched a joint #FightFatigue campaign back in 2018. But since then chronic workforce shortages have only worsened, so we probably shouldn't hold our breath for immediate change.

Jacqui Wise, Kent  
Cite this as: *BMJ* 2022;377:o1424

## Pharmacists and nurses to certify fit notes to cut GPs' load

A wider range of health professionals will be able to certify fit notes to ease pressure on GPs, under new rules going through parliament.

New legislation will allow pharmacists, nurses, occupational therapists, and physiotherapists to provide sick notes. Once passed, the law change will take effect from 1 July and apply across England, Wales, and Scotland.

The BMA has welcomed the move, but the Royal Pharmaceutical Society said it had a

“number of concerns.” Its president, Claire Anderson, said, “First, although pharmacists working in general practices have access to medical records, this is not the case for community pharmacists: it is essential this is changed

to ensure pharmacists have access to all the information required to be able safely to provide a fit note. Second, pharmacists have a significant workload so additional roles must be properly planned for and funded services developed.”

### Clear information

Anderson added, “It is essential that the public is given clear information about where fit notes can be obtained and not misled that they can be provided by all pharmacists.”

A spokesperson for the Department of Health and Social Care for England clarified that the policy is aimed at professionals working within general practices or hospital settings. “The intention is that where the fit note is certified will remain the same, but who provides it will change.”

They added, “Fit notes should only be given following a full assessment of a patient’s fitness for work and therefore would be an unsuitable service to be provided over the counter.”

The BMA has been lobbying for change for some time. Kieran Sharrock, deputy chair of its England GP committee, said, “This is a positive step. The BMA has been clear for many years that it may not always be necessary or appropriate for a GP to provide a fit note, especially where a patient has seen a different member of the practice team for their condition, such as a nurse or physiotherapist.”

He added, “Reducing unnecessary administration and bureaucracy, while taking a more flexible and pragmatic approach to patient services, is absolutely vital.”

Jacqui Wise, Kent

Cite this as: *BMJ* 2022;377:o1436

## Javid says workforce plan may not be fully published

A highly anticipated workforce plan that will set out the numbers of staff required by the NHS may not be published in full.

England’s health and social care secretary, Sajid Javid, told a committee of MPs last week that the 15 year strategy report currently being drawn up by NHS England and Health Education England would be ready by the end of the year.

It will include data on workforce requirements by specialty and provide a gap analysis to inform training plans. He said, however, that while he would like to see the document published in full he could guarantee only that its conclusions would be published.

“When the workforce strategy is complete, we will certainly publish the conclusions,” he told the Health and Social Care Committee on 7 June. He added that publishing the report in full was “something I’d like to do” but the decision would be subject to cross government agreement and he could not pre-empt that decision.

Javid was giving evidence to the final session of the committee’s inquiry into the recruitment, training, and retention of NHS and care staff. He described the strategy as “very important” work and “something the NHS has never done before.”

The plan is one of three major strands of work that the government is undertaking to examine and tackle workforce

### WHAT IS THE GOVERNMENT'S STRATEGY?

- 1 Health Education England’s “Framework 15”—a review of the long term strategic trends and drivers in healthcare and associated requirements in care delivery (technology required, and the skills needed by care staff). The report was to be published in the spring but is at final stages and is expected before the parliamentary summer recess
- 2 An update to the 2019 NHS long term plan will take account of covid-19 and future demands of the service. Report is to be published this summer
- 3 A workforce plan—a 15 year workforce strategy—to set out what numbers of staff the NHS will need now and in future. NHS England and HEE have been asked to produce the report by the end of the year. Its conclusions will be reported, but it’s not clear whether the full modelling and figures will be published.

### OPINION

## MPs struggle to get answers on plans to solve the workforce crisis

If it’s futile to do the same thing again and again while expecting different results, then MPs on the health and social care committee must be feeling rather disturbed.

Throughout their staffing inquiry they have heard from frontline workers how shortages affect their work and care standards.

Leicester based GP Emma Hayward told

them she had never seen so many colleagues so close to burnout or working while burnt out. Workloads, she said, had become so tough that a day in general practice felt like being “pelted with rocks.”

But the committee already knew that excessive workload was damaging patient care and staff retention—its inquiry into burnout and

resilience last year had made that very clear.

So, at the final evidence session in its latest inquiry on 7 June, “When will the NHS get the sufficient number of staff to meet demand?” seemed like a very reasonable question.

During the session, the MPs quizzed NHS England’s chief executive, Amanda Pritchard, followed by the man with

pressures in the NHS and social care in the future, he said (see box).

During the session the panel of MPs, chaired by former health secretary Jeremy Hunt, questioned Javid and NHS England chief executive Amanda Pritchard about plans to tackle the staffing crisis across health and social care services.

Sharing evidence gathered from patient facing workers during the course of their inquiry, which began last November, they raised concerns about the lack of evidenced based workforce planning, as well as the impact of inadequate staffing on care givers.

### Significant challenges

With the current 100 000 vacancies in the NHS, it is apparent that major workforce challenges will remain for some time, since there were no new “ready made” solutions the government could deploy. Yet staff will see their workloads rise as the NHS tackles the backlog of care because of covid.

Javid told the committee the number of people waiting for NHS care now stood at 6.3 million. “Somewhere between 11 and 12 million people stayed away because of the pandemic and, obviously, I want as many of those people to come back,” he said. This would see NHS activity increase to 130% on its pre-pandemic level.

Both Javid and Pritchard acknowledged the efforts of NHS staff

in delivering services despite staff shortages. Pritchard said, “As we look back over the past few years, what we can see is that the NHS—having done an absolutely tireless job of trying to pull out all the stops to look after patients over covid and continuously adapting, introducing new services, and scaling up critical care services overnight—is now facing what, if anything, is an even harder task of recovery.”

