this week

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"Gaslit" GPs vote against 9 to 5 core hours

GPs at the annual conference of local medical committees have called on the BMA to negotiate safe workload limits, after describing the relentless pressure they face.

The ever growing workload is vastly outstripping the workforce and undermining patient safety, they warned at the conference in York on 10 May.

But a call for working hours to be limited to 9 am to 5 pm fell because of concern that it would do nothing to reduce workload and could lead to a salary cut.

Rachel McMahon, representing Cleveland LMC, said, "Our workload is impacting our health and wellbeing and the safety of our patients. Guidance on safe work in general practice tells us that we should be having 15 minute appointments and seeing a maximum of 25 contacts per day. The average is 37."

Paula Newton, of Cambridgeshire LMC, supported a successful motion to see workload caps embedded into the new GP contract "before it is too late."

"Primary care is crumbling in plain sight," she said. "When we collapse we will take the rest of the NHS with us, and this is perilously close to happening.

"Guidance from the GPC workload and general practice strategy is now four years old. Those of us working in frontline general practice know that things have got a whole lot worse since 2018."

The meeting carried a motion to instruct the BMA's General Practitioners Committee to review the effect of contractual negotiations on the stability and sustainability of general practices across the four nations. Supporting it, Carter Singh, from Nottinghamshire LMC, said, "We need to refocus our efforts by utilising contractual levers that actually have teeth—and provide some life support to the dwindling number of frontline GPs to resolve this workload threat that is destroying our profession."

Shaba Nabi, from Avon, proposed the rejected motion on core hours, which had been trailed in the national media. "With all this fuss going on, you'd think this motion was about asking for a company Ferrari for every GP in the land," she said.

"It is merely requesting to cover 40 hours in our core contract instead of the current 52.5. But the outrage and the reactions to this motion just goes to show how gaslit we are as a profession, that we have to agree we are of no value and should be working 12 and a half hours more than everyone else."

Adele Waters, *The BMJ*

Cite this as: *BMJ* 2022;377:o1176

Shaba Nabi (left) and Rachel McMahon both took up the issues of workload and patient safety at the LMC conference

LATEST ONLINE

- US abortion law: leaked opinion sparks protests and calls for changes to the Supreme Court
- Northern Ireland can wait no longer for Assembly to fix healthcare crisis, say health experts
- Researchers propose new evidence based scale for describing patients' skin colour

SEVEN DAYS IN

Tens of thousands of patients "in limbo" waiting for cancer diagnoses, says charity

More than 65 000 people in England are being left to wait too long to find out whether they have cancer, a new analysis by the charity Cancer Research UK indicates.

Last year the government set a target for 75% of people urgently referred by their GP to receive a diagnosis or have cancer ruled out within a month, to try to tackle the large backlog. But this has yet to be met nationally, with an average of 65 400 people a month waiting longer than 28 days between last October and February, said CRUK.

Even if the target were met, 55 000 people each month would still be left waiting to find out whether they had cancer, it said, and it urged the government to set and deliver a more ambitious target to reduce the number of patients being left "in limbo." There is wide variation across the country, with just over half of hospital trusts (78 of 143) meeting the 75% standard, data for February show.

Michelle Mitchell (left), CRUK's chief executive, said, "As a country we should not be willing to accept that over one in four people on an urgent referral are left waiting over a month to find out whether they have cancer. Nor should we stand for the variation that exists across the country."

Gareth Iacobucci , *The BMJ* Cite this as: *BMJ* 2022;377:o1157

Covid-19

True global death toll is almost 15 million

The World Health Organization estimated that 14.9 million direct and indirect deaths had resulted from SARS-CoV-2 in 2020-21, almost three times the 5.4 million reported by governments around the world. The undercount was the result of a lack of covid testing and death certification, it said. Of the excess deaths, 68% were concentrated in 10 countries: Brazil, Egypt, India, Indonesia, Mexico, Peru, Russia, South Africa, Turkey, and the US. Middle income countries accounted for 81% of the excess deaths, while high income countries accounted for 15% and low income countries 4%.

Arthritis drug baricitinib reduces deaths

The rheumatoid arthritis drug baricitinib will now be used to treat covid-19 in the NHS, after the Recovery trial found that 13% fewer severely ill hospital inpatients died from covid when treated with the drug rather than existing treatment options. Patients will be given baricitinib for 10 days or until discharge, on top of other treatments. The trial's co-chief investigator, Martin Landray, said, "Although we have effective vaccines and treatments, hospitalisation with covid-19 is still associated with poor outcomes, so it's vital that we continue to use randomised trials to identify new therapies that can reduce risk further."

Racism in healthcare increases vaccine hesitancy

Around 7% of people from ethnic minority backgrounds who refused a covid vaccine had experienced racial discrimination in a medical setting since the start of the pandemic, said a paper published in the *Journal of the Royal Society of Medicine*. The study of 633 adults from ethnic minority groups found that the same 7% had experienced twice as many incidents of racial discrimination as those who accepted the vaccine. The lead author, Elise Paul (below), said, "More work is urgently needed to mitigate the unequal and severe effects of the pandemic on ethnic minority populations."

Racial abuse

London primary care staff are frequent victims

Around a third of the primary care workforce in London have faced "appalling" racial discrimination or harassment from patients while at work in the past year, a survey by Health Education England found. The survey of 1025 workers (37% GPs) found that racism usually involved subtle or underhand comments or actions, although a small proportion of workers (9%) had experienced aggressive or threatening behaviour. A workforce race equality strategy for primary care in London has been created to ensure that all staff can seek advice and support if they have concerns about discrimination or harassment.

Refugee health

Offer Ukrainians hepatitis vaccines, says WHO

Governments in Europe should offer hepatitis B vaccinations to children and adolescents arriving from Ukraine with unknown vaccination status, or known delayed or missing vaccinations, and others with risk factors who have no official records or evidence of immunity, WHO said. Hepatitis A vaccinations for refugees should be considered in line with local guidelines, it advised, and close contacts of acute hepatitis A cases should be traced and offered vaccination. In the event of a hepatitis A outbreak, rapid and widespread vaccination should be considered, said WHO.

Economy

Food poverty "will lead to health crisis"

Figures from the Food Foundation showed that in April some 7.3 million UK adults said they had gone without food, a 57% rise on January. The charity, which campaigns for access to healthy food for all, urged the government to increase benefits in line with inflation and expand access to free school meals and the Healthy Start programme.

Suicide prevention

Recipients of £5.4m support fund are revealed

The government announced that 113 charities had received a share of the £5.4m suicide prevention grant fund for voluntary, community, and social enterprise organisations that it distributed earlier this year. The funding has enabled recipient groups to set up new projects or to expand or sustain current services. Support has predominantly been targeted at people in high risk groups who may have struggled the most during the pandemic, such as those with a pre-existing mental illness, young people, and those from groups considered to be at higher risk of self-harm or suicide.

MEDICINE

Environment

Wellcome commissions report on science's impact

The Wellcome Trust pledged to support scientific researchers around the world in considering, assessing, and mitigating the environmental effect of their work. It noted that laboratories had been found to consume five to 10 times more energy per square metre than other academic spaces, while another study found life sciences responsible for 2% of the world's plastic waste. Wellcome will commission a report to allow it and other organisations to learn from global best practice and to understand where more work needs to be done to make scientific research more sustainable.

