

this week

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JANE BARLOW/PALAMY

Half consultant physician posts unfilled

More than half (52%) of advertised consultant physician posts in England and Wales went unfilled last year, shows a census conducted by three royal colleges. This is the highest rate since records began in 2008 and compares with 43% before the pandemic and 48% last year. Nearly three quarters (74%) of the unfilled posts had no applicants at all.

The 2021 consultant census conducted by the Royal College of Physicians of London, the Royal College of Physicians of Edinburgh, and the Royal College of Physicians and Surgeons of Glasgow ran last October to December and covered 18 646 people. The response rate was 23%. The full dataset will be published later this year.

In light of these shortages, the colleges are calling on the candidates for the Conservative party leadership to commit to delivering the 15 year NHS workforce strategy.

The long term workforce strategy was commissioned by the Department of Health and Social Care for England in January. It is being drawn up by NHS England and Health Education England and will include data on workforce requirements by specialty and provide a gap analysis to inform training plans. However, last month the then health secretary, Sajid Javid, told a committee of MPs that although the strategy report would be

ready by the end of the year it might not be published in full.

Andrew Goddard, president of the Royal College of Physicians of London, said the figures should be “a wake-up call” to the next prime minister, who must make delivering a workforce strategy “a priority.” He warned, “Without a concerted effort to expand the number of medical school places, there is a real risk that the NHS will be unable to deliver high quality care to all those who need it, both now and in the years ahead.”

The situation is likely to worsen, as the census data also indicate that 44% of current consultant physicians will reach retirement age in the next 10 years. This will further deplete the workforce even as the population ages and demand for care increases.

The number of female consultants is rising, and they now make up 39% of the consultant physician workforce. A large majority of men and women work full time until their mid-30s, but then 42% of women aged 35-44 work less than full time, against 6% of men.

The census also showed that 45% of consultants said they worked excessive hours or have an excessive workload “almost always” or “most of the time.”

Jacqui Wise, Kent
Cite this as: *BMJ* 2022;378:o1782

A census by three royal colleges showed consultant physician vacancy rates reached 52% last year

LATEST ONLINE

- Pay gap: Women in healthcare sector earn 24% less than men, international report finds
- Covid-19: MPs call for greater efforts to reach unvaccinated and partly vaccinated people
- Undergraduate degrees will no longer count towards specialty training applications



SEVEN DAYS IN

High covid rates and lack of hospital beds put “intense pressure” on ambulances



LEON NEAL/REUTERS/ALAMY

England's 11 ambulance services are working under extreme pressure because of rising rates of covid and a lack of available hospital beds, and leaders urged the public to take hot weather precautions to avoid adding to the overwhelming workload.

In a statement issued on 12 July, Martin Flaherty, managing director of the Association of Ambulance Chief Executives, said the NHS ambulance sector was operating at level 4, the highest level of local resource escalation action plans, which is normally reserved for “major incidents or short term periods of unusual demand.”

Flaherty said, “Severe delays in ambulance crews being able to hand over their patients at many hospital emergency departments are having a very significant impact on the ability to respond to patients as quickly as we would like to, because our crews and vehicles are stuck outside those hospitals.” He added that staff absence caused by covid and the “additional pressure caused by the current hot weather” were making the situation even tougher.

June data published on 14 July show the average response time for the most urgent incidents in England was just over nine minutes, two minutes over the mean standard.

Elisabeth Mahase, *The BMJ* Cite this as: *BMJ* 2022;378:o1763

Covid-19

BMA calls for long term plan to keep cases low

The BMA urged the government to develop a long term plan to keep covid cases at low levels after the latest Office for National Statistics survey showed that an estimated one in 19 people in England, one in 17 in Wales and Northern Ireland, and one in 16 in Scotland tested positive in the week to 6 July. Philip Banfield, BMA council chair, said, “There must be recognition from the government that heightened waves of infection lead to greater staff illness and absences, stretching health and care settings to the limit and beyond.”

Over 50s to get autumn vaccine booster

The government accepted the advice of the JCVI to offer an autumn covid booster to people aged over 50, care home staff and residents, frontline health and care workers, unpaid carers, people in clinical risk groups, and household contacts of immunosuppressed people. Eligibility for a flu vaccine will also be expanded to everyone aged 50 or over, primary and secondary school pupils in years 7-9, as well as people in clinical risk groups, unpaid carers, and household contacts of immunosuppressed people.

Mesothelioma

NICE recommends life extending cancer treatment

NICE has published final draft guidance recommending nivolumab (Opdivo) with ipilimumab (Yervoy) as a first line treatment for unresectable malignant pleural mesothelioma in adults. Most cases of this rare and aggressive form of cancer are linked to occupational exposure to asbestos. It is estimated that more than 600 people in England could benefit from the intravenous treatment. Clinical trial results show that on average people having nivolumab plus ipilimumab survive for four months longer than those having chemotherapy.

Alcohol

Young face higher health risks than older adults

A new analysis from the Global Burden of Diseases study found that 59.1% of people who consumed unsafe amounts of alcohol in 2020 were aged 15-39, with three quarters of them male. For adults over 40, a small amount of alcohol (one to two small glasses of red wine) can provide some health benefits, such as

reducing the risk of cardiovascular disease, said the study. The authors wrote in the *Lancet* that alcohol consumption recommendations should be based on age and location, with the strictest targeted at men and boys under 40.

Health inequalities

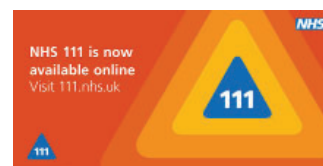
Welsh organisations call for action plan

Fifty organisations, including the Welsh NHS Confederation and the Royal College of Physicians, called on the Welsh government to produce a plan to reduce poverty and tackle inequalities. A report, *Mind the Gap: What's Stopping Change?* said that as the everyday cost of living continued to rise, an increase in poverty and inequality would lead to greater strain on people's health and the NHS. The report came as a YouGov poll found that 60% of people in Wales believed their health to have been negatively affected by the rising cost of living.

NHS 111

Call handler workload not cut by online service

The introduction of an online version of NHS 111 in England made no discernible difference to the workload of the telephone helpline



service, a study published in *BMJ Open* concluded. The analysis, by researchers from Sheffield University, also suggested that use of the online service could cause a rise in the number of ambulance dispatches if users followed its advice. On average, for every 1000 online contacts the number of recommendations for an ambulance was 6.7% higher than with telephone contacts.

Learning disabilities

Study says half of all deaths were avoidable

People with a learning disability continue to have a much shorter life expectancy than the wider general public, with six in 10 dying before age 65, compared with one in 10 in the general population, said the sixth annual report of the learning from life and death reviews programme (LeDeR). People with epilepsy and from ethnic minority backgrounds were more likely to die younger. Around half of all deaths of people with a learning disability were deemed to be avoidable, against less than a quarter in the general population.



MEDICINE

NHS pressures

Ambulance and hospital wait times continue to rise

Ambulance response times across all incident types rose in June, the latest NHS performance data showed. In June one in 10 patients waited longer than one hour and 54 minutes for a category 2 ambulance call. Time spent in A&E also grew, with 28% spending more than four hours from arrival to admission, transfer, or discharge, up from 13% in June 2019. The elective care waiting list also continues to grow: in May 6.6 million people were waiting for planned hospital treatment.

Vaccination

Childhood rates decline globally, figures show

Coverage of the third dose of diphtheria-tetanus-pertussis (DTP3), a marker for immunisation coverage, fell worldwide from 86% in 2019 to 81% in 2021, the lowest since 2008. The latest estimates from WHO and Unicef show that 25 million children were unvaccinated or undervaccinated in 2021, with 18 million not receiving any. A rise in the number of children living in conflict and fragile settings, increased vaccine misinformation, and service and supply chain disruptions were all cited as factors.