But neither could be pinned down on when the NHS would have sufficient capacity to meet its growing demand or when it would meet key staffing targets.

Pritchard told the committee the NHS was tackling staff shortages by focusing on improving retention of current staff, through providing wellbeing services and pension reforms, and recruiting new staff to fill some gaps from both domestic and international markets. Also, looking to the future, more professionals would be trained, and there would be plans to create new roles and use technology to work in different ways.

Rosie Cooper, a member of the committee and MP for West Lancashire, asked whether the full outcome of the workforce plan should be kept secret.

**JAVID** told the committee the number of people waiting for NHS care now stood at **6.3 million**



JACOB KING/PALAWMY

**Sajid Javid, here with Amanda Pritchard, head of NHS England, told MPs that only the plan’s conclusions are certain to be published**

“I don’t understand why we can’t share the numbers,” she said. “If it’s a secret, that makes everybody suspicious.”

David Wrigley, BMA council deputy chair, said it was “imperative” that the plan be published in full.

He said, “The BMA, alongside more than 100 other expert organisations, charities, and former NHS leaders, has been pushing for independent, long term workforce projection data to be routinely published throughout the Health and Care Act’s recent journey through parliament. This modelling is key to putting the workforce back on a sustainable footing and supporting more strategic spending decisions, yet it was bafflingly rejected by the government.

“If ministers won’t commit to publishing the workforce strategy in full, including the analysis of shortfalls of staffing numbers, we’re left to question what they’re trying to hide.”

Adele Waters, *The BMJ*

Cite this as: *BMJ* 2022;377:o1429

overall responsibility, England’s health secretary, Sajid Javid.

However many ways the committee tried to extract an answer to this fundamental question, it never got an answer. And by the end of the near two hour session it wasn’t clear they ever would.

An exchange between the committee’s chair, Jeremy Hunt (the Tory former health secretary) and Pritchard gave a flavour of the discussion. Hunt asked when the NHS would get the 2000 midwives and 500 obstetricians

recommended not only by his committee but by the Ockenden review.

Since it was published in March, he said, the NHS had lost 552 midwives, so “what precisely is happening to make our maternity units safer?”

Pritchard responded by setting out how she would reply. “Let’s talk about the wider challenge around maternity services,” she began and then talked about “increasing investment.” This “isn’t just a ‘this year’ thing. It’s very much something that’s

been now,” she said.

She talked numbers—£95m last year and £127m this year were invested in maternity services. “A lot of that goes directly into additional establishment,” she said.

Hunt tried again: “I understand the money’s going up, but the midwives are going down—and that’s the worry. So why is that

happening? And what are you going to do to stop that?” he asked.

Undeterred, Pritchard continued where she left off. “So, we’ve seen 1692 additional midwifery roles recognised in establishments, 181 full time obstetric roles, but there is a difference between having the role and having the skilled person available to fill that role, which I think is the distinction we’re drawing.”

If Hunt was irritated, it didn’t show. He reframed the question simply,

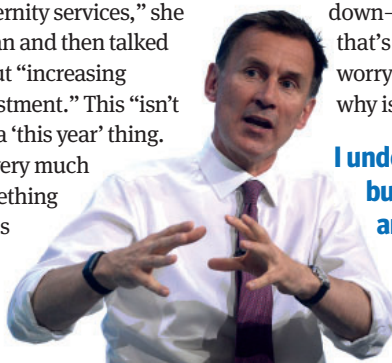
“When do you think the number of midwives is going to start going up?”

Surely now she’d give him something? But no, Pritchard took the question as a cue to talk about increasing midwifery training places by March 2023.

Hunt resorted to asking if her department could supply an answer in writing instead. The committee won’t be holding its breath.

Adele Waters, *The BMJ*

Cite this as: *BMJ* 2022;377:o1428



**I understand the money’s going up, but the midwives are going down—and that’s the worry** Jeremy Hunt

# NHS faces management overhaul after review finds discrimination and bullying

After the publication of the Messenger report the government has announced the “biggest shake-up in health and social care leadership in a generation.” **Jacqui Wise** reports

**O**n 8 June the government published the findings of an independent review into health and care leadership in England that found evidence of discrimination, bullying, and blame cultures in the NHS.

The review—led by Gordon Messenger, former vice chief of the defence staff, and Linda Pollard, chair of Leeds Teaching Hospitals NHS Trust—recognises the current pressures faced by the workforce and found many examples of inspirational leadership.

But it also notes a lack of consistency and coordination and says that over time “institutional inadequacy” has developed in the way that leadership and management staff are trained, developed, and valued.

“A well led, motivated, valued, collaborative, inclusive, resilient workforce is the key to better patient and public health outcomes, and

**NHS leaders shouldn't be treated as football managers, sacked before they have had time to turn round performance**

Matthew Taylor

must be a priority,” said Messenger. “The best organisations are those which invest in their people to unlock their potential [and] foster leadership and accountability at every level, with good leadership running through the entire workforce.”

## Damaging scandals

The review was commissioned after a number of damaging scandals at NHS trusts. Earlier this year a damning review of maternity services at Shrewsbury and Telford NHS Trust found a longstanding failure of clinical governance, where a “continual churn” of the executive team and board had led to an inability to deliver improvement.

The review team met more than 1000 frontline staff, managers, and leaders across health and social care to hear their views. They found that acceptance of discrimination, bullying, blame cultures, and avoidance of responsibility, had become almost normalised in certain parts of the system. The team sensed a lack of psychological safety to speak up and listen in the NHS, despite progress made since the Francis report of 2013 into care failings at Mid Staffordshire NHS Foundation Trust.