Life sciences are "responsible for 2% of the world's plastic waste"

Acute hepatitis

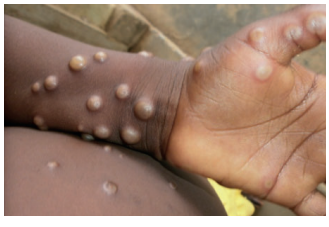
More cases are identified in children

As of 3 May the UK Health Security Agency had identified 163 cases of sudden onset hepatitis in children, as investigations continued into the cause of the unusually high number. The agency said that an association with adenovirus remained the most likely, as this was the virus most often detected in the samples it had tested. But it continued to investigate other potential factors, including previous SARS-CoV-2 infection, a change in susceptibility possibly due to reduced exposure during the pandemic, and a change in the adenovirus genome itself.

Infectious disease

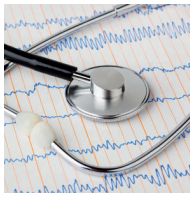
Monkeypox case is confirmed in England

Monkeypox has been diagnosed in one person in England, officials disclosed this week. The UK Health Security Agency said that the patient had recently travelled from Nigeria and was believed to have contracted the infection there before travelling to the UK. The patient is being treated at Guy's and St Thomas' hospital in London. The agency says that monkeypox is a rare viral infection that does not spread easily between people. It is usually a mild self-limiting illness, and most people recover within a few weeks, but severe illness can occur in some.



Digital health records

EU sets out plans to share data across 27 states



The European Commission is looking to digitise all medical records in the European Union by 2025 to make it easier for individuals to access and share their personal data with medical professionals throughout the 27 member bloc, particularly when they are in another country. Raw data from the European Health Data Space would also be available for scientific research, subject to strict conditions. Individuals would be able to add information, rectify wrong data, restrict access to other people, and find out how and why their personal data were being used. EU governments and the European parliament must approve the proposal before it can become law.

Cite this as: *BMJ* 2022;377:o1163

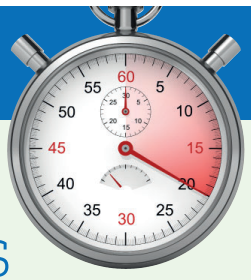
HEALTH SPEND

The UK's total healthcare expenditure grew by 7.1% in real terms in 2021 to £277bn, including government and non-government spending. This compares with growth of 10% in 2020

[Office for National Statistics]

Correction

In the 16-23 April issue (p 85) we incorrectly included a picture of MRSA as an example of a carbapenem resistant Gram negative bacterium that would be targeted by the new antibacterials cefiderocol and ceftazidime-avibactam. We apologise for this error.



SIXTY SECONDS ON . . . NASAL VACCINES

HASN'T MY NOSE SUFFERED ENOUGH?

Now, now. You must admit the nasal swab has proved invaluable in the pandemic. And it seems vaccine developers are interested in this orifice too. Trials of 12 potential nasal vaccine candidates against SARS-CoV-2 are currently under way.

WHAT DO WE NOSE SO FAR?

Today's covid vaccines are all delivered through an intramuscular injection and have been shown to reduce severe illness and death. Nasal vaccines may go a step further, however, by blocking infections completely at the site of entry. Also, they would have the added bonus of needle-free delivery.

SINUS UP!

Researchers at Lancaster University have developed a nasal spray candidate, based on a poultry virus, and are starting human trials. During the preclinical phase, they reported the spray "significantly reduced lung pathology, inflammation, and clinical disease" in rodents. Virologist Muhammad Munir said, "Our studies demonstrate that induction of a local immune response at the point of entry of SARS-CoV-2 has the potential to limit not only clinical disease but also—and perhaps even more importantly—virus transmission."

SMELLS LIKE TEEN SPIRIT

Nasal sprays are often used in children and teenagers, but their potential to block infection and even transmission means that, in the case of covid, there could be benefit in offering them to more people.

SO WHAT'S THE BLOCKAGE?

Nasal vaccines are quite tricky, especially as not much is known about mucosal immunity. Ensuring that the right dose doesn't get sneezed out or swallowed is tricky, and then the vaccine needs to get past the mucus. There are also concerns over the vaccine being delivered so close to the brain.

THAT'S A BLOW

It's certainly not easy, but not impossible. Professor of vaccinology at Oxford University Sarah Gilbert, who led the development of the AstraZeneca covid vaccine, is optimistic. "I'm hopeful about the advances made with the delivery of mucosal delivery vaccines," she said last week.

Elisabeth Mahase, *The BMJ*

Cite this as: *BMJ* 2022;377:o1148

Stop doctors retiring to boost workforce for elective care recovery, says NHS England

MARK THOMAS/SPL

PROPOSALS TO BOOST THE WORKFORCE

- Remove caps on consultants' job plans so they can exceed 10 programmed activities a week
- Support educational, training, and leadership time
- Encourage recently retired staff to return to work
- Encourage staff considering retirement to stay
- Create options to increase contracted hours, including bank shifts, to reduce reliance on locum and agency staff
- Maximise the use of collaborative staff banks
- Attract volunteers who have helped to deliver local vaccination programmes to NHS roles
- Increase capacity during peak periods of leave by effective rostering and planning leave within teams
- Use NHS reservists to support surges and peaks in activity
- Use alternative staffing models to support increased care delivery within safe staffing parameters
- Accelerate recruitment of substantive posts

Employing retired doctors and trying to persuade those planning to retire to follow a new career path in the NHS instead are among measures devised by NHS England to help hospitals tackle the care backlog resulting from the covid pandemic.

The 11 "high impact enablers" (box) were sent to all English trusts in a letter on 3 May, aiming to shore up the workforce to optimise elective capacity. However, the advice omits any measures that would remove the tax burdens that are a disincentive to many experienced doctors, particularly consultants, to work for the NHS beyond pensionable age.

In response the BMA called the omission "extremely disappointing." Vishal Sharma, chair of its Consultants Committee, said the association had contacted NHS England several times to ask it to take steps to fix the problem of punitive pensions taxation and correct misleading information on its website about NHS pensions. He said, "In an example on the NHS England website, rather than receiving a higher pension by staying for an extra year and continuing to contribute towards their pension, a consultant would instead be tens of thousands of pounds worse off over the course of their retirement."

The BMA has asked for the NHS scheme to become a tax unregistered pension scheme, similar to the one the government introduced for the judiciary, which would substantially reduce the tax burden.

NHS England's letter, from five directors, asks trust leaders to continue the "local innovation and grassroots improvement activity" that benefited patients during the pandemic. It encourages creative solutions to job roles and ways of working.

In response, Neil Mortensen, president of the Royal College of Surgeons, warned, "The biggest challenge remains the availability of staff. There are 110 000 vacancies in the NHS, and this is adding pressure to an already overstretched workforce. We need to make sure there are enough staff now and in the future to care for our patients. This means both support for surgical trainees and a credible long term workforce plan from government."

