this week

TWITTER BLUE page 297 • **NHS ON STRIKE** page 298 • **PREVENTING RSV** page 300

LYNSEY ADDARIO /GETTY

New seven day row as waiting list grows

The seven day working argument resurfaced this week, with a consultant arguing that the NHS needs to make better use of facilities at weekends to tackle the growing waiting list.

In 2012 Bruce Keogh, then the NHS's medical director, set out seven day working standards for England, designed to tackle worse outcomes among patients admitted to hospital at weekends. The issue became heavily politicised during the junior doctors' contract dispute in 2016.

With figures showing 7.1 million people were waiting for planned hospital care in September, up from 4.4 million before the pandemic, there have been calls to change consultants' working patterns.

Andrew Stein, a consultant in renal and general medicine who served on Keogh's seven day working group, told BBC Radio 4's *Today* programme, "This is an unfinished job and we should have another go. The NHS simply won't work unless we work seven days a week. No individual has to work seven days, but there's no reason why we couldn't, for example, have one team working Monday to Thursday and the other Thursday to Sunday."

Stein acknowledged that staff were "under huge pressure" but said just hiring more people would not necessarily make the NHS more productive. "In most hospitals in the UK, it's like the *Mary Celeste* on a Friday afternoon," he said. "CTs are not done, operations are not done. So just getting more staff in doesn't necessarily solve that problem, because that's an efficiency problem."

The BMA rejected the comment and said that there were simply not enough staff.

Vishal Sharma, chair of the association's Consultants Committee, said, "These comments are hugely disrespectful and very disheartening when the truth is that the NHS is under extreme pressure and staff are routinely having to work above and beyond to provide care for their patients.

"While we recognise there is less elective and non-urgent work happening at weekends than during the week, the fundamental issue is that there are not enough staff. Stretching an already overstretched workforce will not increase the number of patients that get treatment but would arguably be even more damaging to patient care as a result of diluting the number of staff available each day."

Sharma said the government must instead significantly boost the workforce, restore "successive years of pay cuts," and tackle the pension taxation concerns "driving highly skilled doctors out of the profession."

Gareth Iacobucci, *The BMJ*

Cite this as: *BMJ* 2022;379:o2754

One consultant said hospitals are like the Mary Celeste on Fridays, and only weekend working can reduce waiting times for elective care

LATEST ONLINE

- Water fluoridation confers modest benefit to children's dental health, study finds
- Paediatrician who tried to hide cause of child's death from hyponatraemia 26 years ago is struck off
- Skin to skin care can start before small and preterm babies are clinically stable, WHO says

SEVEN DAYS IN

Hospitals are told to provide healthy hot and cold food 24 hours a day

HANNAH MCKAY/PA/ALAMY

NHS trusts will have to ensure their staff can access healthy hot and cold food 24 hours a day under new food standards published by NHS England.

The standards follow a year long grassroots campaign (#NoHungryNHSStaff), led by Neely Mozawala, a community specialist diabetes podiatrist in Somerset, and Saliha Mahmood Ahmed, a gastroenterologist and winner of BBC One's *MasterChef* 2017.

In 2014 an independent report commissioned by the Department of Health led to legally binding standards on the nutritional quality of the food served to staff and patients in hospitals, but there was no requirement for this food to be available 24 hours a day.

A survey of members by the Medical and Dental Defence Union of Scotland (MDDUS), released last week, found that 32% of doctors aged between 25 and 34 were rarely or never able to buy nutritious meals or snacks during working hours. Of the 850 UK junior doctors who responded, 77% said they had experienced burnout at work, with 39% citing lack of access to good food at work as a contributing factor. Half (51%) said they had felt fatigued because of a lack of access to nutritious food, and 16% said they were considering leaving the profession owing to a lack of access to nutritious food.

Ingrid Torjesen, *The BMJ* **Cite this as: *BMJ* 2022;379:o2729**

Alcohol

Sales reflect minimum unit pricing in Scotland

In the first 12 months after Scotland introduced the 50p minimum unit price on alcohol, prices of alcoholic drinks in supermarkets increased to match those in convenience stores, showed research from Public Health Scotland. The greatest price rises were for drinks that were priced the lowest relative to their alcohol by volume, such as some ciders, perries, and supermarket own brand spirits. The amount of beer and cider sold in the largest multipacks also fell, while sales in smaller multipacks increased.

Mental health

Bipolar disorder lacks specialist support

A report from the Bipolar Commission, convened by the charity Bipolar UK alongside a group of experts with experience of the condition, found that the "episodic" model of care—where patients have access to a GP but are referred to a psychiatrist only if they become unwell—was not working. Instead, it recommended embedding a new specialist care pathway in primary and secondary care to provide specialist treatment and continuity of support. Screening for bipolar disorder should occur across primary and secondary services, it advised, and specialist training should be introduced throughout the NHS.

Osteoarthritis

Rubber sole "pods" could reduce knee pain

NICE launched a consultation on whether people with osteoarthritis who are eligible for knee surgery should be offered shoes fitted with rubber "pods" on the soles, designed to re-educate muscles, correct abnormal walking patterns, and reduce pain. Analysis seen by NICE shows that Apos (left), could potentially save the NHS £1958 a patient when compared with standard care over five years. The cost for the footwear and associated treatment from trained professionals is estimated at £875 a patient. The consultation closes on 12 December (bit.ly/3hNICE).

Diabetes

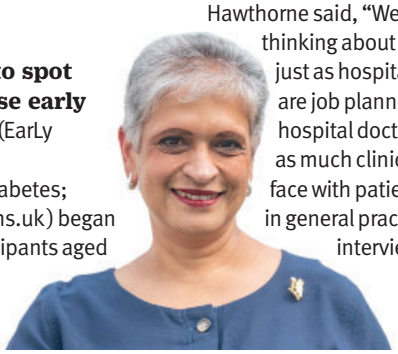
Study aims to spot type 1 disease early

The ELSA study (EarLy Surveillance for Autoimmune diabetes; elsadiabetes.nhs.uk) began recruiting participants aged 3-13 years to test the feasibility of a screening programme for type 1 diabetes. Funded by Diabetes UK and the non-profit JDRF, the study will screen 20 000 children for autoantibodies. People with two or more autoantibodies have an 85% chance of developing type 1 diabetes within 15 years and are almost certain to develop the condition in their life. Early support for people at risk could improve long term outcomes, said Diabetes UK.

General practice

RCGP: scrap part time and full time classification

The classification of "part time" and "full time" GPs should be discarded because it no longer reflects the hours or intensity of the role, said Kamila Hawthorne (below), incoming chair of the Royal College of General Practitioners. Most GPs work three to five days a week with 11 hour days, and many also do paperwork in the evenings and at weekends. Hawthorne said, "We need to be thinking about job planning just as hospital doctors are job planned, and most hospital doctors don't do as much clinical face to face with patients as we do in general practice." (See interview, p 306)



Vaccines

Lebanon launches campaign against cholera

Lebanon began vaccinating all refugees and people in host communities aged 1 year and over against cholera on 12 November after receiving a shipment of 600 000 doses from WHO. The country is experiencing its first outbreak of cholera in over 30 years. As of 7 November some 2722 suspected cholera cases (448 laboratory confirmed) and 18 associated deaths were reported, 25% in children under 5.