The new review also highlights widespread evidence of considerable inequity in experience and opportunity, particularly regarding race and disability. It identifies a lack of equal opportunity for managers to access training or to progress in their careers, because those with existing networks or contacts can more easily access such opportunities.

Collaborative behaviour is not always encouraged or rewarded in a system that still relies heavily on siloed personal and organisational accountability, the review says. It adds that very public external and internal

pressures combine to generate stress in the workplace. “The sense of constant demands from above, including from politicians, creates an institutional instinct, particularly in the healthcare sector, to look upwards to furnish the needs of the hierarchy rather than downwards to the needs of the service user,” it says.

The review sets out new plans to attract leaders to the most pressured areas of the NHS, with a package of support and incentives. It recommends greater support for managers and leaders at induction and a stronger focus on good appraisals for staff.

England's health and social care secretary, Sajid Javid, said, “The findings in this report are stark: it shows examples of great leadership but also where we need to urgently improve. We must only accept the highest standards in health and care—culture and leadership can be the difference between life and death.”

The report has been broadly welcomed, although the NHS Confederation and the King's Fund have criticised it for giving only a limited focus on supporting leaders in primary care and social care.

Matthew Taylor, chief executive of the NHS Confederation, said that the report was right to point out the gaps in support for NHS leaders, particularly those who take on more challenging roles. “NHS leaders are not football managers, and they shouldn't be treated as such, taking on difficult jobs only to be sacked before they have had time to turn round performance,” he said. “We need to better support them and reward them for taking on tough roles.”

Taylor added that the review had shown the need for more diverse leadership. “We can't hide from the fact that all too often staff from ethnic minority backgrounds are still not

## KEY RECOMMENDATIONS

The report makes seven recommendations, all of which have been accepted by the government:

- An induction for new joiners to instil core values across health and social care and a mid-career programme for managers
- Stronger action to improve **equality**, diversity, and inclusion
- Consistent management standards, delivered through accredited training
- A simplified, standard appraisal system for the NHS
- A new career and talent management function for managers, providing clear **routes** to progression and promotion
- More effective recruitment and development of non-executive directors, and
- Greater incentives and **support** to encourage top talent into the parts of the system facing the greatest challenges.





**THE BMA's** report on racism in medicine  
found that **60%** of Asian and **57%** of black doctors  
cited racism as a barrier to their career progression

being provided with the support they need to progress to leadership roles. We need to move beyond admiring the problem and make concrete progress in addressing it," he said.

**Exhausted workforce**

The King's Fund pointed out that the report comes during a deep workforce crisis that the government has been reluctant to face up to. Suzie Bailey, the fund's director of leadership and organisational development, said, "Health and care leaders can—and will—work hard to support their staff and get the most out of the resources available, but there is a limit to what a leader can do when faced with an exhausted workforce and chronic staff shortages."

Saffron Cordery, interim chief executive of NHS Providers, said that the "constructive" report "rightly highlights the crucial role of NHS managers and the importance of investing in people alongside operational and political priorities." But she added, "We continue to call for a fully costed and funded workforce plan to deal with future demand."

Malte Gerhold, the Health Foundation's director of innovation and improvement, said the report was a "promising start" but the recommendations needed to be backed up with action and resources. "If the NHS is to retain good managers and encourage talented people to join, it is vital that ministers and senior officials

**Linda Pollard, coauthor of the leadership review**



give the profession their full and unequivocal backing and champion their value to the NHS," he said.

Ricky Bhabutta, joint chair of the BMA's Committee for Medical Managers, said, "We share the review's commitment to tackle bad behaviour, end the blame culture, and improve working relationships. The need to tackle discrimination and ill treatment, and instead respect the potential for leadership and creativity at all grades, is key. Our recent report on racism

**It is vital ministers give the profession their full, unequivocal backing**

Malte Gerhold

as a failing of the institutional set-up," he said. "Medical managers and their teams shouldn't have to endure an 'us and them' mentality: the benefits of a good leadership structure are incalculable for the whole NHS, and as representatives of both medical managers and doctors we embrace the collaborative spirit this review was written in.

He added: "We will be watching the progress of the government's response to these recommendations closely.

By giving doctors the right tools we can ensure the conditions where the best candidates—not only the most confident ones—can thrive."

Jacqui Wise, Kent

Cite this as: *BMJ*

2022;377:o1419

OPINION, p400

**FIVE MINUTES WITH . . .**

**Martin Griffiths**

The head of NHS England's violence reduction programme on breaking the cycle of aggression among young people

"Anybody who works near or has been affected by violence asks the question, 'Why? Why is this happening in a first world country? Why are we seeing young people harmed by other young people? Why is it not changing?'

"Young people coming through our emergency departments, having been injured, often seriously, on our streets, are going back to challenging homes and then reattending hospital with other injuries or harming other people. The likely outcomes? They end up in the criminal justice system, at a criminal healthcare facility, or dead.

"[I came to realise that] there wasn't really a solution fit for purpose. There were lots of things going on that had some good elements, but no one engaged with these individuals and their families at a human level. I thought that we could do that at the Royal London Hospital: give those affected by violence the space in hospital to take time to take stock of their lives, independently speak to non-biased facilitators, build a solution right for them as individuals, and work from there.

"The London Violence Reduction Programme aims to extend work started in some hospitals and will produce tools and guides. It helps provide support for people aged 11-25 who are affected by violence.

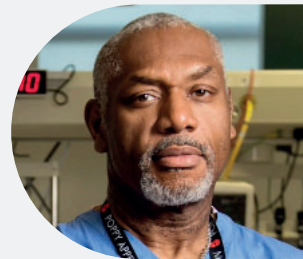
"Using methods outlined in the programme's in-hospital guide, the Royal London has seen a reduction in the number of young people returning with further injuries, down from 25% to less than 7% over a six year period—the longest observed period recorded.