Oxygen in ICU

Race a factor in variation in supplementation

A cohort study of 3069 patients in an intensive care unit in the US found that Asian, black, and Hispanic patients received significantly less supplemental oxygen for a given average haemoglobin oxygen saturation than white patients. The research,



In June one in 10 patients waited nearly two hours for a category 2 ambulance call

One hour and 54 minute delay

in *JAMA Internal Medicine*, found the differences were associated with pulse oximeter performance. The data, from 2008 to 2019, did not include patients with covid-19, but the researchers said hidden hypoxaemia may contribute to care inequalities seen in the pandemic.

Mental health

Psychiatrists call for better workplace support

The Royal College of Psychiatrists described what a “good” workplace looks like, as part of a drive to help people with mental health challenges to stay in or return to work. As well as offering standard benefits such as job security, an appropriate wage, positive work-life balance, opportunities for career progression, and supportive mental health policies, workplaces should actively support employees with existing mental health disorders.

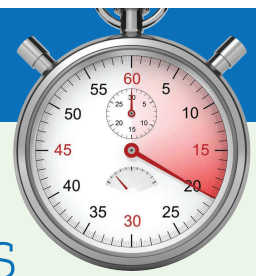
GP pensions

Treasury sympathetic to call to tackle unfair charges

The Treasury agreed to look at a quirk of the NHS Pension Scheme that leaves some doctors subject to unfair pension tax charges that are based on “pseudo-growth” of their pensions. Richard Fuller, economic secretary to the Treasury, made the pledge in a House of Commons debate called to highlight the detrimental effect soaring inflation will have on the medical workforce, by forcing doctors to cut their hours or retire early.

Cite this as: *BMJ* 2022;378:o1784

SIXTY SECONDS ON... HANGOVERS



THE DREAM IS FINALLY HERE

A new pill touted as the end of hangovers sold out less than 24 hours after it was released. De Faire Medical, the Swedish probiotics firm behind Myrkl, claims it is the first in history to break down alcohol effectively. Consumers are advised to take two pills at least one hour—and no more than 12 hours—before drinking alcohol.

WHAT'S IN THIS MAGIC COCKTAIL?

The main ingredients are probiotics such as *Bacillus subtilis* and *B coagulans*—though it also contains L-cysteine, an amino acid found in protein rich foods, and vitamin B₁₂. De Faire Medical says the combination is the result of 30 years of research.

SCIENCE OR JUST PUB CHAT?

When alcohol reaches the liver it is broken down into acetic acid. This produces acetaldehyde, a toxic byproduct that De Faire says causes the sore head, fatigue, and nausea after a heavy night out. By breaking down alcohol into CO₂ and water in the stomach before it reaches the liver, the bacteria cut the chance of a nasty hangover.

JUST MARKETING CLAIMS?

In an independent study published in *Nutrition and Metabolic Insights* participants who consumed Myrkl had 70% less alcohol in their blood an hour after drinking and 50% less after two hours. Alcohol in their breath was also reduced by around 30%. But the study has some serious limitations.

SUCH AS?

Participants consumed the recommended daily dose of two pills a day but every day for a week rather than just two pills

on the drinking day, as recommended. And participants consumed a single glass of 40% strength vodka—so not quite a Friday night binge. The measures were so small that alcohol levels were not measurable in 10 of the 24

participants. The remaining 14 were white, healthy, and had an average age of 25.

SO, NOT TIME TO GET A ROUND IN?

If the supplement does prevent a hangover, it will also stop people from getting drunk. It also acts once alcohol has passed through the stomach—so if you're susceptible to vomiting the morning after, it probably won't help.

Luke Taylor, Portsmouth

Cite this as: *BMJ* 2022;378:o1753

COVID DEATHS

The number of covid related deaths recorded across the UK surpassed

200000

as at 1 July

[*Office for National Statistics*]



Scottish NHS patients can visit US expert for mesh removal

Patients in Scotland who suffered life changing side effects from transvaginal mesh implant surgery have been told they can go to the US to have the mesh removed, with costs met by the NHS.

NHS Scotland has signed a contract with a clinic in Missouri that employs mesh removal specialist Dionysios Veronikis. Travel and accommodation costs will be paid for, in addition to the surgery, which typically costs £16 000 to £23 000. Scottish patients can also benefit from a contract signed with Spire Healthcare in Bristol to carry out mesh removal under the care of Hashim Hashim, professor of urology.

Any patient in Scotland who opts for mesh removal surgery has to be

Travel and accommodation will be paid in addition to the surgery, which costs £16 000 to £23 000

assessed by the Complex Pelvic Mesh Removal Service based at NHS Greater Glasgow and Clyde. If the surgery is

considered appropriate the patient can then choose to be treated by the Scottish or English NHS specialist centres. If neither is seen as suitable the patient can opt to travel to Bristol or Missouri.

Mesh implants were designed to treat issues such as incontinence and prolapse after childbirth, but in 2018 their use was halted in the UK after a campaign by women who had suffered serious side effects. They complained of internal damage leading to chronic pain, inflammation, and infection.

Earlier this year the Scottish parliament approved a bill to reimburse patients who had already travelled abroad or paid for removal surgery.

A network of specialist centres has been set up around the UK to help people who have suffered complications. However, earlier this year Alec Shelbrooke, co-chair of the Surgical Mesh All Party Parliamentary Group, told MPs that the centres were not working.

Bryan Christie, Edinburgh
Cite this as: *BMJ* 2022;378:o1735

GP partnership model won't be scrapped, officials insist

Senior officials have insisted that there are no plans to scrap the GP partnership model despite the expressed preference for a salaried service from the now former health secretary Sajid Javid.

At the final hearing of the Commons Health and Social Care Committee's inquiry on the future of general practice on 12 July the committee chair, Jeremy Hunt, pressed government and NHS officials

on Javid's comments from an earlier hearing that had caused consternation among GPs, now asking them directly whether scrapping the partnership model was government policy.

Matthew Style, director general for NHS policy and performance at the Department of Health and Social Care, said, "It is not our policy to scrap the partnership model but to work with the profession to develop the vision set out in Clare Fuller's stocktake." GP Fuller's May

report, commissioned by the government to review primary care integration, called for primary care networks to evolve into more collaborative "integrated neighbourhood teams" to improve access.

Amanda Doyle, director of primary and community care at NHS England, concurred. "We have no policy to scrap the partnership model," she said, adding that the issues facing the profession affect partners as well as salaried doctors. "It's important we retain all our GPs, so we don't want to do anything that is going to lead to a greater loss of GPs."

Revising targets

Also giving evidence, the newly appointed minister for patient safety and primary care, James Morris, made a commitment to revising primary care targets. While



Satisfaction with GP services falls sharply

Patients' satisfaction with GP services, particularly regarding the ease of getting an appointment, has fallen dramatically in the latest annual GP patient survey for England. Ipsos Mori sent out 2.47 million questionnaires to patients aged 16 and over, with 719 137 returned completed from January to April 2022, a 29% response rate.

Only 56% of respondents reported a good overall experience of making an appointment, down from 71% in 2021. Around half of respondents said they did not find it easy to get through to their practice by phone, up from less than a third last year.

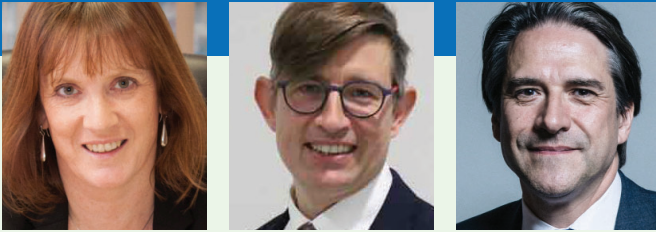
The survey found that 55% of people who said they needed an appointment had avoided making one over the past year, up from 42% the previous year. Seventy two per cent had a good overall experience of their GP practice, with

38% describing their experience as "very good." But the proportion of patients reporting a good overall experience was down 11% on the 2021 survey. The proportion of people with a poor experience of their practice overall has doubled in a single year, from 7% to 14%. Some 6% described their experience as "very poor."

Many measures of trust and good quality care remain strong although still down on previous years. At their last appointment, 93% of patients said they had confidence and trust in the healthcare professional, down from 96% in 2021. Some 91% said their needs were met, and 84% said the healthcare professional was good at treating them with care and concern.