Adele Waters, *The BMJ*

Cite this as: *BMJ* 2022;377:o1145

Anonymisation led to fall in ethnic minority referrals to GMC

Setting up independent panels to review anonymised case information before doctors are formally referred to the GMC has helped reduce the disproportionate rate of referrals of doctors from ethnic minorities in the east of England, the GMC's annual conference has heard.

Anton Emmanuel, head of the NHS's workforce race equality standard, told the conference on 4 May there was now parity of referral between white doctors and those from ethnic minorities at three quarters of trusts in the region. "That's an impressive downturn, which you don't see from the national picture," he said.

Decision trees

Trusts working with the NHS's workforce race equality standard are also using decision trees to help guide decisions over referrals and improving induction programmes.

The NHS's workforce race equality standard team has been working with 22 trusts in England to help them tackle a range of racial inequalities, including rates of staff entering disciplinary procedures and wider problems.

Doctors from ethnic minorities are twice as likely as white doctors to be referred to the GMC by their employers for fitness to practise concerns, while the referral rate among doctors who qualified outside the UK is three times the rate among UK doctors. The GMC has a target to end racial inequalities in fitness to practise referrals by 2026.

Jo Wren, head of GMC London, said that ineffective induction, feedback, and support for doctors joining the NHS could leave doctors from ethnic minority groups and those who qualified overseas feeling isolated.

John Smyth, assistant director of the case examiner team at the GMC, said this meant that these doctors were at risk of not benefiting from the revalidation cycle of appraisals, which encourages doctors to reflect on things that go wrong to gain insight and understanding, because they were not familiar with it.

Emmanuel, a consultant gastroenterologist at UCLH

"Fourth mRNA vaccine dose is safe and boosts immunity"

Fourth doses of covid-19 mRNA vaccines are safe and provide a substantial boost to antibody concentrations and cellular immunity when given more than six months after a third Pfizer vaccine jab, a study has found.

The latest findings from the UK Cov-Boost study, published in *Lancet Infectious Diseases*, show that a fourth dose of Pfizer's or a half dose of Moderna's vaccine was effective at increasing antibody levels and cellular immunity up to and above the baseline and peak levels seen after third dose boosters.

Although pain at the vaccination site and fatigue were the commonest side effects, there were no serious adverse events, and the fourth doses were well tolerated, the authors said.

Some study participants had maintained high antibody levels and cellular responses before the fourth dose, which had limited boosting. Researchers said this trend was also noted in participants with previous infection, indicating that a fourth dose may not boost immunity if baseline levels are high.

Saul Faust, the trial lead and clinical research facility director at University Hospital Southampton Trust, said, "There is a hint from some in the trial that it might reach a ceiling. That will depend on the vaccine, the host immunity, and the dose."

The researchers randomised 166 people who had received a third dose of the Pfizer vaccine to receive either a full dose of the Pfizer (n=83) or a half Moderna dose (n=83) as a fourth dose. These were given around seven months after their third dose.

The study will help inform the UK Joint Committee on Vaccination and Immunisation's decision whether to recommend fourth doses to a wider group of people later this year.

"The key data [for the JCVI] are going to be severe infection, hospitalisations, and deaths in people who have received either two or three doses," said Faust.

Gareth Iacobucci, *The BMJ*

Cite this as: *BMJ* 2022;377:o1170

There's been an impressive downturn in three quarters of east of England trusts

Anton Emmanuel

and the National Hospital for Neurology and Neurosurgery, said only one in 10 trusts in England had taken up offers from the NHS's workforce race equality standard to tackle ethnic workforce inequality.

Ineffective support can leave ethnic minority doctors feeling isolated

Jo Wren

"Of course, they are post-pandemic and still in recovery," he said. He hoped the number of trusts engaging would rise considerably this year.

Ingrid Torjesen, *The BMJ*

Cite this as: *BMJ* 2022;377:o1153

Sexual harassment: **Only tough action will change culture, GMC delegates hear**

Regulators, governing bodies, and professional organisations need to do more to tackle sexual assault and harassment of female NHS staff by male colleagues, the GMC's annual conference heard on 4 May.

In 2021 a report from the Royal College of Surgeons highlighted sexual harassment, sexual assault, and rape of female doctors and trainees, including several shocking accounts from young surgeons. Since then more women have offered similar testimonies.

In three quarters of cases the perpetrators were male consultant surgeons, said Tamzin Cuming, chair of the Women in Surgery Forum at the Royal College of Surgeons of England. If the victim was a junior doctor or a student, she said, "It's very hard for that person—if they're brave enough to come forward—to get taken seriously, so that's where we need help from NHS Employers, NHS England, and the GMC."

Female doctors needed to know that perpetrators of sexual assault will lose their licence to practise, she added.

Leaving the profession

A GMC survey of doctors who left practice between 2004 and 2019 found that 0.25% of women had done so because of sexual harassment.

"While this might seem small, it translates to 96 female doctors leaving the profession," said Claire Light, GMC's head of equality, diversity, and inclusion, adding that female doctors were eight times as likely as men to leave for this reason. Male doctors were nine times as likely as women to be subject to complaints about sex, gender, or sexual orientation discrimination, she said.

"Sexism is rife in the NHS," said Cuming. "There's evidence that if you are working in an environment that is sexist, actually that enables sexual assault to take place."

A 2021 BMA survey found that 91% of female doctors had experienced sexism at work in the past two years and that 42% of doctors who had experienced or witnessed sexism had not reported it.

Cuming said there was no protection for women who reported sexual assaults but that the Project S reporting system, which is to be launched in the next few months, will allow anonymous reporting of incidents that occur in the NHS and should allow understanding of their prevalence. If data showed several reports about a potential perpetrator at a hospital then there should be an outside investigation, she said.

Light said that bystanders also had an important role to play in reporting incidents. "Doctors must speak up and challenge sexism and harassment and any other form of sexual misconduct if we experience or witness it," she said.

Ingrid Torjesen, *The BMJ*

Cite this as: *BMJ* 2022;377:o1151

A 2021 BMA survey found that 91% of female doctors had experienced sexism at work in the past two years and that 42% of doctors who had experienced or witnessed sexism had not reported it

UK-Rwanda migration plan fails to safeguard refugees' medical care, say campaigners

An outcry has greeted the UK's plan to tackle what it calls "illegal" migration by sending people who arrive by small boats or hidden in lorries to have asylum claims processed in Rwanda.

Ministers said the asylum partnership, signed by the UK and Rwandan governments in Kigali last month, will break the criminal smuggling trade and support those whose asylum claims are accepted to have a "new and prosperous life" in Rwanda. But the UK stands accused of trading refugees as commodities to a repressive state, trashing legal obligations, and undermining international protections of refugees.

"Irresponsible and inhumane"

Leading refugee campaigning and rights groups have warned that costly and cruel offshore processing regimes have already failed elsewhere, particularly in Australia, and led to humanitarian catastrophe, with a heavy toll in lives lost and damaged.

Judith Dennis, policy manager at the Refugee Council, said, "This announcement is already having a horrifying effect on some of the people we support. Traumatised people—who have lost everything, fleeing from war or persecution—now face the anxiety and stress of believing they may be sent 4000 miles across the world against their will."