"Our case workers' primary agenda is to support the individual. It's about helping them reimagine the future and achieve it. Our case managers have life experiences that are helpful and unique sets of skills: communication, understanding, and emotional intelligence.

"This is the culmination of the efforts of a huge number of individuals. It's the voice of a community; and one thing we've learnt, most importantly, is that healthcare hasn't got all the answers but that we can be an advocate for change—and we can change life for the better."

Martin Griffiths is a consultant trauma surgeon at Barts Health NHS Trust and clinical director of the London and NHS England National Violence Reduction Programme

Melina Zachariou, London Cite this as: *BMJ* 2022;377:o1380



**THE NUMBER OF YOUNG PEOPLE RETURNING WITH FURTHER INJURIES CAME DOWN FROM 25% TO LESS THAN 7% IN SIX YEARS**

**THE BIG PICTURE**

**Doctors act to fulfil duty of care  
in the climate crisis**





Healthcare professionals from across the UK gather outside Downing Street to protest against the continued use of government subsidies and licences for fossil fuel producers.

The protesters, whose action was organised by Doctors for Extinction Rebellion, Medact, and Health for a Green New Deal, also delivered a letter to the prime minister. It pointed out that the government's healthcare guidance states that the country is "particularly at risk of drought, flooding, and extreme weather events, all of which threaten the water, food, infrastructure, and supply systems we depend on."

Speaking at the 11 June demonstration, Fiona Godlee, former editor in chief of *The BMJ*, said, "Our political leaders are neglecting their duty of care to the young people of this country whose futures are now at risk, so we as health professionals feel morally obliged to protest on their behalf."

Alison Shepherd, *The BMJ* [Cite this BMJ 2022;377:01450](#)



HECTOR RETAINAL/AFFGETTY

# Inhaled anaesthesia and climate change

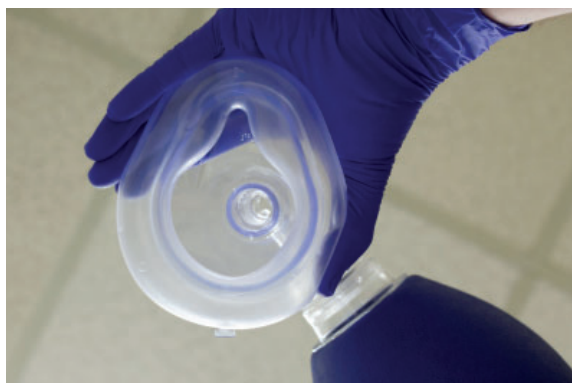
We need clear targets and timelines for reducing emissions

The healthcare industry is a major contributor to harmful pollution, including nearly 5% of all global greenhouse gas emissions.<sup>1</sup> Inhaled anaesthetics are a uniquely clinical source of greenhouse gases, making them of particular interest.<sup>2</sup>

All inhaled anaesthetics are potent greenhouse gases with heat trapping properties hundreds to thousands of times greater than an equivalent mass of carbon dioxide.<sup>10</sup> In addition, some inhaled anaesthetics, notably nitrous oxide (N<sub>2</sub>O), also contribute to the depletion of the ozone layer. During clinical use, inhaled anaesthetics are mostly exhaled through gas scavenging (vacuum) systems to protect against indoor occupational exposure and are ultimately all released to the outdoor atmosphere in an uncontrolled manner.

Volatile hydrofluorocarbon anaesthetics (desflurane, sevoflurane, isoflurane), and N<sub>2</sub>O are used routinely during intraoperative care.<sup>2-11</sup> Estimates of their contribution to total global greenhouse gas emissions range from 0.01% to 0.1%.<sup>2-11</sup> In clinical contexts, inhaled anaesthetics can account for 50% of perioperative emissions,<sup>12</sup> 5% of emissions from hospitals,<sup>13-14</sup> and 3% of total national healthcare emissions.<sup>2-14</sup>

N<sub>2</sub>O is also widely used for analgesia in labour and in dental clinics, paediatric units, emergency departments, and pre-hospital settings. N<sub>2</sub>O analgesia is often inadequate in labour, with around 40-60% of women changing to epidural analgesia,<sup>17-18</sup> and more selective use of N<sub>2</sub>O—for its anxiolytic properties, for example—should be explored. Recent independent reports from the UK, Australia, and the US further note that large fractions (77-95%)<sup>3-7</sup> of hospital N<sub>2</sub>O are lost before clinical use, through leaking central pipeline



**All inhaled anaesthetics are potent greenhouse gases**

systems. Beyond anaesthesia and analgesia, compressed N<sub>2</sub>O gas is also used as a primary refrigerant for cryosurgery in cardiac and endoscopic ablations.<sup>19</sup>

In clinical doses, the carbon dioxide equivalent emissions associated with desflurane and N<sub>2</sub>O are about 40 times greater than those associated with sevoflurane or isoflurane at similar gas flow rates.<sup>2-4</sup> And, desflurane and N<sub>2</sub>O account for the overwhelming majority of measured emissions from anaesthetic gases.<sup>12-20</sup> By comparison, life cycle greenhouse gas emissions of intravenous propofol, sedatives, and local anaesthetics are several orders of magnitude lower than for inhaled anaesthetics.<sup>4-21</sup> Environmentally preferable drug and clinical care pathways should be selected when clinically safe.