Global vaccine market "needs changes"

WHO's director general, Tedros Adhanom Ghebreyesus, said its *Global Vaccine Market Report 2022* showed that free market dynamics were depriving some of the world's poorest and most vulnerable people of the right to vaccines. The report called on governments to develop clear immunisation plans, with stronger investment and stronger oversight of development, production, and distribution.

MEDICINE

Fewer children and staff caught covid in Massachusetts schools that had insisted on masks after February

Covid-19

Schools that kept masks for pupils had fewer cases

Researchers in Massachusetts conducted a natural experiment on the effectiveness of face masks in limiting the spread of covid, as two of 72 schools in the greater Boston area continued mandatory wearing of masks after they ceased to be required in February 2022. Reporting in the *New England Journal of Medicine*, the authors found that during the following 15 weeks the lifting of masking was associated with an additional 44.9 cases in every 1000 students and staff (95% confidence interval 32.6 to 57.1), corresponding to an estimated 11 901 cases in total (29.4% of cases at that time).

England's health declined in first year of pandemic

The Health Index for England declined from 100.5 in 2019 to 100.1 in 2020, the first year of the pandemic, driven largely by falls on indicators relating to personal wellbeing and mortality, showed data from the Office for National Statistics. But lockdown rules were associated with improvements in air pollution, road traffic incidents, and crime. Gwen Nightingale, assistant director at the Health Foundation, said, "Good health is one of the nation's primary assets, and the index provides leaders with authoritative information to inform local plans to improve health."

Funding is "sucked away" by war in Ukraine

A funding gap of around £10.5bn has emerged in developing countries' pandemic preparedness, a conference was told, as governments in richer countries divert finance to military aid for Ukraine and other urgent domestic priorities such as energy costs. The conference on development finance was organised by Devex, a non-profit umbrella group for development charities. The UK has reduced its development aid budget from 0.7% of GDP to 0.5%, and commitments from other countries are "falling away," said Mark Malloch Brown, former UN deputy director general and now head of the development charity Open Society Foundations.

Overseas news

Australia axes 24 year old medicines advice agency

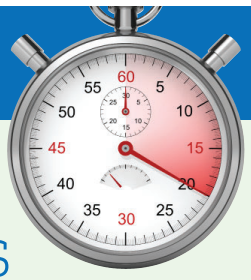
NPS MedicineWise, an Australian organisation that has offered independent information on medicines for 24 years, will close at the end of the year after cuts were made to its funding. The Australian Commission on Safety and Quality in Health Care, which works in hospital settings, will take over some of NPS MedicineWise's functions, and other services will be put out to tender, but it is not clear what will happen to some functions such as the Choosing Wisely campaign. NPS MedicineWise said that it had delivered a net return on investment of more than 2:1 to the government by making more than A$1.1bn (£620m) in direct savings.

Cite this as: *BMJ* 2022;379:o2744

STAFFING

In 2021-22 a total of 60 trusts in England spent **£2.5** bn on temporary staff through agencies and staff banks. Across the NHS in England that would amount to **£8.9** bn

[Labour Party]



SIXTY SECONDS ON . . . TWITTER BLUE

A NEW MEDICAL SYNDROME?

It might well be. But here we're talking about one of the changes made to the popular social platform since billionaire Elon Musk took over. Causing the biggest stir are his changes to official verified status and its merging with the service's subscription tier called Twitter Blue.

WHAT'S THAT?

It's a premium service that, for a fee, adds various exclusive features, the most notable of which (until Musk's takeover) was an "undo tweet" button and later an edit button. But Musk's ownership added a coveted "blue tick" mark to the list—a mark that previously was awarded only to verified notable accounts, such as organisations, politicians, celebrities, and journalists, to prove they were real and not an imposter. The addition means anyone willing to pay $8 a month can now get that mark.

WHY ARE TWEEPS FLAPPING?

It has led to a slew of fake accounts, including several for Musk himself. But of concern to *BMJ* readers might be the potential for misinformation about science, health, and medicine. Already a fake Eli Lilly account has caused a stir, posting, "We are excited to announce that insulin is free now."

IT IS?

No, no, it was a parody account and clearly marked as such on its profile. But the (paid for) blue tick meant the message was shared widely, and many people were taken in.

COLOUR ME GULLIBLE

Not at all. It shows just how fast rumours can spread on social media, particularly Twitter, which, despite having an active user base of only around 436 million people a month (Facebook has around 2.9 billion), is extremely influential among politicians and the media, which in turn influence the general public.

HAS THE BIRD FLOWN THE COOP?

Users are reportedly fleeing the platform in droves. But Twitter has become something of a mainstay of debate among sections of academics and medics—#medtwitter being one of the most popular hashtags among healthcare professionals. What happens to those networks, those discussions, and that sounding board remains to be seen.

Mun-Keat Looi, *The BMJ*

Cite this as: *BMJ* 2022;379:o2730

Nurses vote to strike over pay, as other health workers are balloted

I deeply regret that some union members have voted for industrial action
Steve Barclay

Many nurses across the UK have voted to take strike action in their fight for a pay rise, with industrial action expected to begin before the end of the year and to run until May 2023, the Royal College of Nursing has announced.

The ballot saw just over half of NHS trusts in England (102 of 215) reach the 50% turnout threshold needed for strike action, while all nursing staff in Northern Ireland and Scotland will be included, and all but one of the health boards in Wales met the threshold.

The Fair Pay for Nursing campaign is calling for a pay increase 5% above inflation, which would currently mean a 17.6% pay rise. The government said this would cost around £9bn, as the uplift would also need to cover all staff on the Agenda for Change contract, which covers many NHS staff groups, though not doctors, dentists, and very senior managers.

The RCN has said that nurses' pay has "consistently fallen below inflation—a fact which is being exacerbated by the cost of living crisis—and must now rise significantly to reflect that."

The ballot followed anger over the NHS Agenda for Change pay announcement in July, which saw many NHS staff, including nurses, paramedics, and midwives, receive a pay rise of around 4-5%. The RCN said this left experienced nurses 20% worse off in real terms than a decade ago.

A recent NHS Providers survey found that NHS trust leaders were concerned about the mental, physical, and financial wellbeing of their staff as a result of cost of living pressures, with 61% reporting a rise in staff sickness absence for mental health issues.

THE RCN said experienced nurses were 20% worse off in real terms than a decade ago

Nearly three quarters of leaders (71%) said staff struggling to afford to come to work had a significant or severe effect on their trust. The rising cost of living was also forcing staff to look for roles elsewhere, such as in the hospitality or retail sectors.

Food banks

Meanwhile, the Trussell Trust, which runs one of the UK's largest food bank networks, has said nurses were among the workers who were accessing their food banks, while some hospitals have set up their own food banks for staff.

RCN general secretary and chief executive Pat Cullen said, "Anger has become action—our members are saying enough is enough. Our members will no longer tolerate a financial knife edge at home and a raw deal at work." She said the government had "the power to stop this now and at any point."

The BMA's deputy chair of council, Emma Runswick, said, "Like us,

GP who faked diamorphine prescriptions is suspended

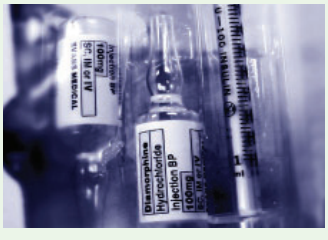
A GP who wrote prescriptions in the names of deceased patients to obtain diamorphine for himself has been suspended from the medical register for three months.