The survey also found that people living in more deprived areas were more likely to have a bad experience than those living in more affluent areas.

THE SURVEY found that **55%** of people who said they needed an appointment had avoided making one over the past year



MPs' witnesses: Amanda Doyle, Matthew Style, and James Morris

targets had an important role in performance management, said Morris, "In terms of the challenges we face in primary care and in the context of stocktakes, I think it is legitimate that we would evaluate anything and everything to improve the situation."

He later added, "It's entirely appropriate that we set some very clear national expectations for what we expect our colleagues in health and care to deliver for patients but at the same time have more flexibility within those targets for local leaders to set their priorities."

Hunt said, "If you're actually going to look at them, then I think GPs up and down the country will be cheering."

Workforce numbers

Committee member Rosie Cooper challenged the panel on the apparent secrecy over

staffing projections, and Hunt bemoaned the fact that the government didn't publish its own estimates of gaps in the numbers of doctors, nurses, and allied health professionals or commission any independent projections, suggesting it was trying to "cover up" the problem.

Style said the figures would be published but added, "It is absolutely critical that the workforce strategy is done in tandem with NHS England's other work on the future of the long term plan. Those two things absolutely have to go hand in hand."

Hunt said, "This is us simply wanting to know that the numbers we were going to be told about are not the numbers the Treasury decides we can afford but the numbers we actually need."

Shaun Griffin, London
Cite this as: *BMJ* 2022;378:o1742

The BMA said the decrease in satisfaction was a "stark reflection of the workforce crisis." Farah Jameel, BMA England GP committee chair, said, "We've been saying for years that general practice needs investment, more GPs, and more support to see as many patients as possible in a way which meets their needs."

Nuffield Trust chief executive Nigel Edwards said, "Today's GP patient survey shows one of the most alarming collapses in NHS performance we have seen since the height of covid-19 and suggests the crisis we have long feared is arriving. It may be that worse public health since the pandemic, and a rise in how many people are unwell, is tipping the system over the edge."

Martin Marshall, chair of the Royal College of GPs, said, "Ultimately, GPs, our teams, and patients want the same thing—access to high quality and timely care. This is why we are calling on the government to introduce a bold plan for general practice."

Jacqui Wise, Kent
Cite this as: *BMJ* 2022;378:o1764

This shows one of the most alarming collapses in NHS performance since the height of covid
Nigel Edwards



Large study shows how well different drugs work for patients with insomnia

Two drugs not yet licensed in the UK, eszopiclone and lemborexant, seem to perform better than others in the acute and long term treatment of insomnia, show the results of a large comparison study.

Melatonin, which is licensed in the UK to treat insomnia in adults over the age of 55, did not show overall material benefits, according to the meta-analysis published in the *Lancet*. There was also insufficient evidence to support the prescription of benzodiazepines and zolpidem for long term treatment, found the research, which was funded by the National Institute for Health and Care Research.

The study included 154 double blind, randomised controlled trials that involved 44 000 people and 30 licensed or unlicensed drugs and placebo. The researchers compared the effectiveness of different pharmacological treatments for efficacy, acceptability, tolerability and safety in both acute and long term treatment of insomnia disorder.

"We looked at all information published and unpublished to achieve the most transparent and comprehensive picture of all the data available," said Andrea Cipriani, professor of psychiatry at Oxford University and honorary consultant psychiatrist at Oxford Health NHS Foundation Trust.

Insomnia disorder is characterised as at least three months of difficulty in initiating and maintaining sleep and is associated with increased risks of cardiovascular diseases, obesity and diabetes, depression, anxiety, and suicide. Around 10% of European adults have chronic insomnia, two thirds of them women.

Considering both acute and long term treatment, the researchers found that lemborexant and eszopiclone had the best profile in terms of efficacy, acceptability, and tolerability. However, eszopiclone might cause substantial adverse events such as dizziness and nausea, and data on the safety of lemborexant were inconclusive.

Lemborexant and eszopiclone are licensed in European countries and the US. Eszopiclone is a member of the class of Z drugs, which act on the GABA receptor. Lemborexant acts on a different brain pathway: the orexin neurotransmitter system.

Benzodiazepines (short acting, intermediate acting, and long acting) were found to be very effective in the acute treatment of insomnia, but their tolerability and safety profiles were not favourable, and no data from longer term trials were available. The findings indicated that benzodiazepines with intermediate half lives, such as temazepam and lorazepam, have better acceptability than short acting or long acting compounds.

Of the Z drugs (zopiclone, eszopiclone, zaleplon, and zolpidem) included in the analysis, eszopiclone had the best profile in terms of short term and long term efficacy and acceptability.

"Insomnia drugs are not all created equal, even within the same class," Cipriani told a Science Media Centre briefing. "There is not a one size fits all approach; there should be discussion with the patient about which is the best treatment for them."

Sleep hygiene and cognitive behavioural therapy are the recommended first line treatments for insomnia. In May NICE recommended the digital app Sleepio, which provides tailored cognitive behavioural therapy as an alternative to sleeping pills.

Jacqui Wise, Kent
Cite this as: *BMJ* 2022;378:o1758



EXCLUSIVE

Campaigners demand action on NHS doctors' "unacceptable" conditions

A campaign group run by doctors has written to all medical unions and the General Medical Council asking for urgent talks to discuss unacceptable working conditions in the NHS.

The group, EveryDoctor, filed the letters on 14 July, urging support in persuading the government to tackle mounting problems affecting patient safety. Signed by Julia Patterson, the group's chief executive, the letter warns that the current NHS hospital contract is not protecting doctors from exploitation.

Often doctors are asked to fill staffing gaps with very little notice because of poor management in failing to cover staffing gaps in good time. This means that doctors are exhausted while working, putting patients at risk.

"From the frontline testimony we hear each day, it's clear to us that the contracts doctors are working under are exacerbating the pressures upon doctors," wrote Patterson. "The contracts enable NHS workplaces to request doctors to provide emergency cover at the last minute to protect

patient safety. This has been the case for many years, and the medical profession have always respected the need for this in order to safeguard their patients.

"However, in many places currently, rota gaps are being identified months in advance, and yet cover arrangements are left until the last minute in order to present them as an emergency situation to the doctors involved. This is exploitative of the medical workforce and is contributing to staff exhaustion and burnout."

Responsibility to respond

The letter—sent to the BMA, Doctors in Unite, and the Hospital Consultants and Specialists Association, as well as the GMC—says, "We're becoming increasingly concerned about NHS working conditions. This situation is impacting both NHS staff and the patients they care for. As such, our trade unions and professional regulator have a responsibility to immediately respond to the issues."

EveryDoctor, which has a closed Facebook forum of more than 25 000

doctors, has collected and verified testimonies from doctors around the UK in the weeks since 27 June. The dossier of evidence includes an example of an emergency department consultant having to work double shifts to cover staffing gaps in recent months—in one case a 2-10 pm shift that turned into an all-nighter, ending at 8 am. Other examples include doctors being asked to go home and to return for a night shift after several hours of working and commuting.

A consultant in southwest Wales said a deficit of cover because of expected gaps was a big problem. "As these are known about, we are not contractually obliged to cover these," they said, "but often nothing is done about it until too late, or else there is no one available to cover as a locum—or the health board are not willing to pay the costs of a locum."

Patterson told *The BMJ* there were many reasons for the "absolute crisis" in the NHS: a very high staff vacancy rate, the covid-19 workload, staff absences, and additional pressure to tackle the waiting list backlog. But other



It's clear to us that the contracts doctors are working under are exacerbating the pressures upon doctors
EveryDoctor

DOCTORS' TESTIMONIES: "IT'S DEMORALISING AND EXHAUSTING"

Junior doctor, southwest England

"Recently I came in to do my shift that started at 8 am, and by mid-morning the doctor who was meant to be working that night—who I'd hand over to—had called in ill. As day shifts are easier to cover by pulling other doctors from clinics or educational opportunities, I was asked to leave work and come back that night to work the on-call night shift instead. By the time I returned for work that night to start at 8 pm, I'd already worked for three hours and driven for three hours. We're so physically and emotionally stretched by not having enough doctors, and by being asked to work extra on-call shifts without proper remuneration, that we're all feeling broken and demoralised."