## Trapping gas

New technologies for capturing (volatiles) and destroying (N<sub>2</sub>O) waste anaesthetic gases may be promising,<sup>2-23</sup> but substantial quantities of gas never make it into scavenging systems for potential collection or destruction.<sup>7-24</sup> For example, the pain of labour makes it difficult for many women to exhale properly through the face masks used to self-administer N<sub>2</sub>O. Inhaled inductions of anaesthesia and deep extubations are also poorly scavenged and often used in children.

Reuse of captured and reprocessed volatile drugs has yet to receive

broad regulatory approval, and sequestration presents new environmental concerns regarding transportation and storage. Avoiding use of inhaled anaesthetics and preventing waste (lowering fresh gas flow rates and decommissioning central pipelines) remain higher priorities (see box on [bmj.com](http://bmj.com)).<sup>2-23</sup>

To guide improvement and accountability, health systems should measure their emissions of inhaled anaesthetic gases, set reduction targets and timelines, and track progress. The American Society of Anesthesiologists' inhaled anaesthetic 2022 challenge suggests aiming to reduce emissions by 50% this year.<sup>25</sup>

Health facilities can use procurement records to estimate their emissions, and these should be adjusted for clinical activity to enable meaningful comparisons between institutions. Clinician performance can be tracked using mean gas flow rates per hour of anaesthetic and intensity of emissions (kgCO<sub>2</sub>e/hour) where electronic health records exist. A data driven, iterative process of comparative reporting against best practice standards can be effective in inspiring improvement among individual clinicians and healthcare organisations. Accountability can be enhanced through institutional, national, and international policies and through professional societies.

Efforts to decarbonise healthcare risk not going far enough or fast enough if progress relies on the voluntary initiative of individual clinicians, facilities, or health systems. A regulatory framework of standardised, mandatory reporting and accountability is critical to achieve the widespread engagement required to reduce healthcare's substantial greenhouse gas emissions.

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# Looking at HRT in perspective

Helping women make informed choices

**W**ith average life expectancy in developed countries now exceeding 80, many women will live around a third of their lives after the menopause. More than 75% of those experiencing the menopause report symptoms, and over 25% describe their symptoms as severe. Average duration of symptoms is seven years, and a third of women have symptoms for longer.

For those seeking help, the National Institute for Health and Care Excellence (NICE) and others<sup>1-4</sup> recommend an individualised and comprehensive approach that includes advice on exercise, optimising weight, stopping smoking, and reducing alcohol consumption as well as management options such as hormone replacement therapy (HRT). The latest evidence for women considering HRT is reassuring, including for all-cause mortality.

The main indication for HRT remains control of problematic menopausal symptoms and improving quality of life. Evidence from randomised trials shows clear benefits in this context,<sup>5</sup> and no arbitrary limits should be placed on duration of use.<sup>1-4</sup> HRT may help relieve short term cognitive symptoms related to the menopause, but evidence does not support use of HRT to reduce the risk of dementia.<sup>1-7</sup>

Current evidence suggests that oestrogen only formulations are associated with little or no change in the risk of breast cancer, while combined HRT (oestrogen plus a progestogen) can be associated with an increased risk. This appears duration dependent and may vary with the type of progestogen used.<sup>1-10</sup> However, the risk is low (absolute excess risk of breast cancer over 10 years is 3-7/1000 women taking combined HRT for up to 5 years).

## Risk of breast cancer should be placed in the context of the overall benefits from HRT

Risk of breast cancer should be placed in the context of the overall benefits from HRT. For most women with menopausal symptoms the benefits are likely to outweigh the risks.<sup>1-10</sup> NICE's review of trials and cohort studies shows that HRT significantly protects against fragility fractures related to osteoporosis and helps prevent osteoporosis in both spine and hip.<sup>1-4</sup>

## Coronary heart disease

Furthermore, evidence from a Cochrane review of randomised trials and from large observational studies in symptomatic menopausal women noted a significant reduction in coronary heart disease, including cardiovascular mortality, among women who started HRT before the age of 60 (10/1000 v 18/1000 with placebo; relative risk 0.52, 95% CI 0.29 to 0.96). An additional analysis in 9088 women found a significant reduction in all-cause mortality (16/1000 v 22/1000 with placebo; 0.70, 0.52 to 0.95).<sup>11</sup>

This protective effect was not seen among women who started HRT more than 10 years after the menopause in either the long term follow-up of the Women's Health Initiative trials (WHI) or the Cochrane analysis. Notably, there was no increase in risk of cardiovascular events, cardiovascular mortality, or all-cause mortality.<sup>11</sup>

A pooled analysis of the WHI trials found a significant reduction in all-cause mortality among women aged 50 to 59 years who took HRT for an average of 5.6 years (combined HRT) or 7.2 years (oestrogen only) compared with placebo, after a median of 18 years' follow-up (hazard ratio 0.69, 95% CI 0.51 to 0.94).<sup>14</sup>

An analysis of long term follow-up data of 9939 women aged 50-79 from WHI also reported a significant reduction in all-cause mortality among 1129 women



BSIP/LAWNY

aged 50-59 who took oestrogen-only HRT after bilateral salpingo-oophorectomy compared with those who received placebo (hazard ratio 0.68, 0.48 to 0.96).<sup>13</sup>

A systematic review and meta-analysis of observational studies and randomised trials noted a significant reduction in all-cause mortality in women who started HRT before the age of 60 within the observational studies. However, no significant reduction was noted in the subgroup analysis of randomised trials.<sup>15</sup>

Finally, a systematic review and meta-regression analysis of 31 randomised trials found that women who started HRT under the age of 60 had lower odds of coronary heart disease (odds ratio 0.61, 0.37 to 1.00), cardiovascular mortality (0.61, 0.37 to 1.00), and all-cause mortality (0.72, 0.57 to 0.91) compared with controls or those not taking HRT.<sup>16</sup>

The balance of benefits and risks, however, does not support use of HRT for primary or secondary prevention of disease, and international guidance recommends against use of HRT without a clear indication.<sup>2,4</sup>

Healthcare providers should take an individualised approach to assessment and empower women to make informed decisions. Nobody should be suffering in silence or feel that the effect of the menopause is not adequately recognised.