When colleagues confronted him over the 66 bogus scripts in 2018, Praveen Alla firstly claimed he had been blackmailed into writing them by a patient who threatened to falsely accuse him of sexual abuse. But he confessed the truth within 36 hours.

He was convicted in October 2020 of fraud by abuse of position and received a 12 month prison sentence, suspended for two years. He has not worked as a GP since and resigned from his practice at Bolsover in early 2019.

Alla, who qualified at Sheffield University in 2003, admitted at the outset of his medical practitioners tribunal hearing that he had lied to colleagues when confronted.

The GMC's lawyer, Alexis Dite, argued that Alla's fitness to practise was impaired because of his conviction and because of his dishonesty. Alla's lawyer, Alan Jenkins, argued that though his dishonesty constituted misconduct it had happened four years ago and did not merit a current finding of impairment because he had shown extensive remorse and remediation.



"I know my actions will have undermined public trust in doctors," Alla told the hearing in a written statement. "The fact that my actions have had this impact on the profession that I love is devastating to me."

The Crown Court heard that Alla had a serious depressive illness at the time of his offences. Part of his tribunal hearing was held behind closed doors, a common practice when doctors' health problems are being discussed, and details have been redacted from the written decision. The tribunal agreed with Alla's defence that he was not currently impaired because

The Crown Court heard that Alla had a serious depressive illness at the time of his offences

of misleading his colleagues but was impaired because of his conviction.

It rejected, however, his counsel's argument that, as the NHS was "crying out" for experienced GPs, a period of conditions imposed on his work was the proper sanction. Instead, it opted for a suspension as recommended by the GMC.

At the end of the three months Alla will have to attend a review hearing before resuming practice.

Clare Dyer, *The BMJ*

Cite this as: *BMJ* 2022;379:o2742

nurses are showing that they have had enough of being undervalued by this government . . . We urge the government to listen to the concerns of frontline health staff and deliver the investment that the NHS and its workforce so desperately need."

The RCN said any strike action will be carried out "legally and safely at all times," bearing in mind minimum safe staffing levels. Alongside pay, the college is also calling for the government to ensure that nursing is seen as an "attractive, rewarding profession to tackle the tens of thousands of unfilled nursing posts." There are around 47 000 nursing vacancies in England, almost 12% of nursing posts.

England's health and social care secretary, Steve Barclay, said he "deeply regrets that some union members have voted for industrial action" and that his priority was to keep patients safe during any strikes.

He said, "These are challenging times, which is why we accepted the recommendations of the independent NHS Pay Review Body in full and have given over one million NHS workers a pay rise of at least £1400 this year. This is on top of a 3% pay increase last year, when public sector pay was frozen, and wider government support with the cost of living."

NHS on strike

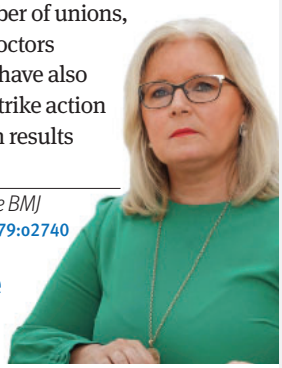
Other health workers have also voted to strike. In Northern Ireland ambulance workers, hospital porters, cleaners, caterers, clerical staff, technicians, care workers, social workers, and transport workers have voted to take industrial action possibly before Christmas.

GMB organiser Jim Donley said the workforce was "desperate" after years of "real terms pay cuts, a deadly pandemic, and now a crushing cost of living crisis." He said the action was as much about patient safety as pay.

In Scotland nearly 4000 GMB members, including paramedics, technicians, nurses, porters, domestic staff, and radiographers, have also backed strike action.

Across the UK many other NHS staff across a number of unions, including junior doctors through the BMA, have also been balloted on strike action related to pay, with results still pending.

Elisabeth Mahase, *The BMJ*
Cite this as: *BMJ* 2022;379:o2740



Our members will no longer tolerate a financial knife edge at home and a raw deal at work Pat Cullen

GPs can order ultrasound, MRI, and CT scans for vague symptoms

GPs in England can now directly order CT, ultrasonography, or brain MRI for patients who have concerning symptoms but do not meet the threshold for an urgent suspected cancer referral, NHS England has announced.

Under the Direct Access scheme, around 67 000 people whose cancer would normally be diagnosed through non-urgent testing will now be eligible for fast tracking, which could cut waiting times to four weeks, NHS England has said. It claims the move will enable tens of thousands of cancers to be detected sooner each year, while freeing up hundreds of thousands of hospital appointments.

It has previously announced that "one stop shop" diagnostic centres, set up to tackle the backlog, will enable the NHS to meet the demand for these tests. It also plans to expand the scheme in 2023-24 to include a wider range of tests.

NHS England chief executive Amanda Pritchard said GPs were referring record numbers of people through the urgent cancer referral pathway and that the "shortfall in people coming forward for cancer checks caused by the pandemic has now been eradicated."

Katharine Halliday, president of the Royal College of Radiologists, said it was essential GPs booked the right scan to avoid "costly repeat scanning and devastating delays" and recommended the iRefer clinical decision making system.

Elisabeth Mahase, *The BMJ*
Cite this as: *BMJ* 2022;379:o2760

UK and Ireland see sharp rise in maternal deaths

The number of women dying during pregnancy or shortly after has risen sharply in the UK and Ireland, with the increases steepest in the poorest areas, a report has found.

In 2018-20 a total of 229 women died during or up to six weeks after pregnancy from pregnancy specific causes or conditions made worse by pregnancy, found the ninth report from Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE-UK). This was a 24% rise on 2017-19— or 19% if covid deaths are excluded.

A further 289 women died between six weeks and a year after pregnancy in the same period, in line with previous years.

Death rate

In 2018-20 in the UK the maternal death rate during or within 42 days of the end of pregnancy was 10.9 (95% confidence interval 9.5 to 12.4) of 100 000 maternities, up from 8.79 (7.6 to 10.1) in 2017-19 (rate ratio 1.24 (1 to 1.5; P=0.03). Over the same period, women living in the most deprived areas were more than twice as likely to die as women in the least deprived areas: 17.96 (14.2 to 22.35) versus 7.12 (4.2 to 11.3) of 100 000 maternities.

As in previous years women from black ethnic backgrounds were three times as likely as white women to die from birth related causes (34 (22.2 to 49.8) versus 9.23 (7.7 to 10.9) deaths in 100 000), and women from Asian ethnic backgrounds had a twofold higher risk (16.1 (10.9 to 23)), although these differences have narrowed slightly.

Marian Knight, professor of maternal and child population health at Oxford Population Health, who led the study, said, "Many women who died had multiple disadvantages and health and social problems. Urgent action needs to be taken across the maternity system to ensure that this worrying increase in maternal deaths is reversed."

Ranee Thakar, president elect of the Royal College of Obstetricians and Gynaecologists, said, "It is clear from the report that disparities in society have a clear impact on the likelihood of mortality. We continue to call on the government to commit to a time specific target to reduce maternal inequities."

Maternal suicide was the leading direct cause of death between six weeks and one year after the end of pregnancy, accounting for 18% of deaths.