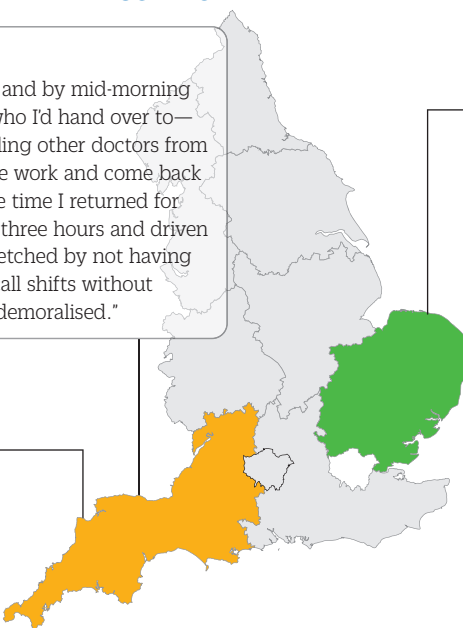
Consultant, southwest England

"The numbers of patients have exponentially increased, and as a team we've stretched ourselves to ensure enough senior cover for patients to be safe. But we're all exhausted. Covering all of the last minute gaps means time away from families and loved ones but also less time to rest and refresh before the next gruelling shift."

Emergency department consultant, east of England

"Over the last three months I've twice had to work double shifts to cover for staff shortages, due to a lack of senior doctors on our emergency department rota and because we can't get locums in to cover shifts."

It's both demoralising and exhausting to continuously work in this way . . . It's no longer unusual for patients to wait seven or eight hours in the back of an ambulance before we can get them into the department."





MARK FELIX/AP/GETTY

factors were making the situation even worse, she said, such as Home Office delays in helping secure visas for overseas recruits and an unnecessary cap on locum fees, something she said ought to be scrapped as a temporary measure.

She told *The BMJ*, “Obviously, with huge shortages, this situation isn’t really going to resolve itself unless the medical organisations and institutions really challenge the government on what they’re doing about it.”

National training survey

The GMC said it recognised that as the profession’s regulator it had an important role—along with employers, education bodies, governments, and others—to improve the wellbeing of doctors and the profession. A spokesperson told *The BMJ*, “We see supporting doctors to deliver first class care as central to our role. Through our national training survey we’re able to understand what’s happening on the ground, right down to provider level, and identify where clinicians’ wellbeing may need better support.

“In addition to these hard data, through our outreach teams and national offices we gain invaluable insights that provide a detailed picture of doctors’ working lives, meaning interventions can be targeted and action can be anticipatory.”

All unions were asked for comment. The BMA said that it would respond to EveryDoctor in due course. The others had not responded by the time *The BMJ* went to press.

Adele Waters, *The BMJ*

Cite this as: *BMJ* 2022;378:o1773



This situation isn’t going to resolve itself unless the medical organisations and institutions really challenge the government

Julia Patterson

FIVE MINUTES WITH . . .

Becky Cox and Chelcie Jewitt

The cofounders of the Surviving in Scrubs campaign discuss their work to expose and highlight cases of sexism, sexual harassment, and sexual assault in healthcare

“Both of us have experience of sexism and sexual harassment in the workplace. We know many of our friends have as well. We thought, well, what if we launch a website where people can feel safe to talk about their experiences—we’ve then got evidence of what’s going on. Because that’s what’s missing.

“They [the testimonies from healthcare professionals to the website] are all shocking, and none of them should be happening in this day and age. Some of the worst are when there’s a level of humiliation involved. We’ve had stories where somebody said, ‘A colleague touched me inappropriately and I tried to report it and then I was publicly humiliated by the person I reported it to in front of the rest of my team.’ That is just appalling—appalling that you’re not being believed and then you’re being belittled and laughed at in front of everybody that you work with, while the perpetrator carries on as normal.

“The first thing we’ve tried to prioritise is raising awareness about this matter, because while we all know that it happens, we know that very few of us actually ever talk about it.

“Step 1 is raising awareness and providing evidence, and then we want to campaign for change, which is why we’ve asked for a specific update to [the GMC’s] Good Medical Practice to include misogynist behaviour and abuse.

“Then, extending on from that, we want the royal colleges to provide some formal recognition of this guidance for their members, and we would like medical schools to start tackling this problem because a lot of what’s within healthcare starts in medical school and nursing school.

“[We need] a reporting system that’s safe for people to use, because at the moment you can speak to your clinical supervisor, but chances are they will know the perpetrator—they may be friends with them. Hospitals are very interconnected, intertwined environments, and it may be that your complaint doesn’t go anywhere or you feel so worried about what could happen that you won’t ever report it. So there needs to be somebody who’s independent that we can feel safe to go to.

“We also think medical students and medical schools should be setting a standard of practice.

“So, that’s our first call to action—for people to get in touch with us and to share their stories, and we want to hear stories from as many different professionals who work within healthcare as possible, and we also want to hear the intersectional side of it as well. We want to hear from people who have a disability, people from different ethnic backgrounds, and people who are trans. We want to know what their experience is, because if we don’t have documentation we can’t do anything.

“We need people to submit their stories, no matter how big or small they think they are. They all add to this collective narrative, and it’s through these voices that we are going to show the human side of this problem. Stories are powerful. We need these powerful stories in order to drive change.”

Becky Cox is an academic GP researching domestic abuse and GP specialist in gynaecology in Oxford. Chelcie Jewitt is an emergency medicine trainee in Liverpool



THE TESTIMONIES ARE SHOCKING, AND NONE OF THEM SHOULD BE HAPPENING IN THIS DAY AND AGE
BECKY COX



WE WANT TO HEAR FROM THE MANY DIFFERENT PROFESSIONALS WITHIN HEALTHCARE
CHELCIE JEWITT

Marina Politis, *The BMJ* Cite this as: *BMJ* 2022;378:o1777



THE BIG PICTURE

Palestinian hands learn to teach in Jerusalem

More than a decade after a small team of UK surgeons first headed to East Jerusalem to pass on their skills to a group of Palestinian doctors, they have started to hand on their baton.

Their teaching programme, endorsed by the Royal College of Surgeons of Edinburgh, first ran in 2011 with the goal of training doctors to carry out core surgical skills. The two day programme has run 15 times, and in May it hit a milestone when Palestinian doctors delivered part of it for the first time.

Supported by the Juzoor Foundation, a health and social development programme based in the Palestinian Occupied Territories and Jerusalem, the course offers practical skills in

training sessions on two sites—Hebron and Gaza—with a Zoom link-up. The programme was established by the Cornwall based surgeon Magdalena Ionescu after a holiday to the region in 2010.

Ionescu, who was part of the May training team, said, “The journey has been hard work for all the doctors in the UK and Palestine, but to see generations of candidates enjoy the course and some even become tutors themselves has brought immense joy. We hope we can secure the course for future generations.”

Adele Waters, The BMJ

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Magdalena Ionescu, founder of the training programme, with Palestinian colleagues, who use meat to teach surgery

The NHS is not living with covid, it's dying from it

The government must be honest about the threat the pandemic still poses

During a brutal week for the NHS, headlines may focus on the heatwave, but this situation is the culmination of many factors, including prolonged periods of underfunding,² lack of an adequate workforce plan,^{3,4} and a cowardly and shortsighted failure to undertake social care reform.⁵ The nation's attempt to "live with covid" is the straw that is breaking the NHS's back.