Dennis said the UK's plan, if put into practice, would have an "appalling impact on the mental health of both those who are sent to Rwanda and those who fear they may be." She told *The BMJ*, "Apart from the lack of assurances about how people will access health and other services, this policy is irresponsible and inhumane."

The UN High Commissioner for Refugees (UNHCR) said that transferring refugees and asylum seekers to third countries in the absence of sufficient safeguards and standards was "contrary to the letter and spirit of the Refugee Convention."

UK ministers say Rwanda is "fundamentally safe and secure" and has a track record in supporting thousands of asylum seekers, primarily from Democratic Republic of Congo and Burundi. The Home Office told *The BMJ*, "Under this agreement, Rwanda will process claims in accordance with the UN Refugee Convention, and national and international human rights laws, and will ensure their protection from inhuman and degrading treatment or being returned to the place they originally fled. There is nothing in the UN Refugee Convention which prevents removal to a safe country."

Refugees will be offered a comprehensive integration package lasting up to five years to help them put down roots and start a new life in Rwanda
Home Office

ALISSA EVERETT /REUTERS/ALAMY

More than 17 000 Congolese refugees live in the Kiziba camp in Rwanda

But others take a different view. On 27 April details emerged of the first legal challenge to the plan, after the charity Freedom from Torture instructed lawyers to demand "disclosure of information" about the policy amid "serious concerns" about its lawfulness.

Will refugees' healthcare be protected?

The UK government, which is paying Rwanda an initial £120m, said it would "screen" asylum seekers before relocation and provide details of any special needs and health needs of those to be accommodated. "Upon arrival, Rwanda will provide each relocated individual with accommodation and support that is adequate to ensure their personal health, security, and wellbeing. This will include free access to healthcare," the Home Office said.

People who are granted refugee status will be offered a "comprehensive integration package lasting up to five years to help put down roots and start a new life in Rwanda if they wish." This will include help in "learning the language, finding a job, contributing to the economy, and becoming a productive member of the local community."

Rwanda's minister for foreign affairs and international cooperation, Vincent Biruta, said that people would be "protected, respected, and empowered to further their own ambitions and settle permanently in Rwanda if they choose."

But Yasmine Ahmed, UK director of Human Rights Watch, said Rwanda's human rights record was "appalling" and said there was a lack of oversight to deliver commitments under a deal

that was wrong in both practice and principle. She said that refugees in Rwanda lived in "incredibly difficult conditions" and that most of the population was in poverty, yet the country's record of curtailing free speech made it almost impossible for people to publicly criticise government policies.

Human Rights Watch cited the killing in 2018 by Rwandan security forces of 12 Congolese refugees and many arrests after protests against a cut in food rations from $8.9 to $6.7 a month. "This raises serious questions about how these new asylum processes will be independently monitored," Ahmed said.

Just last year the UK government, which has granted asylum to Rwandans who have fled the country, voiced concern about Rwanda's continuing curbs on civil and political rights and media freedom.

The Refugee Council estimates that 172 people could have been sent to Rwanda from the UK last year had a deal been in place then.

Two tiered system

Experts have said it wasn't clear how promises to new arrivals in Rwanda will be kept, and under whose jurisdiction medical care and welfare will fall, and whether they can expect the same or better levels of support and assistance than the country's existing refugees. Therefore, they said, there was a risk of a two tiered system that discriminates against one group on the basis of their mode of arrival, undermining international standards.

Tania Kaiser, a senior lecturer in forced migration studies at SOAS University in London, said, "In Rwanda it's still the case that the vast majority of existing refugees live in rural refugee camps outside the metropolitan centres.

"It certainly doesn't have a great deal of experience in urban resettlement programmes, the kind of thing you've got to assume is what they're promising."

Even in longstanding camps refugees face limited access to electricity and clean water.

Kaiser said there was a risk of an "extraordinary double standard" being applied in relation to meeting the needs of refugees. "If anything like a decent level of provision is made for the people who are being transferred from the UK, they are instantly going to be several tiers above the experience of locally arrived refugees," she told *The BMJ*.

"Rwanda is a pretty unequal society economically. There are going to be very large numbers of people in Rwanda who don't have a hope in hell of accessing consistent and high quality health services, for example, and education and other basic social services as well."

Kaiser added, "A question that needs to be asked is: what does it mean to be a refugee hosting state, and what kind of hosting experiences are under the belt of the states in question and what are the expectations?"

Australia's experience

Other countries, such as Israel and Australia, have introduced similar migration schemes for refugees in the past, and campaigners say that the UK is failing to heed the mistakes made there.

"When Australia sent people seeking asylum for offshore processing, there were shocking levels of self harm, depression, and attempted suicide," Dennis said.

David Berger, a doctor who moved to Australia from the UK, campaigned against Australia's policy of sending asylum seekers to offshore processing camps in Papua New Guinea and Nauru, which he described as of the "greatest inhumanity."

According to Human Rights Watch, 12 people died in these camps between 2013 and 2021.

Ahmed said, "Men, women, and children have suffered inhumane treatment and medical neglect, and years of indefinite detention led to an epidemic of self harm and frequent suicide attempts."

Berger said that the Australian government effectively "subcontracted out" its responsibility for people's welfare, with "all major medical decisions screened through the Australian Border Force." This led to "difficult dilemmas for doctors and healthcare workers" who tried to safeguard people's health without being complicit in an unjust system, he said.

JEAN BIZIMANA/REUTERS/ALAMY

Home secretary Priti Patel and Rwanda's foreign minister Vincent Biruta, after signing the agreement on 14 April

In Australia's offshore processing camps, there were shocking levels of self harm
Judith Dennis

This is pandering to a racist, xenophobic core of the UK population
David Berger

The passing of a law known as the Medevac Bill (since repealed) allowed for doctors to evacuate sick refugees who needed urgent medical assistance to Australia for treatment, but campaign groups said the refugees remained in limbo, with no permanent visas and little support, under threat of being returned to Papua New Guinea or Nauru at any time.

Nearly 1000 people were resettled to the US under an Australia-US resettlement deal. More than 230 people remained in Papua New Guinea and Nauru, Human Rights Watch said in 2021.

Denmark has passed legislation allowing the transfer of asylum seekers to offshore locations.

Israel was sending refugees to Rwanda from 2014 for asylum processing until a policy under former prime minister Benjamin Netanyahu was halted in the wake of legal challenges.

Berger said it was "beyond disgusting" to see the UK beginning offshore processing of refugees to Rwanda. "It has to be seen for what it is, which is pandering to a racist, xenophobic core of the population," he told *The BMJ*.

Dennis said, "The government should be ashamed of this agreement, given the small proportion of asylum claims we receive in this country."

Matthew Limb, London

Cite this as: *BMJ* 2022;377:o1087

HUMAN RIGHTS WATCH cited the killing in 2018 by Rwandan security forces of 12 Congolese refugees and many arrests after protests against a cut in food rations from $8.9 to $6.7 a month

1. Fatima Shuaibu, who is 8, lives with her mother and siblings in Damaturu, Yobe State, Nigeria
2. This Ukrainian family escaped the war by fleeing to Warsaw, Poland
3. Three year old Sarra (left) and her family, who have fled their Syrian home four times, now live in a camp for displaced people

THE BIG PICTURE

Portraits of fear turned to hope

The International Rescue Committee is highlighting the plight of women and girls in the world's conflict zones with photographs taken in IRC programmes, linked to a fundraising appeal.