Gareth Iacobucci, *The BMJ*
Cite this as: *BMJ* 2022;379:o2732

IT IS CLEAR THAT DISPARITIES IN SOCIETY HAVE A CLEAR IMPACT ON THE LIKELIHOOD OF MORTALITY Ranee Thakar

RSV: **UK to examine whether to offer monoclonal antibody routinely to all babies**

Nirsevimab has received regulatory approval in the UK, and researchers will now assess its benefits in protecting babies from serious illness from respiratory syncytial virus, as **Jacqui Wise** reports

The Medicines and Healthcare Products Regulatory Agency has approved nirsevimab, a long acting monoclonal antibody, to protect newborn babies against respiratory syncytial virus (RSV) lower respiratory tract disease. The European Medicines Agency gave its approval earlier this month.

Approval was based on the results of two studies published in the *New England Journal of Medicine* showing that nirsevimab has a good safety and efficacy profile in preterm and full term infants. One trial involving 1490 healthy infants showed that a single injection of nirsevimab, in comparison with placebo, produced a 74.5% reduction in RSV associated lower respiratory tract infections needing medical care.

However, the preventive injection won't be offered routinely to all babies in the UK until more data are available on whether it prevents hospital admissions for RSV. A new trial, Harmonie, is trying to answer that question. This study hopes to recruit more than 20 000 infants up to 12 months old in the UK, Germany, and France.

Most babies who end up in hospital are otherwise fit and well
Simon Drysdale

A collaboration between the UK National Institute for Health and Care Research and the drug companies Sanofi and AstraZeneca, the study will last around 12 months, with the results expected soon after.

RSV infection rates are currently higher in the UK than during the covid pandemic but are still in line with a normal winter. Data from 10 November 2022 show that admissions to hospital of children with RSV have been broadly steady in the past few weeks, with the highest positivity in the under 5 year age group, at 26.3%. However, in the US the incidence of RSV infections is surging, and experts are warning of a triple epidemic of flu, RSV, and covid-19.

RSV is one of the world's leading causes of admission of infants to hospital and affects 90% of children before the age of 2

S EDMONDSON / ALAMY

Infant hospital admissions

RSV is one of the world's leading causes of admission of infants to hospital and affects 90% of children before the age of 2. It often causes only mild illnesses, such as a cold. However, in some babies it leads to more severe lung problems such as bronchiolitis and pneumonia.

"What we can't do is predict which infants are going to end up in hospital with RSV or go on to intensive care versus those babies which will just get it as a relatively mild disease," Simon Drysdale, joint chief investigator of the study, told a media briefing.

Four fifths of babies who end up in hospital have no underlying problems, said Drysdale, a consultant paediatrician in infectious diseases at St George's University Hospital NHS Foundation Trust in London. "There are some risk factors for severe disease: those babies who are born very prematurely, those with significant underlying heart or lung problems or immunodeficiency. But most babies who end up in hospital are otherwise fit and well."

In the UK RSV produces a significant burden on healthcare, with 87 deaths, 29 000 hospital admissions, and 900 intensive care admissions every year. It also contributes to the workload of GPs, with almost half a million primary care attendances a year. Healthcare costs associated with RSV in children under 5 years old amount to £54m a year, or £87 a year for each child, Drysdale said.

Limited treatment options

The only currently available preventive treatment for RSV is palivizumab, a monoclonal antibody developed in the 1990s, which is used in a very small number of high risk infants. However, this requires monthly injections over five months. Current treatment is supportive care only; there is no widely used antiviral.

There is currently no licensed vaccine for RSV in infants, although a few are in development. In October GSK published results for a vaccine candidate showing a 94.1% reduction in severe RSV disease among older adults over 60 years.

Another possibility is vaccinating pregnant women to protect their newborns. Earlier this month Pfizer announced results of its maternal RSV vaccine in a press release. This claimed that Pfizer's study, which has not been peer reviewed, showed that giving the vaccine to pregnant women reduced the risk of severe lower respiratory tract illness from

RSV in infants in the first six months of a baby's life.

"Maternal vaccination would protect babies in the first 2-3 months of life," said Saul Faust, professor of paediatric immunology and infectious diseases at the University of Southampton and also a Harmonie investigator. "But whether all mums will accept the vaccine in pregnancy is not known."

Nirsevimab is an antiviral monoclonal antibody that has been designed to attach to the protein that RSV needs to infect the body. When it is attached, the virus becomes unable to enter the body's cells. Because the drug is removed slowly from the body, over a period of several months, a single dose can protect against RSV disease for the entire RSV season. "It works instantly as soon as it has been injected," said Drysdale.

By contrast, vaccines work by prompting the body's immune system to produce antibodies, which can take a month or two to build up. Vaccines are also not usually given to babies in the first couple of months of life. "If you give a vaccine the baby may still be vulnerable for the first crucial two months, which is one of the highest risk periods for RSV," Drysdale added.

More data needed

The UK Joint Committee on Vaccination and Immunisation will look at all RSV technologies before deciding whether to routinely offer nirsevimab to newborn babies.

Faust said that both maternal vaccination and giving an injection of a monoclonal antibody at birth offered protection in the critical first two months. "Until we have all the data available on the impact on hospitalisations, policy makers will find it difficult to make a decision," he said.

"We will probably need all options available as part of our armoury. We may well end up with different things being done at different times of year and possibly in different groups of patients—mums, babies, and older children—to get as wide a protection as possible."

Jacqui Wise, Kent

Cite this as: *BMJ* 2022;379:o2725

SIMON TURNER / ALAMY

NHS IN ENGLAND

Four hour emergency department target hits record low

The performance of accident and emergency departments in England hit a record low in October, with fewer than 70% of patients seen within the target four hours for the first time since records began in 2004, according to the latest official data.

NHS England, however, has highlighted a 60% drop in the numbers of people having to wait for 18 months or longer for routine treatment.

The latest monthly NHS performance data for emergency departments showed a mixed picture but one dominated by worsening achievements in the NHS overall.

Elective care

Elective times were also poor, as other new data show that 7.1 million people in England were waiting to begin hospital treatment at the end of September—up from 6.8 million in July — which includes more than 400 000 people who had been waiting for more than a year.

Additional data on cancer showed that in September only 61.3% of patients with a new diagnosis were starting treatment within two months, the worst performance on the national target, which is for 100%.

NHS England said that staff had faced the busiest October ever for emergency department attendances and the most serious ambulance callouts.

It focused on positive developments, highlighting that the NHS had reduced the number of people waiting 18 months for treatment by almost 60% in one year. The number of patients waiting 78 weeks was 73 430 fewer than the 123 969 in September 2021, as a result of a drive to prioritise the longest waits.

The NHS's medical director, Stephen Powis, said, "There is no doubt October has been a challenging month for staff, who are now facing a 'tripledemic' of covid, flu, and record pressure on emergency services, with more people attending emergency departments or requiring the most urgent ambulance callouts than any other October.

"Pressure on emergency services remains high as a result of more than 13 000 beds taken up each day by people who no longer need to be in hospital.

"But staff have kept their foot on the accelerator to get the backlog down, with 18 month waiters down by three fifths on last year."

Just 69% of people attending emergency departments were seen in under four hours in October, a fall from 71% in September and well below the 95% target. Some 43 792 patients waited more than 12 hours in emergency departments to be admitted to hospital (the highest on record) in October—up 34% from 32 776 in September

Worse to come

Siva Anandaciva, chief analyst at health thinktank the King's Fund, said, "Just days before the autumn budget statement, today's figures present government with an uncomfortable truth: many NHS services are already in crisis and the situation is likely to worsen as winter bites and demoralised staff show their discontent through industrial action.