In 2020 and 2021 the NHS coped with pandemic peaks by stopping or slowing much of its routine work. 2022 was meant to be the year of full speed recovery. One of the assumptions underpinning this hope was that covid-19 would be nothing more than an irritant for most of the year, with perhaps a winter wave in December. It is now July, and not counting the first omicron surge that peaked in January, the UK and the NHS have experienced two further covid waves.⁶ The current wave of hospital admissions^{7,8} driven by the BA.4 and BA.5 variants may be peaking, but other variants will be ready for global distribution soon.⁹

Weekly hospital admissions to English hospitals, for those testing positive for covid-19, averaged just over 9000 in the first six and half months of the year. In 2021 the number was just under 6000, with most admissions concentrated in the first two months of the year. The average in 2020 was just under 7000.¹⁰

The omicron variant is less severe, and just under 40% of hospital patients are being treated "primarily" for the disease.¹⁰ But a covid-19 diagnosis is a complicating factor for many conditions, worsening outcomes and lengthening recovery times. The need to keep people with covid-19, uninfected people, and



MARK THOMAS

Especially concerning is the lack of political, public, or media outcry about the covid driven collapse in services

contacts apart means an increase in effort. Higher rates of covid-19 in hospitals and the community also result in more staff sickness, further hollowing out an already overstretched¹¹ and exhausted workforce.¹²

What the hospital admissions figures hide is a rising tide of people with long covid, now at two million¹³ and likely to be a major burden on the health service¹⁴ and the nation's productivity, for a generation.

Government complacency

How is the government responding to this crisis? Largely by pretending it is not happening. Government health spokesperson Lord Kammal recently repeated the spurious line: "We managed to break the link between infections and hospitalisations and hospitalisations and death." But the link between infections and hospital admissions has clearly not been broken.

As for deaths, the latest ONS figures¹⁷ indicate just under 24 000 fatalities "involving covid" in the first six months of 2022. That figure is more than the 21 000 people who died in the last six months of 2021. Excess deaths from all causes are also still running above five year averages before the pandemic.

The constant pressure created by repeated covid waves is already the main reason that the NHS is nowhere near reaching the activity levels needed to begin to recover performance. Elective activity is still around 10% below 2019.¹⁸

The Conservative party leadership contest—which will deliver the UK's next prime minister—is shedding little light on the crisis, and health is barely mentioned in leadership debates. What is especially concerning is the lack of great political, public, or media outcry about the covid-driven collapse in services.

At no other time in the past 50 years have so many parts of the NHS been so close to ceasing to function effectively. The heart of the problem is the failure to recognise that the pandemic is far from over and that a return to some of the measures taken in the past two years is needed.

Existing public health advice to wear masks in crowded places, ensure good ventilation, and test regularly need to be communicated much more powerfully and widely. This should include a return to mask wearing in healthcare settings and on public transport, as well as re-introduction of free tests for the public.²¹ Vaccination is the fourth pillar of action. Large sections of the population,²² particularly ethnic minorities and younger age groups, are still not fully vaccinated.

Above all, the government must stop gaslighting the public and be honest about the threat the pandemic still poses to them and the NHS. This will have two positive results, it will encourage the public to modify behaviour and, we hope, provoke urgent reflection about how the NHS is in such a mess so soon after the nation was applauding it on their doorsteps.

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Healthcare priorities for the next prime minister

Avoid zombie policies and invest in growing the workforce and reducing inequalities

The UK will soon have a new prime minister. Boris Johnson stepped down as Conservative party leader on 7 July 2022, but intends to stay on as prime minister until a new leader is elected by September.

Meanwhile, England also has a new secretary of state for health and social care. Steve Barclay—previously chief of staff at Downing Street—has replaced him in Johnson’s caretaker government. Barclay has a reputation as a hawk on health spending¹ and a sceptic of NHS bureaucracy.²

The context for whoever emerges as the next prime minister is grim. Pressures on health services are extreme, with the waiting list for routine hospital treatment at 6.5 million and counting.³ Public satisfaction with the NHS fell 17 percentage points between 2020 and 2021, falling to its lowest level since the 1990s.⁴ Covid-19 hospital admissions are back on the rise.⁵ And government risks colliding with NHS workers later this summer over pay.⁶

The health system is also in flux. The English NHS is being reorganised under the Health and Social Care Act 2022—the biggest legislative overhaul of the NHS in a decade. Right wing commentators are calling for more fundamental (though typically unspecified) “reform.”⁷⁻⁹ Zombie policy ideas—like switching the NHS funding model—continue to rear their heads.¹⁰⁻¹² Yet top down NHS reorganisations deliver little benefit,¹³ and international evidence points to no perfect model.¹⁴ The new prime minister must avoid tinkering with NHS structures and focus on the real problems facing health services instead.

Workforce shortages are top of the list. Staff gaps stand at around 110 000 in NHS trusts and 100 000 in adult social care.¹⁵ Shortages of fully qualified general practitioners are estimated at 4200 and without a



GO NAKAMURA/GETTY IMAGES

Unfair differences in health between more and less deprived areas are vast and growing

change in policy could grow to 10 700 by 2030-31—over one in four of projected GP posts.¹⁶ Staff gaps affect quality of care,^{17,18} and tackling them is a top priority for the public.¹⁹

National NHS bodies have been asked by government to produce a plan for how to recruit and retain the workforce needed in the future. But this will do little good without the long term investment needed to make it happen.²⁰ Failure to fairly reward staff—for example, if government sticks with its plan for 3% NHS pay increases²¹—might make shortages worse.

Record waiting lists

Tackling unmet need is another priority. The record high hospital waiting list in England could grow to somewhere between 7 and 11 million by 2023.²² Around 320 000 people have waited more than a year for treatment.³ Some patients also face challenges accessing primary care and community services.¹⁸ Growing staff numbers would improve access. But wider policy changes are also needed, such as investing in improving NHS infrastructure^{23,24} and testing service changes that could boost productivity.

Hugh Alderwick, director of policy, Health Foundation
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A new prime minister must do better than the last one on adult social care. Johnson’s government introduced reforms to cap individuals’ care costs over their lifetime, but last minute changes made the policy less fair and generous for people with lower levels of wealth.²⁵ Meanwhile, the social care system is on its knees. Many people go without the care they need, terms and conditions for staff are poor, and reliance on unpaid carers is high.²⁶ Covid-19 made things worse.^{27,28}

A mix of reform and investment is needed to improve and expand the broken system. Yet government spending is barely enough to meet growing demand for care.¹⁵

Reducing health inequalities should be an overarching priority. Unfair differences in health between more and less deprived areas are vast and growing.^{29,30} Johnson’s government produced grand political rhetoric on “levelling up” but failed to match it with the policy changes or investment needed to tackle structural social and economic drivers of health inequalities.^{32,33} Cross government action is needed—for example, to improve living conditions and strengthen social security. Progress in each of these areas would also help the UK respond to future waves of covid-19.