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## MEDICAL REGULATION

# Suspended for just one word: why GMC processes need overhaul and how that could happen

The case of Manjula Arora and her laptop has caused uproar over fitness to practise referrals. **Elisabeth Mahase** asks how they could be reviewed—and reformed

**I**n May the GP Manjula Arora (above right) was given a one month suspension for dishonesty over her use of the word “promised” when speaking to her employer’s IT department about getting a new work laptop. The case has sparked controversy in the medical community, with many questioning what it says about the process for fitness to practise referrals and the decision making that underpins it.

### Does the referral process need a review?

In response to the backlash from doctors the General Medical Council has said it will review the Arora case to see whether there are “lessons to be learnt for future cases.” However, many people believe that more action is needed.

The BMA, the Doctors Association UK (DAUK), and the British Association of Physicians of Indian Origin (BAPIO) have all expressed serious concern about the referral system, in particular its treatment of doctors who train overseas and those from ethnic minority groups.



**Nothing short of radical reform can secure justice and fairness in medical regulation**  
Chaand Nagpaul



### Referral rates among doctors qualifying overseas are three times that among doctors who qualified here

Arora trained in India before moving to the UK in the early 1990s. Compared with white doctors, those from ethnic minorities are twice as likely to be referred to the GMC by their employers for concerns over fitness to practise. And the referral rate among doctors qualifying outside the UK is three times that among doctors who qualified in the UK.

Writing in *The BMJ*, the BMA's chair of council, Chaand Nagpaul, said there must now be an independent review and reform of GMC processes to “ensure fairness in medical regulation.”

He wrote, “The GMC has since indicated that it will seek to understand whether there are lessons to learn from this case. However, this falls well short of what is needed. The catalogue of concerns—from the point of referral, [through the] GMC investigation to a tribunal hearing—further supports the BMA's call for a root-and-branch, independent review with radical reform of the entire pathway. Nothing short of this can secure justice and fairness in medical regulation.”

### Who has the power to undertake a review?

The BMA has said that the GMC could commission its own independent review of its processes, following similar procedures to ones it has used in the past, such as its 2019 “Fair to Refer?” review. Alternatively, the Department of Health and Social Care for England could undertake or commission a review, as it did with the Williams review of gross negligence manslaughter. Third, the Professional Standards Authority for Health and Social Care could undertake a special review.

### What is the Professional Standards Authority for Health and Social Care and what powers does it have?

The authority was created in response to the 2001 Kennedy report on deaths of children undergoing heart surgery at Bristol Royal Infirmary to promote the safety and wellbeing of patients by raising standards of regulation. It has the power to review decisions on

practitioners' fitness to practise made by the regulators it oversees (including the GMC, the General Pharmaceutical Council, and the Nursing and Midwifery Council). If it decides that a decision does not "protect the public properly" it can refer it to court to be considered by a judge.

When the outcome of the Arora case became public the DAUK and BAPIO wrote to the Professional Standards Authority highlighting their concerns. In a statement the authority then said, "We are aware of the recently published decision by the Medical Practitioners Tribunal Service (MPTS) to suspend Dr Manjula Arora for one month. This decision, along with the GMC's investigation and the decision by Dr Arora's employer to refer the case to the GMC, has caused significant concern within the medical community."

The authority said it now wishes to "understand more about the concerns in this case and the extent to which they may apply to other cases" and will be seeking more information from the GMC, BMA, DAUK, and BAPIO. "This information will help inform the scope of any further work we undertake, as part of our performance review function, to understand how the GMC's fitness to practise processes are operating, including the impact they are having on registrants from ethnic minorities and overseas-trained doctors," the statement said.

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### Could a special review lead to reform?

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Although the Professional Standards Authority can decide to carry out a special review of a regulator, without direction from the health secretary or the regulator itself it can only provide advice. This means it will be up to the health secretary or regulator to decide whether any further action is taken.

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### Will the health secretary or regulator carry out reform?

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The GMC's legislative framework was first set out in the Medical Act 1983. Nearly 40 years later the health department is working to reform that legislation.

Commenting last year, GMC chief executive Charlie Massey said, "The world in which doctors practise today is fundamentally different, but the legal framework governing how they're regulated has remained largely unchanged. Until now, regulators have tried to work around this, pushing at the boundaries of legislation to make our interventions more responsive. But we've reached the limits of what we alone can do."

So far the government has carried out two consultations. The first, "Regulating healthcare professionals, protecting the public," looked at ways to modernise the legislation relating to the healthcare professional regulators. It proposed the introduction of a three stage fitness to practise process for all healthcare regulators: initial assessment, a case examiner stage, and a fitness to practise panel stage. It also included the recommendation from the Williams review of gross negligence manslaughter to remove the GMC's right to appeal the decision of a fitness to practise panel, as happened in the case of Hadiza Bawa-Garba.

This was met with a mainly positive response from the GMC, which said that the reform could provide a more flexible regulatory

**The Professional Standards Authority has said it wants to understand more about the concerns in this case and the extent to which they may apply to other cases**



RICHARD H SMITH

**The GMC has reached the limits of what we alone can do**

Charlie Massey

framework, giving it more powers to resolve fitness to practise cases sooner and the ability to develop a fitness to practise process that was less adversarial.