Local services have still not got the £500m promised two months ago Matthew Taylor

"The government's fiscal statement will have a profound impact on the quality and accessibility of health and care services for patients in the coming years."

Matthew Taylor, chief executive of the NHS Confederation, which represents NHS organisations, said, "The NHS continues to operate under huge pressure but has made progress in meeting rising demand for care.

"However, NHS staff are being let down by the fact the government has still not given local services the £500m that was promised two months ago. The failure to provide extra capacity in social care through this £500m fund is causing bottlenecks on hospital wards, all the way back to emergency departments and ambulances queuing outside hospitals."

Adrian O'Dowd, London

Cite this as: *BMJ* 2022;379:o2719

THE BIG PICTURE

China eases covid rules amid rise

Epidemic control workers in Beijing take shelter during China's largest annual online shopping event, known as 11.11, outside a community in strict lockdown because of a covid outbreak.

Despite a new rise in cases—on 10 November more than 10 500 new cases were recorded, the highest daily total since April—the government has slightly eased its strict zero tolerance policy on covid. Quarantine for close contacts has been cut from seven days in a state facility to five days, and three days at home, and officials will also stop recording secondary contacts, so many people will avoid having to quarantine at all.

Public anger against sudden, punitive lockdowns is reportedly growing in major cities, such as Beijing, where 118 new local cases last Saturday led to its population of 22 million being ordered to take PCR tests every day, and access to offices and leisure venues was limited.

Alison Shepherd, *The BMJ*

Cite this: *BMJ* 2022;379:o2743

KEVIN FRAYER/GETTY IMAGES

EDITORIAL

Public health in US midterm elections

When given the opportunity, voters chose health

The US midterm elections on 8 November gave the public a say not only on candidates for both houses of government but state measures put up for popular vote. This election cycle came just after the first national data emerged showing how reversing Roe *v* Wade has affected abortions.[1] Accordingly, abortion was a stated priority for Americans—with only jobs and the economy rated higher—and motivated people's decision to vote as well as how they voted, including in pivotal states.[2]

Conservative candidates across the country felt compelled to soften or conceal previous anti-abortion messages.[3] In all five states where abortion measures were on the ballot, voters protected access: California, Michigan, and Vermont added provisions into their constitutions that explicitly protect abortion; Kentucky rejected an anti-abortion measure; and Montana rejected a referendum that medical professionals stated was clinically irrelevant, potentially harmful, and designed to stigmatise abortion.[4,5]

Other public health and health related measures on the ballot included one in Oregon aimed at increasing firearm safety and another to establish healthcare as a right within the Oregon state constitution, a novel action that would create a basic standard for provision of healthcare. South Dakota, a sharply conservative state, voted to expand Medicaid, the US public insurance programme for families and individuals with low incomes.[6] And Arizona resoundingly passed a measure to limit predatory medical debt collection practices.[7]

Yet overall, public health represented only a small portion of the priorities identified by voters at the polls. Only 7% of voters identified healthcare as the most important issue facing the country.[2] Only 2% said it

HANNAH BEIER/GETTY IMAGE

Conservative candidates across the country felt compelled to soften or conceal previous antiabortion messages

was the covid-19 pandemic, even though the US performed poorly and American life expectancy dropped by 2.7 years, the largest decline in a century. Nested within that statistic are devastating disparities, with a drop of 4 years, 4.2 years, and 6.6 years for Black, Hispanic, and Native Americans, respectively.[8] Addressing such grave failures and inequities requires a robust public health infrastructure. Instead, we risk continuing decades of disinterest and disinvestment in public health.

Spending cuts

Since 2010, per capita spending of state public health departments has dropped by 16% and spending for local health departments has fallen by 18%. At least 38 000 state and local public health jobs have disappeared since the 2008 recession, leaving a skeletal workforce.[10] Meanwhile, the remit of public health agencies is vast, encompassing innumerable essential roles needed to promote health, respond to acute health emergencies, prevent chronic diseases, and ensure receipt of health services.

Americans often mobilise around public health through singular, monolithic issues. But wins in flashpoint issues depend on a strong public health foundation. For example, gaining universal abortion rights may be a hollow victory in the absence of equitable and accessible women's health services across diverse communities.

Public health is also present in our desire to build a strong economy and jobs. Economic growth, high productivity at work, and participation in the workforce are fully enabled when people are healthy and well, and we make them so with a public health infrastructure that is equipped to support the structural determinants of health.

Health professionals and elected leaders need to raise visibility and societal literacy around the role of public health as a vital partner to our security and prosperity. They must lead with vision about what a powerful, responsive, and well funded public health system would mean,[12] including fortified emergency preparedness for emerging health threats; world class disease surveillance and laboratory capacities; data systems structured to detect health inequities and linked to action; a culturally diverse public health workforce, well equipped to provide the broad range of services needed and sustained by liveable wages; and expertise in clear and effective health messaging that builds trust within communities. They must define minimum thresholds for per capita public health funding and standardise public health systems to ensure that every community is assured of fundamental public health services. And they must be clear about how investments in public health have large, meaningful returns on health and quality of life.[13]

When given the opportunity, US voters chose health. We need to give them more and better opportunities to do so, through candidates and ballot measures that envision what a bedrock of public health might offer us as a society.

Matifadza Hlatshwayo, director of health, Health Department, St Louis, Missouri

Esther Choo, professor of emergency medicine, Oregon Health and Science University, Portland, chooe@ohsu.edu

Cite this as: *BMJ* 2022;379:o2741

Find the full version with references at http://dx.doi.org/10.1136/bmj.o2741

EDITORIAL

Failing IT infrastructure in the NHS

Ongoing problems threaten patient safety and data security

Earlier this year, information technology (IT) systems at one of the largest hospital trusts in the NHS stopped working for 10 days.[1] This was the latest in a long history of NHS IT system failures across primary and secondary care.[2 3]

As "paperless" is now the default operating mode for many healthcare systems globally, IT failures block access to records, prevent clinicians from ordering investigations, restrict service provision,[4] and bring to a halt the everyday business of healthcare. Increasing digital transformation means such failures are no longer mere inconvenience but fundamentally affect our ability to deliver safe and effective care. They result in patient harm[5] and increased costs.[6]

This year's 10 day outage occurred during a record breaking heatwave, but the immediate climate related trigger masked the root cause: chronic lack of attention to IT infrastructure,[7] the physical resources underpinning an organisation's software and data. These vital resources include computers, servers, and networks, as well as the supporting processes and staff to ensure their usability, stability, and security. Unlike the procurement of electronic health records, for example, investment in infrastructure is rarely prioritised and easily viewed as a cost to keep down rather than an investment that increases productivity.[8]

The consequences are substantial. Inefficient or unavailable systems compromise patient safety, and the BMA estimates that a substantial proportion (27%) of NHS clinicians lose over four hours a week through inefficient IT systems.[10] The BMA report also found deficiencies in investment and lack of clinician engagement in procurement.

Outdated infrastructure is also a risk to data security. UK central guidance recommends backing up healthcare data off site.[11 12] However, without a transparent audit process, it is unclear how well providers conform to these guidelines. The unprecedented duration of the most recent incident indicates that data security procedures at the affected trust were inadequate.