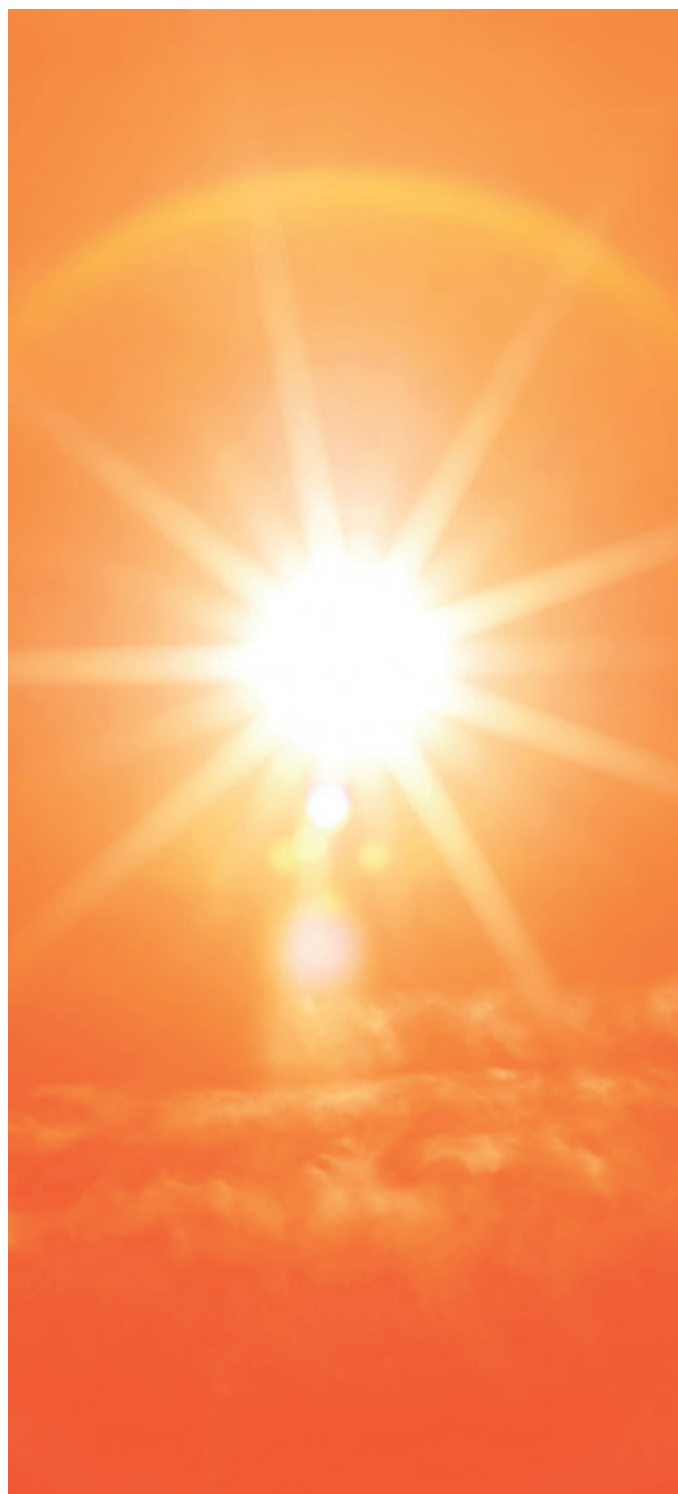
But will it happen? A dominant feature of the Conservative leadership campaign so far has been competing pledges to cut taxes.³⁴ Yet improving health services over the next decade—for example, to expand the NHS workforce or strengthen public health—will require additional public spending. UK tax levels are not high by international standards.^{35,36} Conservative leadership hopefuls should be honest about the consequences of future tax cuts and what they mean for public services.

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How hot weather kills: the rising public health dangers of extreme heat

As heatwaves increase in frequency around the world, taking a toll on individuals and systems, some countries are rising to the challenge better than others. **Sally Howard** and **Geetanjali Krishna** report



Paris, 9 August 2003: Eugénie Thievent, 88, dies alone in her top floor apartment in the Marais district. Alone and confused, Thievent suffers a fatal blood clot as her blood thickens from dehydration. A neighbour finds the retired teacher's body five hours after her death.

On that day the French capital was in the midst of a 20 day heatwave that saw the country's mean maximum temperature exceed the seasonal norm by 11°C on nine consecutive days, reaching an overall temperature of 37°C, while night time temperatures nudged 26°C. Thievent's apartment was four degrees hotter than those on lower floors of her four storey block.

Thievent's was one of 35 000 deaths attributed to that single extreme weather event. The World Health Organization has reported that 166 000 people died of heat stress worldwide in the 20 years to 2017, and the number of people exposed to heatwaves increased by around 125 million from 2000 to 2016.

The UN agency estimates that from 2030 to 2050 climate change will cause around 250 000 additional deaths a year worldwide, from malnutrition, malaria, diarrhoea, and heat stress. Exposure to extreme heat can cause exhaustion and heatstroke, a severe condition that occurs when body temperature rises to 40°C or higher and if untreated can quickly damage the brain, heart, kidneys, and muscles, being fatal in 10-50% of all cases.

Other symptoms of heat stress include swelling in the lower limbs, heat rash on the neck, cramps, headache, irritability, lethargy, and weakness. Heat can also cause severe dehydration and acute cerebrovascular accidents, and it can contribute, as in Thievent's case, to thrombogenesis (blood clots).

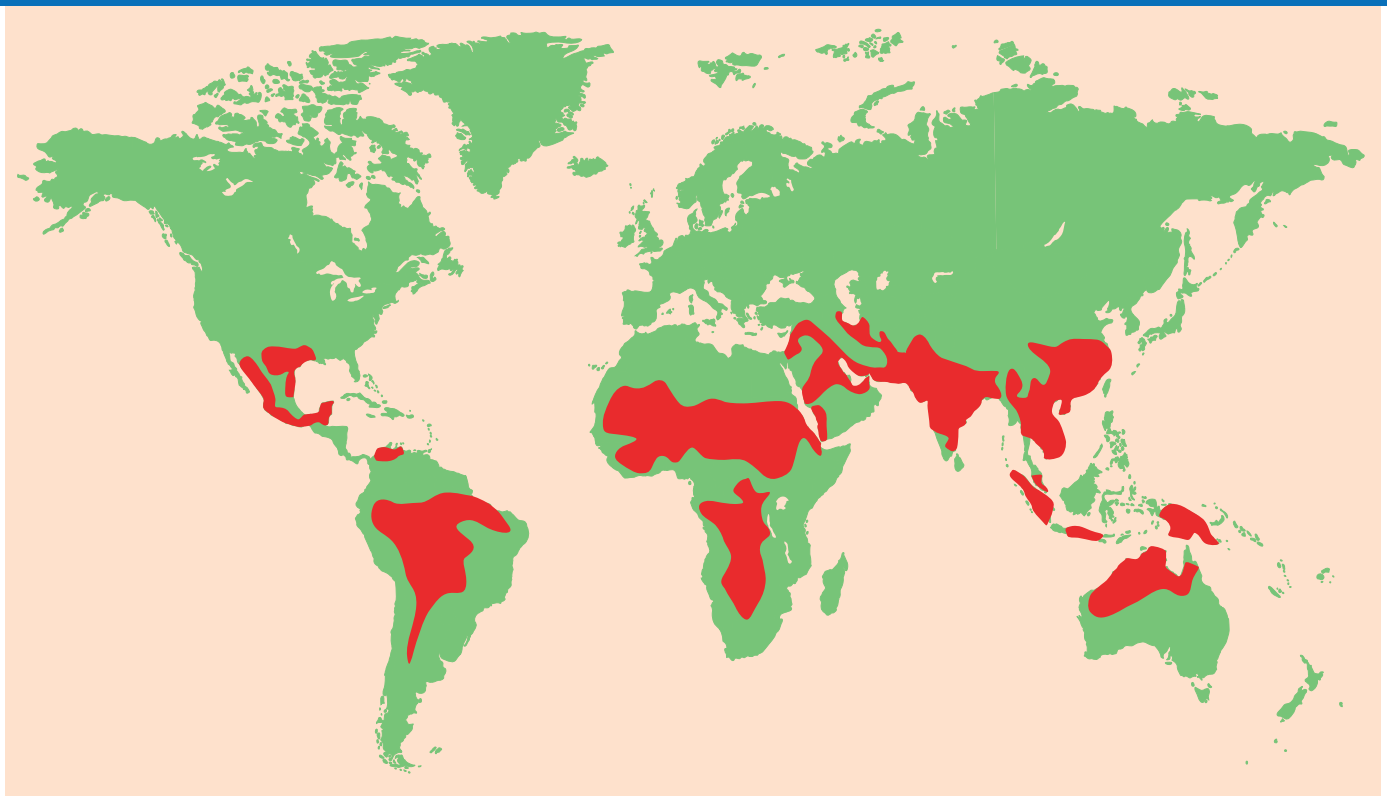
Much public health planning by governments has been reactive. And despite deaths and hospital admissions due to extreme heat making headlines each year, only now are steps being taken for different countries to learn from each other about this increasingly common health danger.

Who is at risk of heatstroke?

Older people (including those in residential care homes) and children are at greater risk of complications and death as a result of heat stress, as well as people with chronic diseases or who take daily medicines and may not know to adjust the dose. Studies have also found risks in pregnant women, linking heat exposure to preterm births and low birth weight.