However, it did raise some concerns, including that the proposed consolidation of the grounds for action in fitness to practise cases to just "misconduct" and "lack of competence" could "risk undermining our ability to protect the public where a health condition or lack of knowledge of English poses a risk to a doctor's ability to practise safely, but where harm has not yet occurred."

The second government consultation, "Healthcare regulation: deciding when statutory regulation is appropriate," looked at which professions require statutory regulation.

Both consultations have yet to report findings.

The GMC has said that, once the health department has finished the consultation process, it will put the new legislation before parliament. At this point, the regulator will then seek views on the rules, policies, and guidance needed to implement the legislation in practice. Any changes will then come into effect over several years after the legislation has passed through parliament.

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### Is this the reform the GMC's critics are calling for?

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In response to the health department's first consultation the BMA said it was not convinced that the effect of the proposed greater powers for regulators had been "comprehensively considered." It warned that the proposals "do not include sufficient representation for registrants within regulators' decision-making structures, leaving entire professions vulnerable to ill considered actions by regulators."

In the short term Nagpaul has called for an external scrutiny panel immediately to begin assessing all potential fitness to practise referrals by an employer to the GMC to ensure they are fair and to consider whether they could be dealt with more appropriately and quickly locally.

When *The BMJ* asked the BMA about specific changes it would like to see to the referral process it provided no further detail.

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FEATURE

# Public health experts decry India's star ratings for processed food

Critics of new front of pack labelling scheme clash with food industry over its influence in a country naive in regulation in the sector. **Neha Bhatt** reports

India's packaged and processed foods will soon have a health star rating (HSR) displayed on the front of packaging after the scheme was approved by the country's food safety regulator.

The front of pack labelling (FoPL) regulation, approved by the Food Safety and Standards Authority of India (FSSAI) under the central health ministry, will aim to start awarding stars a year from now, grading processed foods based on salt, sugar, and fat content, as well as other ingredients, to give an overall assessment of the product.

Companies will then be asked to display the HSR on packaging voluntarily, though the policy is likely to state that ratings will become mandatory from 2027. Currently, packaged food companies are only mandated to display back-of-pack nutritional information.

But India's health and nutrition experts and consumer advocacy groups are collectively opposing the move. Over 22 organisations—including the Public Health Foundation of India, the Indian Academy of Paediatrics, and the Centre for Science and Environment—said in a position statement that what India needs to fight a growing epidemic of lifestyle diseases is mandatory warning labels on ultra-processed, packaged food.

**It's like using a silencer with a gun—it does not reduce the injury**

K Srinath Reddy



A system such as HSR will create a “health halo” around unhealthy products and confuse and mislead consumers, they said. As part of their campaign against the new regulation, representatives have written to Prime Minister Narendra Modi to intervene and roll back the decision to go with HSR.

Indian experts fear the star rating will be misused and dilute the purpose of FoPL and the right of consumers to make informed decisions about food. “Promoting an HSR is a devious attempt to present packaged food as healthy,” said K Srinath Reddy, president of the Public Health Foundation of India. “By adding a smattering of protective foods, and by not

reducing salt and sugar, you are not in any way decreasing the addictive nature of the foods. It's like using a silencer with a gun—it does not reduce the injury.”

## Star ratings

HSRs have been criticised before. Australia and New Zealand adopted similar systems in 2014, but studies found that they had little positive impact on health. The voluntary nature of the system lowered the effectiveness “because labels were mostly placed on already healthy products.” Others found foods high in sugar were awarded 4 or more stars by adding “positive” ingredients such as protein or vitamins.

The food industry in India is valued at £35bn a year and this is expected to double in 5-10 years. As accessibility, affordability, and demand for processed foods rockets, malnutrition worsens; less than 10% of children in India have access to nutritiously diverse food, says Vandana Prasad, a community paediatrician and public health professional.

“The penetration of these foods is very high in remote areas and it's available cheaply, for as little as INR5-10 (£0.05-0.10) a packet. So, while we need other kinds of





JEFFREY ISAAC GREENBERG/ALAMY

social protection measures, simple warning labels—such as a red sign for ‘unhealthy’—will work for the population that is not nutrition literate.”

Government data show that one in four Indians is obese. Non-communicable diseases comprise 60% of total deaths in India. “Moving forward with HSR is a retrograde step. A star rating may further enhance our rising consumption of processed foods because a star will give a positive connotation to unhealthy food products,” said Arun Gupta, convener, Nutrition Advocacy in Public Interest, citing alternative examples of warning labels successfully curbing junk food consumption in countries such as Chile and Israel.

### Survey criticised

FSSAI’s new policy has long been in the making. In 2013, a Delhi high court directed it to curb the sale of junk food and tighten regulations. After years of discussions on FoPL with representatives from the food industry, consumer groups, and the public health sector, in 2021 FSSAI decided to take the question to consumers, surveying over 20 000 participants from across the country on their preferences for nutrition labels.

**The general philosophy is that positive nutrients should never outweigh the effects of harmful ingredients**

Arun Singhal

The authors of the survey report concluded that both HSR and warning labels are “highest in the pecking order” when it comes to ease of identification, understanding, reliability, and influence. Though under some parameters warning labels fared higher, the final recommendation states that Indian consumers prefer HSR labelling overall. FSSAI chief executive Arun Singhal says it was “the largest survey of its kind in the world.”

“Our scientific panel is looking into how star ratings will be awarded. But the general philosophy is that positive nutrients should never outweigh the effects of harmful ingredients,” he tells *The BMJ*. “The weightage has to be decided accordingly. Every regulation evolves and if we find there is a problem, we will correct it.”

After a scientific panel reviews the HSR rating plan this month, the draft policy for how ratings will be awarded will be opened for public comment before it is sent for final approval to the central government.