An exhibition, "Protecting Milestones: Portraits of Girls in Conflict," launched the appeal in London earlier this month.

Laura Kyrke-Smith, IRC's UK executive director, said, "Unfortunately, it is all too common for families in conflict zones to struggle to access the food and medical care they need. As 50 million children worldwide suffer from acute malnutrition every year, we want to help girls living in conflict areas to grow and reach their full potential."

For every £1 donated by 3 August the UK government will contribute £1 to fund a programme to treat malnutrition in northeast Nigeria, up to £2m. An IRC donor will also match initial donations, so the public's contributions will go three times as far.

You can donate at help.rescue-uk.org/protecting-milestones

Alison Shepherd, *The BMJ*

Cite this as: *BMJ* 2022;377:o1165

ETINOSA YVONNE; FRANCESCO PASTILLI; ANAS ALKHARBOUTLI/IRC

EDITORIAL

New calorie labelling regulations in England

One small step in the right direction

Regulations came into effect on 6 April[1] requiring restaurants, cafes, and takeaways in England to provide calorie information on menus and food displays, including those online. The legislation applies only to businesses with over 250 employees, with exemptions for charities, hospitals, care homes, and temporary menu items. But this is still an important milestone in government obesity policy—an area where promised interventions are not always delivered.[2]

The global burden of diet-related ill health is growing,[3 4] and the introduction of calorie labelling regulations should be applauded. Up to a quarter of adults' calories are consumed outside the home.[7] The policy should have some, albeit limited, effect through changes to consumer behaviour and reformulation. One systematic review found that calorie labelling on menus led to a 7.8% (95% confidence interval 2.5% to 13.1%) reduction in calories purchased.[8]

Other systematic reviews found limited evidence of a reduction in calories purchased[9] or menu reformulation, although this may be because of a lack of larger studies.[10] In the US, where calorie labelling has been mandatory for large chains since 2018,[11] reductions have been reported in both calories purchased and the number of calories in food items.[12] In New South Wales, Australia, calorie labelling has also had a positive influence on consumer behaviour.[13]

Policies that aim to benefit everyone by working at the population level and require limited personal resources to benefit, such as a sugar tax, are more likely to reduce the overall disease burden and be equitable than individual level policies aimed at high risk individuals, such as referring people to exercise classes.[14]

JUSTIN KASE ZTWOZ/ALAMY

Up to a quarter of adults' calories are consumed outside the home

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Compulsory calorie labelling is a population level policy with both high agency (individuals making choices) and low agency (menu reformulation) mechanisms of action. Evidence suggests that benefits may vary across socioeconomic groups,[15] including data from the US suggesting calorie labelling may have a greater influence on calorie intake among people from higher socioeconomic groups.[16]

Other concerns include the possibility of adverse effects on people with eating disorders,[17] although businesses covered by the regulations must provide menus without calorie labelling on request.

Missed opportunity

Diet-related ill health needs a multifaceted, cross-government response[18] that combines individual level approaches for those at high risk with an increased emphasis on population level, low agency policies[19] that are implemented and evaluated appropriately.[2] England's current obesity strategy includes some population level policies such as banning advertisements for unhealthy food before 9 pm on television and at all times online, and ending multibuy offers in large retail outlets.[20]

The introduction of calorie labelling may be seen as a missed opportunity to provide more comprehensive nutritional information on menus. Labelling policies for packaged foods in Brazil, Chile, and Mexico, for example, mandate clear black and white warning labels on foods high in salt, sugar, or saturated fat. Other schemes include traffic light labelling[21] (red, amber, green) to indicate whether a food contains high, medium, or low levels of fat, saturated fat, sugar, and salt. The Nutri-Score system,[22] which assigns foods one of five colours (red to green) and a letter (A-E) based on multiple nutrients and components, has been used on packaged foods since 2017—on a voluntary basis—in France, Belgium, Switzerland, Germany, Luxembourg, Spain, and the Netherlands. Both colour coded labels and warning labels have been associated with healthier consumer choices.[23]

The policies outlined in England's obesity strategy are unlikely to lead to the profound changes in our food environment required to reverse current obesity trends. The National Food Strategy argues that consumers and businesses are stuck in a "junk food cycle" that "We cannot escape . . . without rebalancing the financial incentives within the food system."[27] Calorie labelling on food eaten outside the home could encourage food outlets to reduce the calorie content of their foods,[28] but it's not the radical change called for. The food strategy's recommendations include a sugar and salt reformulation tax with some of the revenue raised funding subsidies for fresh fruit and vegetables.

The impact of the calorie labelling policy will be monitored through regular reports by food authorities and the secretary of state for health and social care, and by an independent scientific evaluation.[29] It must be considered as just one part of a much broader approach to reshape the food system.

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INVESTIGATION

Call for tighter regulation as hundreds of patient data breaches are left unpunished

Pharmaceutical companies, NHS commissioners, and universities have repeatedly violated data sharing agreements, audits show. Should NHS Digital curtail their access? **Esther Oxford** reports

Hundreds of organisations including pharmaceutical companies, clinical commissioning groups (CCGs), and universities have breached patient data sharing agreements in the past seven years and yet their access to the information is not curtailed, *The BMJ* can reveal.

Companies, commissioners, and leading universities, including GlaxoSmithKline (GSK) and Imperial College London, have carried out "high risk" breaches according to NHS Digital audits examined by *The BMJ*. This means that they are handling information outside of agreed data contracts and may be failing to protect confidentiality.

In one instance of a high risk breach, clinical care commissioners allowed sensitive, identifiable patient data to be released to Virgin Care without permission from NHS Digital. When NHS Digital's audit team tried to get access to Virgin Care to check their compliance, it was denied access for several weeks and the company refused to delete the patient data.

"It is outrageous that private companies and university research teams are failing to comply," says Kingsley Manning, former chair of NHS Digital. "How is it that these organisations can be so lax with data?"

"These breaches will damage public trust that data are being handled safely and securely," says Natalie Banner, former lead for the Understanding Patient Data initiative hosted by Wellcome. "The current system is failing to protect data adequately and a major policy shift and investment is needed," she says.

How is it that organisations can be so lax with data? Kingsley Manning

The BMJ's analysis of NHS Digital audits found that in the past year 33 organisations were audited and every one had breached data sharing agreements, with hundreds more inspected and found in breach since audits began in 2015.

GSK was found to be at high risk regarding "compliance, duty of care, confidentiality, and integrity" by NHS Digital's auditors in December 2021. It had breached the terms of its data sharing agreement with NHS Digital in 10 ways. Breaches included allowing four unauthorised GSK data analysts in North America to access the patient data. The company also processed and stored NHS patient data in locations which had not been declared.

A GSK spokesperson said the company had worked to tackle all of NHS Digital's recent audit findings. They said, "GSK is clear that all

DATA BREACHES

The BMJ's analysis of NHS Digital audits found that in the past year 33 organisations were audited and every one had breached data sharing agreements, with hundreds more inspected and found in breach since audits began in 2015.