TREVOR MOGG/ALAMY

Quality improvement cycles must become routine in IT governance, as they are in clinical care

There is a growing disconnect between government messaging promoting a digital future for healthcare (including artificial intelligence) and the lived experience of clinical staff coping daily with ongoing IT problems.[13] Digital capabilities exist in a strict hierarchy, with IT infrastructure as the foundational layer. This digital future will not materialise without closer attention to crumbling IT infrastructure and poor user experiences.

How to do better

To facilitate a transformation of IT infrastructure in the NHS we need to start with systematic and transparent measurement of IT procurement, capability, and functionality at the level of clinicians, organisations, and commissioners. Higher level data paired with outcomes from end users, including clinicians and patients, would help identify gaps between procurement decisions and the effectiveness of infrastructure on the ground. Transparency will facilitate sharing of best practice and allow independent scrutiny of the health and economic effects of IT failures. In the NHS, the What Good Looks Like framework sets national standards for such granular assessments.[16]

Armed with this understanding, quality improvement cycles must become routine in IT governance, as they are in clinical care. This means developing local cultures amenable to learning and change, along with commissioning body oversight of any variations in practice and quality among regional providers. IT problems should be flagged as quality and safety concerns for urgent attention. Regular re-evaluation of provider performance against peers nationally will introduce regular pressure for improvement.

A centrally directed "carrot and stick" approach could create incentives for change. Government must provide the investment needed to identify and rectify poor performance but also demand accountability, with minimum standards for IT function and stability. Adoption of key standards in areas with known safety and security implications should be enforced through legislation. The NHS has no dedicated health IT regulator, but inclusion of digital issues in the Care Quality Commission's assessments of quality and safety is long overdue.[17]

We must not tolerate problems with IT infrastructure. Poorly functioning IT systems are a clear and present threat to patient safety that also limit the potential for future transformative investment in healthcare. Urgent improvement is an NHS priority.

Joe Zhang, clinical research fellow, Imperial College London joe.zhang@imperial.ac.uk

Sanjay Budhdeo, clinical research fellow, University College London

Hutan Ashrafian, lead for applied artificial intelligence and big data analytics, Imperial College London

Cite this as: *BMJ* 2022;379:e073166

Find the full version with references at doi: 10.1136/bmj-2022-073166

THE BMJ INTERVIEW

Five year GP training could revive partnership model, says new chair of RCGP

Kamila Hawthorne tells **Elisabeth Mahase** about her plans for the Royal College of General Practioners, breaking glass ceilings, and why she hopes that the partnership model survives

GRAINGE PHOTOGRAPHY/RCGP

Kamila Hawthorne's first encounter with the RCGP was not a positive one. "I had done my MRCGP exams and I hated them, actually. I had the old fashioned, oral exam where I felt thoroughly patronised by the examiners. I remember stomping across Hyde Park thinking, 'I'm never going back there again,'" she says, speaking a fortnight before officially taking on the role of RCGP chair on 21 November. "And now look—it's amazing how things change."

After receiving an RCGP research training fellowship in 1991, she decided to give the college another chance, and 30 years later she's now more invested than ever.

"I want the college to be even more welcoming and inclusive than it currently is. We have a real diversity of members and not everybody feels that they belong," Hawthorne says. "As a South Asian doctor—despite the British name and the British accent—I've come across my fair share of inequality and injustice. But I did feel it was better to work from inside rather than from outside."

Hawthorne stood for chair in 2019, when she was beaten by Martin Marshall—a defeat that led to some self-doubt, but, "Over the three years, I think the whole climate changed. The Black Lives Matter movement has made a big difference to the way people think about inclusivity and about diversity—not just for race, but other aspects of diversity as well," she says.

We have a real diversity of members and not everybody feels they belong. I felt it was better to work from inside rather than outside

Hawthorne and her family moved to the UK from Dar es Salaam, Tanzania, in 1970. She went on to study medicine at Oxford University and work as a GP principal in Nottingham, Manchester, and Cardiff. She now works as a salaried GP in Mountain Ash, south Wales, making her the RCGP's first working GP in Wales to become chair, as well as the first ever South Asian woman chair.

"I don't look Welsh and I don't sound Welsh, but I am Welsh because I've been here for 27 years now. That's the longest I've lived in any place in my life," she says.

Workload and workforce

As Hawthorne takes on her new role, she is continuing work in her practice on Mondays. "Our members need to know that we are aware of what's happening. We're not in some ivory tower stuck in the middle of London. We know what's going on. We feel the heat as well and we are representing them."

Hawthorne says she sees the impact of unmanageable workload on her colleagues. "Last Monday one of my partners had 69 patients. It's just not doable. There are big, big worries, not only for the safety of patients and having enough time to deal with them properly, but also the safety and the health of the doctors. It is a real problem."

"The workload and workforce crisis seems to be getting worse rather than better. One person on their own can't turn things around, but I can say a lot on behalf of our members and will have the opportunity to say things to people who have got influence and who have the power to change things," she says.

"Part time" doesn't do us justice

Some anti-GP rhetoric in the press in recent years has centred around the idea that part time GPs are to blame for access problems. This is despite many working the equivalent of what many other jobs consider full time hours.

"Things have changed dramatically since I first started as a GP. Our culture of working is very different—the hours are much longer and the intensity of work is completely different to what I remember 30 years ago," Hawthorne says. "Most GPs are doing about three to five days a week on a regular basis—11 hour days. And many GPs are working more than that. Some of them will be doing their paperwork

Partnership is both cost effective and efficient and provides a level of care for patients that's really unequalled

in the evenings and weekends and some of them will be doing other work."

Hawthorne says the solution may be to "discard the whole classification of part time and full time GPs. They just don't really apply any more." She suggests GPs should be job planned in the same way hospital doctors are.

Could the RCGP have done more to counter anti-GP rhetoric during the pandemic? "That's a difficult question because I think that we didn't respond as robustly as we could have done," she says. "It's not just the college. GPs put a sign on our door that said, 'Don't come in, give us a call instead,' whereas the pharmacy next door was open. And we could have dealt with that in a different way. The whole point was to prevent the spread of covid-19. We didn't realise at the time what message it was giving.

"But, you know, hindsight is such an easy thing, isn't it?"

Hawthorne now wants to engage with the public more, to enable them to understand what GPs do and what their days look like. "When patients come to what looks like a half empty waiting room, they think we're not seeing that many people. But we are. We're seeing them virtually as well as face to face and dealing with all the paperwork and the pathology reports and the letters and everything else that has to be done."

The partnership model is not dead

Another workforce problem that predates the pandemic by some measure is the steady decline in GPs wanting to become GP partners. This decline, coupled with recent talk of making most GPs salaried and contracted by NHS trusts or large scale primary care operators, has made the future of the partnership model uncertain.

"Quite a lot of young GPs are afraid of taking on a partnership because of the additional responsibility and the worry that they may be left as a 'last man standing' in the practice if everybody else leaves," Hawthorne says. "We've got to turn that around."

She suggests providing an optional two year extension to GP training—from three to five years—could help solve this.

"It seems there are a lot of young doctors coming into general practice who are not quite ready for the responsibilities of working independently and of running a practice. And I'd be very keen on a three plus two model, where we have a clinical fellowship after you've done your MRCGP exams," Hawthorne says. "Then you can start concentrating on being that GP that you've always wanted to be and putting what you've learnt into practice in a sheltered and protected environment."