But health and nutrition experts have called the results of the survey biased and the methodology flawed. Antony Kollannur, a health consultant, points out that adolescents, who form a significant proportion of packaged food consumers, have been omitted from the survey. “A single randomised trial is not enough to formulate a policy. Can 20 000 Indians represent all buyers in India?”



### Food industry influence

There is also growing dissonance over what public health campaigners and consumer forums see as the rising influence of the food industry over the food safety regulator. “Making the front of pack labelling voluntary (until 2027) and leaving it to the industry to change their behaviour on their own is going to be difficult. Policy making should remain insulated from industry,” said Reddy.

George Cheriyan, director of consumer group CUTS International, which is a member of FSSAI and FoPL’s stakeholder group, told *The BMJ* that it appears industry “is dictating and deciding on behalf of the regulator, who is supposed to be independent.”

At stakeholder meetings, Cheriyan says he has seen a power imbalance, with more voices from industry, and public health and consumer voices drowned out. “The sense is that, with economic losses from the pandemic, we should not have policies which result in further damage to industry,” he says. Industry representatives did not respond to requests for a comment from *The BMJ*.

Singhal says all stakeholders were consulted equally on the matter. But, finally, consumers decided. “How do you substitute the findings of an objective survey with the opinion and feelings of some consumer groups? That to my mind is not proper,” he tells *The BMJ*.

Even as FSSAI pushes the new regulation towards the finish line, health organisations and advocacy groups say they will continue to campaign against it and demand warning labels, while appealing to members of parliament and health ministry officials to reconsider. Prasad says, “India is fairly new to the space of regulations. It’s an enormous, naive market and consumer awareness is low, making it attractive for industry and a bigger battle for public health experts.”

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## FEATURE

# New data strategy for England aims to rebuild public trust

After the mistakes of last year ministers have strengthened security around patients' information

The government has set out its new data strategy for health and social care in England and put “public trust and confidence front and centre” after widespread concern over consent and confidentiality stalled the GP data collection scheme last year.

*Data Saves Lives: Reshaping Health and Social Care with Data* sets out far stronger safeguards, with researchers only able to access data through trusted research environments (TREs). This means that data linked to an individual will never leave a secure server and can only be used for agreed research purposes. All access to the data and analysis will be monitored to reduce the risk of data breaches or other misuse.

Patients will have greater access to and control over their data including by simplifying the opt out processes for data sharing and improving access to GP records. The public will also be consulted on a new “data pact” which will set out the use of patient data, and what the public has the right to expect.

Last summer 1.5 million people opted out of the planned General Practice Data for Planning and Research (GPDPR) programme after serious concerns were raised about privacy risks. NHS Digital was forced to delay the scheme until tougher safeguards were put in place. The new data strategy says the GPDPR programme will be a “flagship example of a service where data will only be accessible via a secure data environment.”

The strategy was published in draft format in June 2021. This April Ben Goldacre published a report containing 185 recommendations on improving the use of health data. One of its main recommendations was the development of TREs.

**Data linked to an individual will never leave a secure server**

Goldacre, director of the Bennett Institute at Oxford University, said, “NHS data have phenomenal untapped power. This is a momentous document, because it reaches beyond aphorisms and gets into crucial technical detail.

“The move to use TREs, in particular, is historic. TREs earn public trust by protecting patients' privacy, and by sharing detailed transparent audits of all data usage. They also drive efficiency, because all users working with the same datasets can use common tools for data curation and analysis.”

The report says, “We cannot take the trust of the public for granted. In the summer of 2021 we made a mistake and did not do enough to explain the improvements needed to the way we collect general practice data.” It adds, “Not only did we insufficiently explain, we also did not listen and engage well enough. This led to confusion and anxiety, and created a perception we were willing to press ahead regardless.”

Launching the strategy, England's health and social care secretary Sajid Javid said, “We will improve trust in data, which is the currency that data driven technologies need to function. We will work with the public, including people working in health and care, to develop a new pact on data, which will set out how we will use it and what the public has the right to expect.”



### Enhancing the NHS app

The strategy sets an ambition for the NHS app to be a “one stop shop for health needs” with a target of 75% of the adult population registered to use it by March 2023. Patients will have access to their GP records through the app by November. Further improvements, including being able more easily to request historic information including diagnosis, blood test results, and immunisations will be made available by December 2023.



The detailed strategy also outlines the importance of giving patient facing health staff up to date information. It acknowledges that staff spend large amounts of time collecting data. A national information governance transformation plan, focusing on practical data sharing situations and tackling training for patient facing staff, will be developed by December 2022.

Another commitment is to ensure that health and social care data are integrated in order to speed up discharge from hospital. Currently only 45% of social care providers use a digital social care record and the strategy sets a target of 80% by March 2024, with £25m made available to make this happen.

NHS Digital chief executive Simon Bolton said, “Better access to data will be vital for the NHS recovery and patient trust and confidence must be central to this. We are committed to giving patients more control and increasing transparency over how data are used to improve health and care services.”

Martin Landray, professor of medicine and epidemiology, Oxford University, and co-lead of the Recovery trial, said, “Careful use of health data, not just from hospitals but also from across the primary and social care system, is going to be crucial for planning and conducting the clinical trials that drive improvements for those major burdens for patients, their families, and the NHS. The Data Saves Lives report is an important step in that direction.”

But Charles Tallack, director of data analytics at the Health Foundation, said, “While the strategy represents an important step in the right direction, its impact will depend on whether and how the commitments are implemented in the coming years. It will also be important for the public, patients, service users, and staff across the system to be engaged in implementation—to build and maintain confidence in the use of data. And the strategy must be properly resourced, to ensure its ambition can be realised.”

Jacqui Wise, Kent

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