East Staffordshire Clinical Commissioning Group allowed sensitive, identifiable patient data to be released to Virgin Care without permission from NHS Digital. When NHS Digital's audit team asked Virgin Care to delete the patient data, Virgin Care refused. It was deemed "high risk" by auditors.

GlaxoSmithKline was deemed "high risk" with 10 breaches of data sharing agreements and contracts. Violations included allowing four "unauthorised" GSK data analysts in North America to access the patient data, and storing NHS patient data at undeclared locations.

Imperial College, London, was deemed "high risk" by NHS Digital auditors. Breaches included allowing identifiable, sensitive patient data to transit between the primary data centre and the back-up site, without encrypting the patient data.

The University of Cambridge and Cambridge University Hospitals NHS Foundation Trust were found to be at "medium risk". Auditors found the Cambridge team was processing patient data on "unencrypted desktop machines", among other breaches.

The University of Bristol and the University Hospital Bristol NHS Foundation Trust were found to have a history of repeatedly breaching data sharing agreements, dating back to February 2020. The team was rated "medium risk" by NHS Digital auditors.

In the past year every one of 33 organisations audited had breached data sharing deals

BELLE MELLOR

patient data were robustly protected at all times."

A health statistics research unit at Imperial College London was also deemed high risk in August 2021. Identifiable, sensitive patient data were not encrypted while in transit between the primary data centre and the back-up site; two doctoral students were given unauthorised access to the data supplied by NHS Digital; and vulnerability scans had not been conducted on the infrastructure, among other breaches.

An Imperial College London spokesperson told *The BMJ*, "We fully accepted the findings of this audit and quickly put in place an action plan to tackle the matters raised."

Medium risk organisations

Research teams at the University of Cambridge and Cambridge University Hospitals NHS Foundation Trust and the Oxford University Hospitals NHS Foundation Trust and Oxford University's Nuffield Department of Primary Care Health Sciences were found to be at "medium risk" in audits published in February 2022 and November 2021, respectively. Auditors found the Cambridge team was processing patient data on "unencrypted desktop machines."

A spokesperson for the University of Cambridge said the patient data were not identifiable and that "at no point were patient identifiable data at risk of disclosure or loss."

The University of Bristol and the University Hospital Bristol NHS Foundation Trust, also described as medium risk, were found to have a history of repeatedly breaching data sharing agreements dating back to February 2020, according to a post-audit review published in February 2022.

Steve Gray, chief information officer at University Hospitals Bristol and Weston NHS Foundation Trust, said, "We are committed to working with NHS Digital to provide the necessary assurances around the three outstanding recommendations." A spokesperson from the University of Bristol added, "We have been subject to numerous NHS Digital audits over the past decade and any points of actions have always been appropriately tackled."

In a separate high risk instance involving East Staffordshire CCG, sensitive, identifiable patient data were released by the CCG's processors to Virgin Care without permission from NHS Digital.

NHS Digital auditors found that pseudonymised or anonymised data including children's and young peoples' mental health data, data about people with mental health learning disabilities, diagnostic imaging, and other confidential patient data were being processed outside of objectives agreed with NHS Digital, at an address which had not been agreed, and without a data sharing contract.

NHS Digital's audit team was denied access to Virgin Care for several weeks as it tried to get access to check their compliance. Furthermore, Virgin Care was unwilling to confirm to auditors how long it would retain patient data on backup media or where data were being processed or stored, including disaster recovery and backups.

In June 2019 the CCG terminated its contract with Virgin Care and asked it to delete the patient data but Virgin Care refused, a March 2021 NHS Digital audit found.

"Virgin Care has confirmed that data are now being kept only for the purposes of complying with statutory financial reporting obligations and any audit by a regulatory body," NHS Digital said. "This is in line with NHS records management requirements. It should be noted that we have not found any evidence at any point that the patient record level data were at risk, nor transferred outside the European Economic Area."

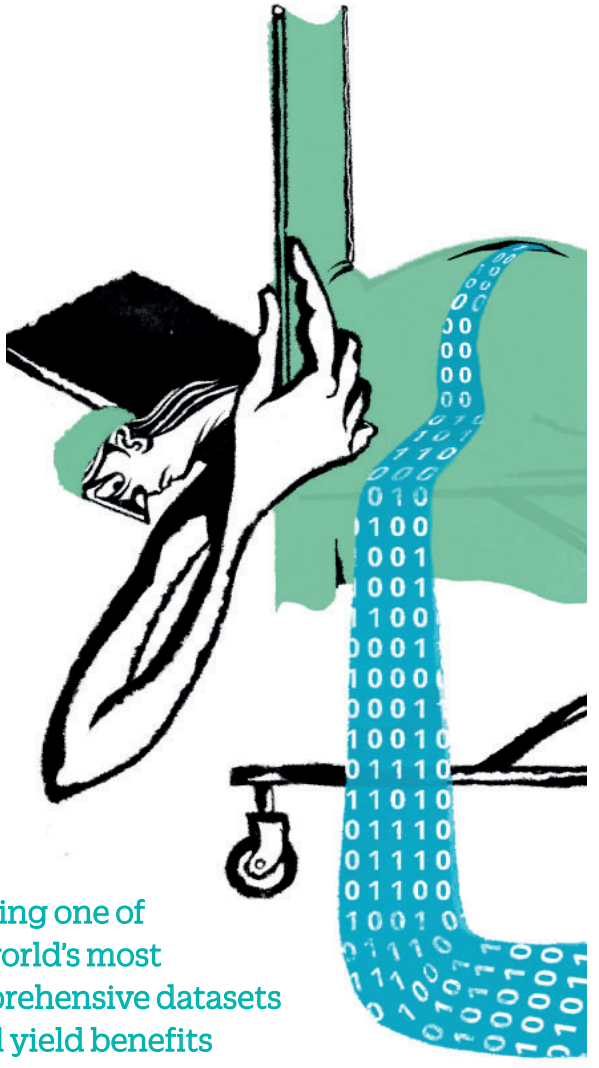
A spokesperson for Virgin Care, acquired by Twenty20 Capital and re-branded as HCRG Care Group, said East Staffordshire CCG had not updated its documentation regarding the partnership. Virgin Care/HCRG is "an experienced provider" with "strong governance" and "robust data protection in place," the spokesperson said.

A major policy shift and investment is needed
Natalie Banner

None of the companies, universities, or CCGs had their access to NHS Digital's data curtailed in light of the breaches. Instead, NHS Digital said it works with the organisations to rectify problems.

Phil Booth, coordinator of campaigning group medConfidential, says there needs to be real consequences if companies, commissioners, and research teams breach their agreements, otherwise data sharing contracts are meaningless. "These contractual requirements aren't just for fun: a single data breach could include sensitive information about millions of patients," he said.

NHS Digital has the power to suspend the provision of data but any decision to curtail access to data would "need to be balanced against any negative impact to



Building one of the world's most comprehensive datasets could yield benefits worth nearly £10bn a year

patient care," a spokesperson said. CCGs would be unable to commission services if they had to return data, and ceasing access to data for clinical trials would mean their benefits would not be achieved, they added.