The risk depends on both temperature and humidity and is indicated using "wet bulb globe temperature," a measurement that considers temperature, humidity, and direct or radiant sunlight. A wet bulb globe temperature above 32°C is defined as "extreme risk."

People in low and middle income countries are those most at risk from heat stress, as are city dwellers. In 2021, the



Areas where a wet bulb globe temperature higher than 32°C (indicating “extreme risk”) would occur for more than 10 days a year at 4°C global warming

UK Met Office estimated that a 2°C rise in global temperatures would lead to a billion people living in extreme heat stress, up from 68 million people today. A study last month found that a 1°C rise in global heat could be linked to a million deaths in Latin America. Many of the world’s people most affected are located on the populous Indian subcontinent, in Brazil, and in central Africa.

People with physical outdoor jobs have a greater risk of adverse health effects (known as exertional heatstroke) because activity increases the core body temperature, compounding the effects of heat and humidity. Evidence also shows a rise in acute and chronic kidney disease in people who experience occupational heat stress.

Early research has also pointed to a worse physiological toll exacted by heat stress in polluted environments, emphasising that “global warming increases the health effects of outdoor air pollution, resulting in more heatwaves, during which levels of air pollutants raise and high temperatures and air

contamination act in synergy, causing more serious health impacts than those estimated from heat or pollution alone.”

Action plans

The 2003 European heatwave, which killed 20 000 people in France including Thievent, was a turning point for the western world, says Franziska Matthies-Wiesler, who has worked on climate change and health for WHO’s regional office for Europe and the EuroHEAT project, which developed the guidance for heat health action plans in 2007.

“Europe began taking heat seriously as a public health risk and planning accordingly,” says Matthies-Wiesler. It’s a pattern in many countries: taking action only when extreme temperatures lead to sudden and alarming deaths. The US developed plans after events such as the 1995 heatwave in Philadelphia, which killed more than 1000 people. Even in Asia, where high temperatures are commonplace, it took a deadly 2010 heatwave that led to 4462

In 2021 the UK Met Office estimated that a 2°C rise in global temperatures would lead to a billion people living in extreme heat stress

excess deaths before any public health plans were drawn up.

The EuroHEAT project of 2005-07, coordinated by the World Meteorological Organization Europe and funded by the European Commission, quantified the health effects of heat in European cities and identified options for improving health systems’ preparedness and their response to heatwaves. France instituted a heat health warning system in 2003—a system of “graded” alerts generated by the country’s meteorological information systems—and a heat health action plan (HHAP) in 2012. Germany did likewise in 2008, as did Portugal in 2010 and Italy in 2012, while England and Wales produced plans in 2004 (guidance is in place for Northern Ireland or Scotland, but there are no formal HHAPs). By 2014, 18 of 51 WHO European member states had instituted a HHAP.

The many ways to tackle heat stress include adaptations

to the built environment and architecture, public awareness campaigns, monitoring vulnerable people, and linking warning systems with healthcare readiness. HHAPs in the US engage GPs, health centres, and civil protection and social services. As most people vulnerable to heat are managed in general practice, a 2018 Australian paper argued that GPs had a role in identifying vulnerable people in their practices and working with these patients and their relatives to incorporate primary and secondary prevention strategies, while advocating for mitigating greenhouse gas emissions.

A groundbreaking 2013 HHAP implemented by the Indian city of Ahmedabad—the first in Asia, triggered by the 2003 tragedy—emphasised capacity building among healthcare professionals, including training medics to treat heatstroke and ensuring enough intensive care beds to deal with heatstroke patients during heatwaves.



JOHN LOCHER/AP/SHUTTERSTOCK

A 2018 pilot evaluation of the impact of Ahmedabad’s HHAP on all cause mortality found a correlation between ensuring the health system was forewarned of heatwaves and lower summertime all cause mortality rates, with the largest declines seen at the highest temperatures. As of 2022, HHAPs had been implemented in 23 Indian states.

Sharing knowledge

WHO works with national health sectors to strengthen governance, preparedness, and the response to heatwaves by developing contingency

plans to map risks, vulnerable populations, available capacities, and resources. “These plans also include early warning systems and ensure vulnerable populations, such as those in health facilities, nursing homes, and schools, have adequate provision of cooling equipment,” a spokesperson said.

Despite the growth of HHAPs, however, knowledge about heat stress and the risks of extreme heat is not yet shared globally, increasing the toll of preventable deaths. Although WHO provides a fact sheet on heat stress, its climate change initiatives focus on the

Knowledge about heat stress and the risks of extreme heat is not yet shared globally

environmental sustainability of health facilities and healthcare resilience (ensuring that healthcare systems can perform essential functions when climate stressed) rather than population heat stress and population messaging. In 2018 the UN and public health specialists formed the Global Heat Health Information Network, designed to increase knowledge sharing around heat health, warning systems, and practices at a local, national, and global level. ENBEL, a project funded by the EU’s Horizon 2020 programme, aims to connect health and climate change research.

Matthies-Wiesler says one problem with HHAPs, which are typically led by environmental departments, is that they don’t fully integrate care providers. A 2021 comparative study of HHAPs found that confusion and overlap between stakeholder roles and governance, including health agencies, hindered many action plans.

In Germany at least, medical and social care professionals have joined forces to tackle these shortcomings. A group including the Berlin Medical Association and the Senate Department for Science, Health, Care and Equality launched the Action Alliance for Heat Protection Berlin project on 20 June, with interventions led by healthcare professionals rather than civic officials. The project will include heat protection of healthcare facilities, such as adapting buildings and increasing water availability in hospital wards. The results will inform other German cities and federal states.

Peter Bobbert, president of the Berlin Medical Association, said, “Between 2018 and 2020 there were around 1400 heat deaths in Berlin and Brandenburg alone.

“As a society, we must protect vulnerable groups from this danger. It is underestimated how many people are already dying here in Berlin as a result of the climate crisis.”

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HEAT WARNINGS IN ENGLAND: PATIENTS RESIST “NANNY STATEISM”

Amina Albeyatti, a Surrey GP with an interest in sun damage and heat stress, fears that the health risks of hot weather are not taken seriously in the UK despite an estimated 2000 deaths a year from heat stress, which are projected to treble by 2050.

“We use the term ‘heatstroke’ very liberally in this country, but when you have a patient with heatstroke it is very dramatic,” she told *The BMJ*. “The indoor risks of heat are poorly understood, and the emphasis with elderly people is often on retaining heat in the home, which puts them at risk. They often don’t know how to adjust medications—such as diuretics, anticholinergics, antipsychotics, and beta blockers, which can make the body more sensitive to heat—to lower the risk.

“At the moment, I don’t think public health messaging is working for either the young people exposed to hot work environments or for frail and vulnerable people. Often patients don’t want to hear these messages from their GPs, either. It’s hard to get through.”

An architect of England’s heat health action plan who wishes to remain anonymous told *The BMJ* that heat health warnings in England should be couched and timed very carefully because of public resistance to the concept of a nanny state.

“The problem is that people love heat in this country, so it’s a very unpopular message,” they said. “The literature also shows that people don’t identify themselves as vulnerable to heat.”



RICHARD BAKER/GETTY IMAGES

Why do NHS hospitals struggle to handle heatwaves?

With record breaking temperatures recorded in the UK this week, health facilities were battling to keep cool. **Chris Stokel-Walker** explores why NHS estates have such a problem with heat regulation—and the impact it has on doctors and patients

After Catherine Flick gave birth to her baby in Leicester's Royal Infirmary on 2 July 2019, she was sent to one of the hospital's three maternity wards to recuperate. "It was absolutely sweltering," the university academic says. "I'm an Australian: I can deal with some heat. But I remember lying there bathed in sweat."

The summer of 2019 saw a UK temperature record of 38.7°C recorded, in Cambridge, the same month as Flick's child arrived. In Leicester, Flick and the other women on her ward asked staff if they could plug in a fan to keep cool. They were told they couldn't for safety reasons. "We were at our wit's end," she says. "I was sitting there, worried about my baby overheating."

How hot is too hot?