She says a good partnership is "both cost effective and efficient and provides a level of care for patients that's really unequalled." It can also give GPs an opportunity to innovate and improve the way they work for themselves and their patients—something they would not normally get in a salaried position, Hawthorne argues.

"A lot of people have gone into general practice because that's what they were looking for, they were looking for that opportunity, they want to be in control of how they provide services to patients," she says, adding that while the "salaried option seems to work better" in some parts of the country, she hopes the partnership model survives.

Climate crisis and health inequalities

Alongside workforce and workload, Hawthorne says health inequalities and the climate crisis are her priorities. "I was dismayed by what was coming out of Liz Truss's government in terms of inequalities," she says. "It is still early days for this new government and they're still finding their feet. Time will tell."

She says the previous "levelling up" under the Conservative government saw an "awful lot of talk" without much funding. "Our role as a royal college—our role in general practice—is to keep reminding them of it, in the nicest possible way. If they are saying that their aim is to protect the most vulnerable in society, then we need to keep encouraging them to do that."

On climate change, Hawthorne says she has seen how enthused GPs have become about sustainable healthcare. She plans to work closely with the new special interest group, which the college is setting up.

"It's everybody's business. And if we're not careful, we're going to head for catastrophe," Hawthorne says. "It's interesting seeing what's going on at COP27 and worries that the 1.5°C target may not be reachable anymore. It is scary. We have a lot to do."

Elisabeth Mahase, *The BMJ*

Cite this as: *BMJ* 2022;379:o2718

GETTING TO KNOW KAMILA

First job?
I worked in a bakery when I was 15. I lived in south east London and I worked in Slatter's bakery. Ken Slatter was famous because he appeared on Bruce Forsyth's *Generation Game* icing cakes. My second job was selling girls' school uniforms in Harrods. It was more fun than it sounds.

Dream job as a child?
An astronomer. It was the time—in the sixties and seventies—when lots of us youngsters were completely captivated by the moon landing, perhaps going to Mars, thinking about space and what was going on out there. It just blew your mind.

Most embarrassing moment?
I was in medical school and it was paediatric surgery week, but I hadn't realised it was also 1 April. I was really keen to impress the paediatric surgeon, so when he asked who would like to assist in an operation I jumped up and volunteered. He said, "Okay, well go and have a shower then. This is paediatric surgery. You've got to be cleaner than for adult patients." So off I went to shower. I hadn't brought a towel so I had to use paper towels and when I finally got back, rather damp, about half an hour later, he said, "April fools!" Of course, the operation was already done and I felt such an idiot. It just shows sometimes you can be too keen.

Favourite part of being a GP?
It's that doctor-patient relationship. The very first time a patient came back to me—to see me as opposed to seeing anybody else—when I was a trainee, I was so pleased. I nearly got up and gave her a hug. Whenever you go through something important with a patient, a little bit of you becomes a little bit of them and a little bit of them becomes a little bit of you. And wherever you meet them again, there's that connection. I think it's so special.

GRAINGE PHOTOGRAPHY/RCGP

COVID-19

Rishi Sunak's covid record—and what it tells us about his views on health, wealth, and the value of science

As chancellor at the height of the pandemic, the UK's prime minister had a profound impact on its course and outcomes. His actions call into question his judgment in pitching the economy as being in opposition to public health, writes **Richard Vize**

Rishi Sunak's actions during the covid-19 pandemic tell us a great deal about his attitudes towards healthcare and science—and therefore how these may fare under his tenure as UK prime minister. As chancellor of the exchequer and one of the government's key decision makers, Sunak had much influence on the course of the pandemic and its economic and other consequences.

Boris Johnson appointed Sunak chancellor on 13 February 2020 after Sajid Javid quit. Sunak had been chief secretary to the Treasury for the previous seven months. Two weeks before his promotion the first covid cases had been confirmed in the UK. Sunak was one of the quartet of key decision makers during the pandemic, alongside Johnson, the health and social care secretary for England, Matt Hancock, and the Cabinet Office minister, Michael Gove.

Sunak had to rewrite his first budget hastily to respond to the rapidly escalating crisis before he delivered it on 11 March. He unveiled £12bn of pandemic spending, including at least £5bn for the NHS in England and other public services, alongside £7bn for businesses and workers across the UK. Promising to do "whatever it takes" to support people and businesses, he added, "Whatever resources the NHS needs to deal with coronavirus, it will get."

Within a week Sunak massively expanded government help, with another £350bn in loans and other support, followed three days later by the furlough scheme, in which the government paid grants of up to 80% of salaries, up to £2500 a month, if companies kept non-working staff on their payroll. The cost of the scheme was initially estimated at £78bn.

Just 39 days after Sunak's promotion Johnson announced the first lockdown.

The UK saw a massive explosion of cases after the launch of Eat Out to Help Out
Thiemo Fetzer

Economy boosters?

The first covid wave peaked in early May 2020, falling from over 5000 confirmed cases a day across the UK to around 545 by 8 July. As the threat seemed to ease, Sunak unveiled his Plan for Jobs, to help the economy recover. This included bonuses to encourage employers to retain furloughed staff and a £2bn Kickstart scheme to create jobs for young people.

Sunak's most controversial scheme to boost the economy was Eat Out to Help Out, which ran during August 2020. It covered half the cost of food and non-alcoholic drinks for an unlimited number of visits in participating restaurants on Mondays to Wednesdays, up to £10 per person every visit. Over 160 million meals were claimed, costing £849m.

As well as helping the hospitality sector, Sunak wanted to encourage people to be less fearful of going out. It reflected his concern that pandemic restrictions were crippling the economy and his desire to open up as soon as possible.

An analysis by Thiemo Fetzer of the CAGE economic research centre at Warwick University, published in the *Economic Journal*, found that areas that had higher take-up of Eat Out to Help Out had a notably higher incidence of infections within a week of the scheme starting and a drop in infections within two weeks of the scheme ending. Fetzer estimated that the scheme may have been responsible for around 8% to 17%

Sunak's Eat Out to Help Out scheme was aimed at encouraging people to be less fearful of going out as well as to boost the hospitality sector

In October 2020 Sunak accused Labour MPs of being detached from reality for supporting a "circuit breaker"

of all new SARS-CoV-2 infections during the period it was active, which he says tallies with Public Health England data showing a surge in the proportion of infections traced to food outlets from 5% to almost 20%. He says the public health and indirect economic costs of Eat Out to Help Out "vastly outstrip its short-term economic benefits."

Fetzer told Sky News, "The UK saw a massive explosion of cases in a way that was not seen in other countries. It's that scheme that has helped to bring about an earlier second lockdown and restrictions on the restaurant sector that it was determined to help economically."

Circuit breaker sceptic

Daily cases were rising again before Eat Out to Help Out ended. By early October the second wave was firmly under way, with infections surpassing the peak of the first wave and growing. By mid-November they reached a new peak of more than 25 000 cases in a single day.

Johnson was being pushed by England's chief medical officer, Chris Whitty, and the UK chief scientific officer, Patrick Vallance, to implement a short "circuit breaker" lockdown to try to contain the massive autumn surge, save lives, and possibly avert the need for a longer lockdown later. The aim was to reduce the R value (the average number of people that an infected person infects) at a time when the Scientific Advisory Group for Emergencies (SAGE) believed that the doubling time for new cases might be as low as seven to eight days.