NHS Digital also has the power to require that patient data provided are destroyed, and to report an organisation to the Information Commissioner's Office (ICO) if there has been a personal data breach.

The ICO said it could not tell *The BMJ* if NHS Digital had ever reported a pharmaceutical company, university, or organisation for breaching a data sharing agreement because of "the way data are held on its systems." There are no examples of enforcement action against these entities published on the ICO website.

Secure platform

NHS Digital has plans to provide a trusted research environment (TRE) for organisations wanting to access health and social care data. TREs, which are already used by organisations like the Office for National Statistics and Genomics England, involve data being kept on a secure platform with approved people accessing it remotely and only being able to export analysis rather than individual level data. "This is much more secure and builds an audit ability into the infrastructure, rather than relying on trust through contracts and manual audits," Banner says.

There are, however, fears about how TREs will work if taken up by the NHS, including how they will be made accountable and transparent. If they become "black boxes controlled by private companies," public trust may be even more detrimentally affected, Banner says.

Data governance is becoming increasingly important as the government has a strategy to turn Britain into a global data "superpower." The long term plan is to link GP data with other NHS data to inform planning and improve care pathways.

Building one of the world's most comprehensive datasets and "putting analytics at the heart of NHS delivery" could yield benefits worth nearly £10bn a year, according to a report from management consultancy Ernst and Young.

Powers in the government's Health and Care Act will enable the secretary of state to abolish NHS Digital and allow NHS England to take on its powers and responsibilities.

Despite NHS Digital's shortcomings, many are worried about this change. NHS Digital has statutory independence and has turned down government requests for data that it considers invasive. "

The move is alarming," says Philip Hunt, member of the House of Lords, who made an unsuccessful bid to amend the government's bill. "NHS Digital is not perfect but by abolishing it you risk removing one of the safeguards we have in the current system."

"NHS England has so many roles and motivations it is never going to be able to protect patient information in the way an independent body with specific responsibilities to do so would," he added.

A spokesperson from the Department of Health and Social Care said, "The obligations that NHS Digital currently has to safeguard patient data will become those of NHS England. This will include the same level of transparency as to how data are disseminated and used."

It will take time to decide on the correct policy and to arrange the new data infrastructure, says Banner. She added, "What's being done about NHS Digital's audits and those failures in the meantime?"

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A single data breach could include sensitive information about millions of patients
Phil Booth

The NHS is never going to be able to protect patient information in the way an independent body would
Philip Hunt

MATERNITY CARE

Implementing Ockenden: What next for NHS maternity services?

Funding, recruitment, retention, and interprofessional training will all be key, says **Emma Wilkinson**—but there are concerns that effective current models of care will be wrongly jettisoned

Doctors have described the Ockenden review as a watershed moment for NHS maternity services, but what's striking about its conclusions is just how many times similar recommendations have been made over the past decade or earlier.

The final report into maternity services at Shrewsbury and Telford Hospital Trust, published at the end of March after a review of the care received by almost 1500 families from 2000 to 2019, described an NHS maternity service that had failed. Those failings were repeated time and time again, with patients and staff not being listened to, investigations not done, and missed opportunities to make improvements.

Underpinning it all were ongoing staff shortages and a lack of training, a culture of "them and us" between midwives and obstetricians, and concerns not being escalated or action not taken.

GILES PERRING

Donna Ockenden, the senior midwife who chaired the review, also criticised a reluctance to perform caesarean sections in the context of a national drive to promote normal births, for which organisations such as the Royal College of Midwives have since apologised.

The wrong lessons are often being taken away from safety reviews
Christine McCourt

The five year inquiry for the report may be the largest and most comprehensive such review in NHS history, but there have been others: Northwick Park in 2006, Morecambe Bay in 2015, and Cwm Taf in 2021.

Current investigations

Investigations are ongoing into services in Nottingham and at East Kent. And as far back as 2008 in *Safe Births: Everybody's Business*, the King's Fund highlighted the need for effective leadership, clear communication, and adequate staffing levels for safe maternity services.

"It's incredible how it's the same things that come up over and over again, and it's really concerning that we don't seem able to break that cycle," says Mary Ross-Davie, the

"TEAMS THAT WORK TOGETHER SHOULD TRAIN TOGETHER"

Drills and skills in your own environment with the multidisciplinary team is key
Edward Morris

One key recommendation, often overlooked, is that teams that work together should train together.

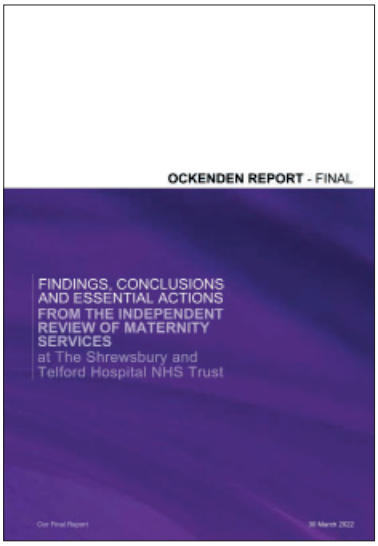
"Drills and skills and training in your own environment with the multidisciplinary team is absolutely key," says Edward Morris, president of the Royal College of Obstetricians and Gynaecologists. "If you work and train together, there's huge evidence that teams are more united and safer. If you get that working well and the workforce is more comfortable with their local environment and in emergencies, it engenders that whole team culture."

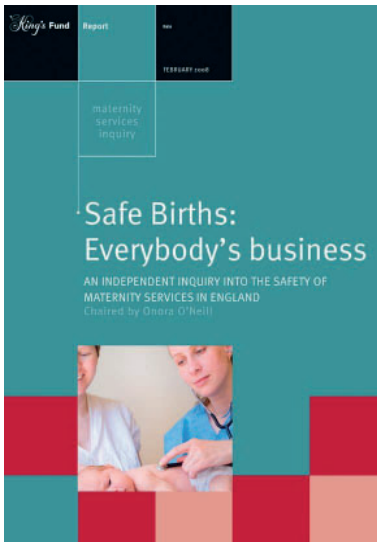
The effectiveness of this approach has been shown by PROMPT, a multidisciplinary approach to training in obstetrics and midwifery developed in Bristol. The evidence from the scheme shows that it improves not only knowledge and training but also outcomes.[7]

For this to work, however, training needs to be protected and mandatory for teams, says Mary Ross-Davie, the Royal College of Midwives' director for professional midwifery—and it should include softer skills of communication and decision making, not just

Training should be about the team coming together around the patient
Liz Anderson

It's incredible how it's the same things that come up over and over again
Mary Ross-Davie





Royal College of Midwives' director for professional midwifery.

Christine McCourt, professor of maternal and child health at City University of London, says that these repeated conclusions in maternity safety reports suggest that the wrong lessons are often taken away.

Her work has flagged up the importance of interprofessional and intraprofessional relationships—ways in which services support collaborative working, mutual respect, and leadership. The other thing that comes up repeatedly is staffing shortages, she says.

how to manage obstetric emergencies and interpret fetal heart rate.