Anyone who's ever been in a UK hospital, whether as a staff member, patient, or visitor, will know that the NHS has a problem with heat regulation. "Hospitals are not well equipped to deal with very warm temperatures," says Sophie Bracke, a foundation year 2 doctor working in the NHS (who asked *The BMJ* not to publish the name of the trust in which she works).

NHS trusts across England reported 4131 incidents between April 2020 and March 2021 when ward or other clinical area temperatures rose above 26°C—the point at which, according to England's health heatwave plan, a risk assessment needs to be conducted and vulnerable patients protected. Almost one quarter of those "overheating occurrences," 1000 in all, occurred in the Warrington, Wigan, and Leigh NHS Foundation Trust.

David Evans, director of estates and facilities for the trust, emphasises to *The BMJ* that "incidents are recorded by area," meaning two wards exceeding 26°C on the same day counts as two incidents. Evans says the trust is "working hard to tackle the current weather conditions" and avoid a repeat of past troubles. But it's not a problem with one trust alone: almost half, 104, of the 216 NHS trusts in England reported at least one overheating occurrence in 2020-21.

What is the NHS's heatwave plan?

England's health heatwave plan—coordinated by the NHS, UK Health Security Agency (UKHSA), Local Government Association and Met Office—outlines four levels that hospitals and other health and social care services should observe. It was drawn up following the 2003 heatwave that resulted in 2139 excess deaths in England and Wales—including many people over the age of 75.



The levels increase in severity, with level 2 triggered when there is a 60% or higher risk of a heatwave in the next two or three days. It mandates regular recording of temperatures in hospitals; ensuring cool areas remain below 26°C; taking extra care of vulnerable and high risk patients; and providing sufficient cold water and ice to keep staff and patients cool.

It also suggests hospitals and care homes consider weighing patients regularly to check for dehydration. Level 2 is triggered before a heatwave occurs because many deaths from overheating happen within the first two days, according to the heatwave plan.

Level 3 begins when high temperatures are recorded in at least one region by the Met Office. Trusts in regions where temperatures are exceeded are instructed, once this happens, to expect increased demand on services and to take more action to try to reduce temperatures, including shading patients and turning off unnecessary lights and equipment that may cause temperatures to rise.

Level 4 is a nationwide emergency, and can only be declared by central government; it is triggered because of a risk of illness and death among the fit and healthy. The UK Health Security Agency (UKHSA) declared the first ever level 4 alert on the morning of 15 July. The alert was, the Met Office said, in parallel with its first ever red extreme heat warning, for parts of central, northern, eastern, and south eastern England on 17 and 18 July.

The BMJ requested to speak to Agostinho Sousa, UKHSA's head of extreme events and health protection, but he was unavailable.

How are doctors and patients affected?

Despite the plans, excess deaths still occur. The three heatwaves the UK experienced in the summer of 2020 resulted in 2556 excess deaths—more than the 2003 heatwave that triggered the plan to be drawn up, although the impact of covid-19 circulation on mortality that year has not been measured. In 2021, the eight days that a level 3 heatwave alert was active caused 915 excess deaths.

Those affected by the heat include the extremely old and extremely young, but other comorbidities can also have an impact on how keenly people feel changes in temperature. Patients taking courses of beta blockers, tricyclic antidepressants, aspirin, and diuretics used for blood pressure are more exposed to heat disorders, alongside those with heart disease and other chronic illnesses. Antihistamines can also cause the body to produce less sweat—meaning it's more difficult to regulate temperature.

Because the summer has been busier, staff are less inclined to take their breaks—and to grab a drink, leading to the possibility of chronic dehydration

How are trusts and doctors trying to beat the heat?

Despite what some claim, there is no legal maximum or minimum temperature in a workplace. “In most NHS hospitals, the heating seems to be on a fixed timer,” says Beg. “Whether it’s warm outside or cold, the radiators are always on.”

He has previously worked in hospitals where staff have asked to turn down the heat, but have been told it’s not possible. “It’s particularly bad these days with the pandemic, because if you’ve got a procedure, you have to wear a gown or additional things that make it even hotter.” While mask mandates have been relaxed in many parts of the NHS, Beg still wears a mask and finds it makes the heat worse.

Faced with rising temperatures, some trusts are taking things into their own hands. *The BMJ* has seen an email sent on 13 July informing staff in Mid and South Essex NHS Foundation Trust of the availability of extra bottled water supplies and the relaxation of the staff uniform policy. “People do not have to wear tights, and can wear shorts as long as they are tailored, knee length, and blue or black,” says the email from Andrew Pike, chief operating officer at the trust.

Dress codes have been informally relaxed at other hospitals, too; Beg decided to don shorts on 11 July to tackle the heatwave.

Ward spoke to staff at four or five NHS trusts last week about their heatwave contingency plans. Measures being taken include fans, ice lollies, and water bottles ready to use when people get hot. “It’s the low tech solutions,” he says. Bracke has been supplied with ice lollies and cold drinks, as well as fans on wards—though she says “it’s kind of putting out small fires.”

Ward, who has worked with the Department of Health on covid-19 contingency planning, says that hospitals he’s spoken to have worried less this year about infection risks from fans circulating covid-19 than they did last year—in part because of the prevalence of vaccines and the comparative mildness of the current variants.

Overhaul needed

Something needs to change—including an overhaul of hospital buildings to handle hotter temperatures. “Looking forward, we are going to have entire summers of what we would today call ‘heatwaves’,” says Nusbacher.

Flick, who gave birth at the height of the heatwave three years ago, faces a conundrum: she’s due to give birth again in late July. She investigated booking a private room—because she could potentially be able to open a window—to no avail. “I’m really hoping it cools down because it adds another level of discomfort that you don’t need at that key point in your life,” she says. (The University Hospitals of Leicester NHS Trust did not respond to *The BMJ*’s request for comment.)

One thing has changed at her hospital since she last gave birth, however—an indication, perhaps, of hospitals’ “small fires” approach to beating the heat. The list of recommendations for what to bring that was provided by the hospital now includes a rechargeable fan or water spray to keep cool. “I don’t remember seeing that last time,” says Flick.

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FABIOLA PAOLA/PALALAMY

Hassan Ali Beg, a cardiology registrar across the Northumbria Healthcare NHS Foundation Trust, says, “We have to promote drinking adequate amounts to patients.” It’s a concern Bracke has, too. “I’m most worried about the patients,” she says. “The staff are all young and get through the day with a fan and cold drinks, but I’m worried about patients’ increased risk of dehydration.”

But because the summer has been busier, staff are less inclined to take their breaks—and to grab a drink. “It really needs to be encouraged,” Beg says, “because when you’re chronically dehydrated, you can get kidney stones.” He says he’s seen colleagues with no other risk factors for getting kidney stones affected by them, which he assumes is down to dehydration.

Ruth May, chief nursing officer for England, has recently tweeted her concern that some staff have been told not to drink at their nurses’ stations. May’s worries were backed up by multiple nurses confirming that was the case. NHS England declined to comment to *The BMJ*.

Why are NHS hospitals so hot?

Hospitals’ heat problems stem in part from the age of the infrastructure. A third of the NHS estate was built before 1965, and 14% before the foundation of the NHS in 1948, according to a 2020 National Audit Office report.

With age comes problems. “High risk backlog maintenance”—issues that require urgent fixes to prevent catastrophic failure and disruption to clinical services—rose 139% between 2014-15 and 2018-19.

“I do a lot of work in the Middle East and Australia, and those countries have no problem with the heat,” says Andy Ward, managing director of WHi Consulting, a hospital infrastructure consultancy. “They have newer builds than we’ve generally got in the NHS, and they specify them to need air conditioning.”

Installing air conditioning would be ideal, says Lynette Nusbacher, a non-executive member of NHS Surrey Heartlands Integrated Care Board, and a former government horizon scanning strategist. Although it needs to happen, it would be difficult at the moment. “We’re just going, in the health world, from two years of unlimited cash—spend whatever you need to keep people alive—to going back to budget discipline. This is not the year for people to be putting cooling systems on their capital expenditure plans.”