A *Sunday Times* investigation found that new restrictions were supported by Hancock, Gove, and Johnson's chief adviser, Dominic Cummings. But Sunak was vehemently opposed, fearing mass redundancies. His opposition led to four people being invited to address Johnson and him on 20 September, of whom three also opposed a lockdown: Sunetra Gupta and Carl Heneghan, professors at Oxford University, and Anders Tegnell, architect of Sweden's controversial policy of avoiding lockdowns.

SAGE, represented by John Edmunds, professor at the London School of Hygiene and Tropical Medicine, argued that "not acting now to reduce cases will result in a very large epidemic with catastrophic consequences in terms of direct covid-related deaths and the ability of the health service to meet needs."

Sunak won. On 14 October he accused Labour MPs of being "detached from reality" for supporting the circuit breaker, claiming they failed to recognise the economic cost.

A report by the House of Commons Health and Social Care and Science

2020

13 February Rishi Sunak is appointed chancellor of the exchequer by Boris Johnson

11 March Budget includes £12bn aimed at mitigating the effects of the pandemic

17 March Government unveils £350bn lifeline for the economy

20 March Government announces furlough scheme

23 March Johnson announces first lockdown

8 May First wave passes its peak

10 May Lockdown restrictions begin to ease

19 June Sunak and Johnson attend party for Johnson's birthday in the Cabinet Room at No 10

4 July More lockdown restrictions are eased in England

8 July Sunak unveils the "Plan for Jobs"

3 August "Eat Out to Help Out" scheme begins

5 September Daily confirmed cases are rising steeply

14 September "Rule of six" begins in England, restricting size of indoor and outdoor social gatherings

22 September Working from home and 10 pm hospitality curfew are imposed in England

31 October Second lockdown in England announced

2 December Lockdown in England replaced with three tier system

19 December Christmas mixing rules tightened

2021

6 January England begins third lockdown

9 January Daily confirmed UK cases peak at almost 60 000

13 January Cases start to fall steeply

29 March Stay at home order ends, small outdoor gatherings are allowed

7 April Cases reach plateau

12 April Non-essential services and retail reopen

8 June Cases are rising steeply

19 July Most legal limits on social contact are removed in England

21 July Daily cases peak at almost 48 000

2022

5 January Daily cases peak at 183 000

12 January Cases start to fall sharply

11 February Sunak denies breaking lockdown rules (left)

12 April Sunak is issued with a fixed penalty notice for breaking covid restrictions by attending Johnson's birthday party in 2020

and Technology Committees a year later said, "In this decision not to have a circuit breaker, the UK government did not follow the official scientific advice. Ministers were clearly overoptimistic in their assumption that the worst was behind us during the summer months of 2020."

By late October infections were rampant. On 31 October, the day after NHS England chief executive Simon Stevens told the ministerial quartet that hospitals would be overrun across the country if nothing were done, Johnson announced a second lockdown to prevent a "medical and moral disaster" for the NHS.

The second lockdown ended after four weeks in England, giving way to a tiered system of restrictions. Infections immediately surged again.

Surveillance funding withdrawal

Sunak seemed to have learnt little about the value of science from this series of events.

In February 2022, as the government moved the country towards "living with covid," he pushed for the dismantling of the covid testing and surveillance network. Free lateral flow and PCR tests under the NHS Test and Trace programme had been costing around £2bn a month. Sunak refused to provide any more money to continue with testing and surveillance and even opposed twice weekly testing for NHS staff, genomic sequencing to detect emerging variants, and the widely praised Office for National Statistics infection survey, after they were defended by the health and social care secretary, Sajid Javid.

The BMA wrote to Sunak to defend the ONS scheme, warning that after the end of systematic testing it was the only source of information that could provide an accurate picture of covid. In the end the survey, sequencing, and staff testing were continued, but the NHS was forced to pick up the bill.

Sunak was not a cheerleader for mask wearing. He did not wear one in the Commons, although he said he did on crowded trains, and in June 2021 he said he would stop wearing one as soon as legally possible.

In a *Spectator* interview in August 2022 Sunak laid bare his scepticism about some scientific advice the government had received. Discussing the early debates about a lockdown, Sunak says: "I wasn't allowed to talk about the trade-off…The script was: Oh, there's no trade-off because doing this for our health is good for the economy." He claims he was the one in government who pushed the issue of the non-covid impact of lockdown on health and adds that he flew home early from a trip to California in December 2021 to oppose the imposition of another lockdown in response to the omicron variant.

One lesson he says he takes away from the pandemic is, "We shouldn't have empowered the scientists in the way we did," adding, "If you empower all these independent people, you're screwed."

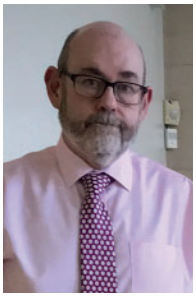
In response to this interview Edmunds emphasised that SAGE's role "was quite narrow: to review and assess the scientific evidence to help inform the decision-makers. It did not consider the economic aspects—it was not asked to do so and was not constituted to do so."

Edmunds points out that Sunak could have set up an economic equivalent of SAGE to give more weight to that side of the debate.

Responding to *The BMJ*'s questions for this article, including whether Sunak struck the right balance between public health and economic priorities during the pandemic, a Number 10 spokesperson highlighted Sunak's comment at his first prime minister's questions: "I will always protect the most vulnerable…We did it in covid and we will do that again."

The spokesperson added that Eat Out to Help Out helped protect the livelihoods of 1.8 million people working in hospitality and that businesses had covid safety measures in place such as screens, social distancing, and reduced capacity. She highlighted that £36bn was added to NHS budgets to fund testing, personal protective equipment, and other infection control measures.

SAGE's role was quite narrow, it did not consider the economic aspects
John Edmunds



Our view was to enable as much as possible to operate as safely as possible
Jim McManus

The UK had some of the highest excess mortality and one of the biggest economic shocks
Anita Charlesworth

Health and wealth: not binary

Jim McManus, public health director at Hertfordshire County Council and president of the Association of Directors of Public Health, emphasises that health and the economy were not binary choices during the pandemic.

"I recall an awful lot of people being somewhat simplistic: that it is either the reduction of covid infections, or opening up and keeping the economy going. But we articulated that they were complex choices that required people to think about them in the round. Our view was to enable as much as possible to operate as safely as possible."

Martin McKee, professor of European public health at the London School of Hygiene and Tropical Medicine, believes Sunak and the government did not strike the right balance between public health and the economy: "We now have lots of evidence that countries that were best at controlling covid had the best economic outcomes. UK policies allowed far too many people to become infected, and now we have a labour shortage that is worse than in any other industrialised country.

"Eat Out to Help Out was a disaster. This really calls into question Mr Sunak's judgment."

Anita Charlesworth, director of research at the Health Foundation and director of its REAL economic analysis centre, highlights a basic misunderstanding at the heart of Treasury thinking at the time: "The UK had some of the highest excess mortality but also one of the biggest economic shocks from the pandemic, and that economic shock ultimately harms people's health.

"The more effectively we dealt with the pandemic, the faster and more robust the economic recovery. The Treasury never quite got that health and economics weren't in conflict."

Richard Vize, journalist, London

Cite this as: *BMJ* 2022;379:o2715