Liz Anderson, professor of interprofessional education at the University of Leicester who has worked as a midwife, says that every maternal safety report involves an aspect of how people work together and communicate.

"I've been saying for a long time that the way in which we train is no longer fit for purpose, in that we stay in our professional silos," she explains. "Training should be about the team coming together around the patient; instead, you have professions who do not properly communicate or understand that they may see the world differently and that [this] is not a bad thing."

Anderson is pleased to see that the Ockenden review makes this point very clearly. "Some of what has gone wrong is people working in isolation, making decisions in isolation, and not being comfortable with each other," she says. "But you can't work in isolation: we have to have ways in which information can be rapidly exchanged, and when things go wrong there needs to be very clear pathways."

In 2021 the Health and Social Care Committee called for a funding increase of £200m-£350m a year

Cash injections

A week before the Ockenden report was published NHS England announced a cash injection of £127m for maternity services, £50m of which will be designated over two years to boost staffing. Another £34m is earmarked for training, developing culture and leadership, and supporting staff retention. This follows a package of £95m announced last year to increase the maternity workforce.

While Ockenden has welcomed this, she wants to see funding at the level recommended by the Health and Social Care Committee, which in 2021 called for an immediate increase of £200m-£350m a year.

For many years warnings about staffing shortages in maternity haven't been taken seriously, says Ross-Davie—an issue the Royal College of Midwives had spent a lot of time trying to bring to the attention of the government and NHS leadership.

She says, "We have also felt that these concerns have not been heard at trust board level. There is a lack of understanding sometimes of the complexity of maternity services and what we do. We are pleased that it's been heard and that more funding has been allocated."

But it can't just be about training new midwives, Ross-Davie explains: we need to stop others feeling so demoralised or unsupported that they leave, creating a knowledge gap.

"If you're not retaining experienced midwives, you're not going to improve the situation," she says, noting some examples of maternity services taking innovative approaches, such as one recent advert in Bradford looking for legacy midwives to support those in their early career. She adds that good leadership needs to be valued, with labour ward coordinators being strictly supernumerary, and every trust should have a consultant midwife to provide professional leadership for auditing and improving care, as well as updating practice and guidelines.

It's "hugely concerning," she says, to learn that some staff felt pressured to pull out of contributing to the Ockenden review at the last minute. The Royal College of Midwives published guidance in February about how to raise safety concerns and what to do if these are ignored. This followed a conclusion from the Health and Social Care Committee that a "blame culture" prevented lessons from being learnt from failures in maternity safety.

Ross-Davie says, "What you could see happen in [the Ockenden report] is that people almost gave up raising concerns because they didn't get a response."

Knee jerk reactions?

For people who have spent years researching safety in maternity services, it's not necessarily about reinventing the wheel—going back to the evidence that already exists around service design is vital. Some are concerned about the report's impact on existing models of care that they say are effective.

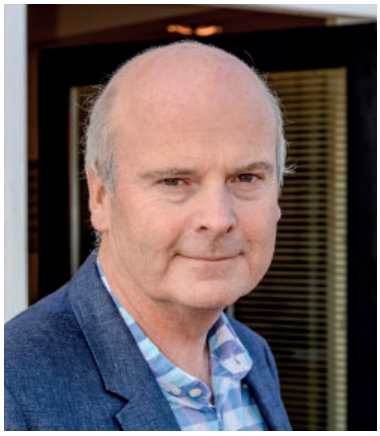
Ross-Davie explains, "The Birthplace in England Research Programme [which was carried out from 2008 to 2010 and assessed 64 000 low risk births] looked at outcomes and found that midwife led units were safe and were particularly beneficial for women who didn't have complex pregnancy and were healthy when they went into labour.

"What is key about the Ockenden report is that it's not about midwife led services not being effective and safe—it's about how you run them and how you staff them and whether you give them equal weight."

McCourt has heard of some midwife led units shutting down, which may relate to staffing levels, but she also has concerns about a knee jerk reaction to Ockenden. The best evidence shows that midwife led units enhance safety and experience and are cost effective, she says.

Her other concern is around the report's recommendation that trusts suspend the "continuity of carer" model (where women receive dedicated support from the same small midwifery team throughout pregnancy) until they are sure that this can be safely staffed. One service McCourt's university is working with has already announced cessation of the model—"even though," she says, "there is no relevant evidence from the report that this could help improve safety, and indeed the service the Ockenden report focused on had no continuity of carer models in place."

Edward Morris, president of the Royal College of Obstetricians and Gynaecologists, says that Ockenden was careful in her wording around the continuity of carer model. In 2021 NHS England published guidance to help trusts use this model at full scale, the ultimate goal being that it becomes the default. Some trusts have done



this really well, says Morris, but they are the ones with well staffed and well resourced units, and others don't have enough staff to do it safely.

McCourt says, "If a service is doing well with [this model], let them continue their work because we do know it has brilliant safety outcomes and patients feel more listened to. We need to follow the evidence, implement the changes that are really necessary, and avoid making changes which have actually not been proposed—and I fear that will happen.

"There is pretty universal concern about staffing levels, but the evidence shows that midwifery units and continuity of carer don't require higher staff numbers or costs overall, although staffing needs to be distributed in a different way for them to work effectively."

Positive signs

Morris believes that people are getting the message that a workforce under pressure is not as safe as it should be. Positive signs include funding from the Department of Health and Social Care for a workforce planning tool, developed by the Royal College of Obstetricians and Gynaecologists, that considers the acuity of the unit, geography, and local demand. The college has also developed a locum competency tool to help trusts and locums feel more confident in the care being delivered.

"It does feel different [this time]," says Morris. "The profession is willing to listen, and we have a series of commitments from NHS England and the Department of Health that recognises there is a problem."

We seem to accept risks in maternity that we just don't accept elsewhere in society
Andrew Shennan

Ockenden has noted improvements already happening in response to her interim report, published in December. For instance, Morris highlights the way people in maternity services work together. He says, "You need a head of midwifery and chief of obstetrics demonstrating that they work together and lead together and can represent effectively at the divisional level and the board level."

He also regards the newer roles of regional chief midwives and regional chief obstetricians as a positive move. And while more funding has been allocated for staffing, it also seems to have been accepted that more is needed—and this is just the beginning, he says.

Early intervention

One of the suggestions from the royal colleges' joint work on reducing brain injuries at birth, says Morris, is that if you intervene earlier at the first signs of things not going well, it doesn't change the ultimate mode of delivery or massively increase the number of interventions.

Andrew Shennan, professor of obstetrics at King's College, London, welcomes the emphasis on training, resourcing, and support for maternity services. "Maternity is the relatively poor relation among medical specialties," he says. "We seem to accept risks in maternity that we just don't accept elsewhere in society."

But he says that in his experience some of the changes called for in culture and multidisciplinary working have already been made, such as around teams training together, including the use of PROMPT—a multidisciplinary approach to training in obstetrics and midwifery that was developed in Bristol.

Shennan concludes, "We now have annual requirements for training, and we do that together—in the same room with a horizontal hierarchy—and have discussions around challenging bad behaviour and wrong decisions. It creates a culture of mutual respect, where we're in this together and sharing responsibility."

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