

this week

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SUSAN BURRELL/LAWY

Sunak urged to honour inequalities pledge

Health leaders have urged the prime minister, Rishi Sunak, to honour commitments to tackle health inequalities that were a key part of the Conservatives' 2019 manifesto pledge on "levelling up."

During her short spell as prime minister Liz Truss cut the cross government health promotion taskforce from the Cabinet committee structure. It was established in 2021 by Boris Johnson to drive a coordinated effort to improve the nation's health and to support economic recovery and levelling up.

It was also reported that Truss's government had decided not to publish the health disparities white paper and was planning to water down policy commitments on smoking and obesity, prompting healthcare leaders to question the government's commitment to tackling health inequalities.

Since Sunak's appointment health leaders have urged the government to rethink. Sarah Clarke, president of the Royal College of Physicians, which convenes the Inequalities in Health Alliance of more than 230 organisations, said, "We are clear that a cross government approach is vital if we're to successfully reduce health inequalities and improve health. We can't continue to see health inequality as an issue for the health and care service to solve alone."

When pressed in the House of Commons last week on Sunak's commitment to tackling health inequalities, health minister Maria Caulfield said, "No decisions have been taken in relation to the health disparities white paper. The department continues to review how health disparities can be addressed."

When asked by *The BMJ* about the health promotion taskforce, a government spokesperson said, "The prime minister has agreed an updated Cabinet committee structure to best deliver on the government's priorities, including creating a stronger NHS."

On smoking, health minister Neil O'Brien told MPs, "The government is determined to address the challenges raised by the independent review [led by Javed Khan] and to meet our bold 'smokefree 2030' target. Over the coming weeks, we will be quickly taking stock on whether a refreshed tobacco control plan is the best way to respond and on how and when to take forward all the suggestions made by that review."

On obesity, O'Brien said the government was "working with the food industry to ensure it is easier for people to make healthier choices and increase progress on the reformulation of foods."

Gareth Iacobucci, *The BMJ*
Cite this as: *BMJ* 2022;379:o2683

The government is considering a "refreshed tobacco control plan," said Neil O'Brien, a health minister

LATEST ONLINE

- Patients with bipolar disorder are being failed by NHS, report concludes
- US pharmacy chains settle opioid lawsuits for \$13bn
- Covid-19: Evusheld protects the most vulnerable patients, analysis finds



SEVEN DAYS IN

Two in three people have trouble getting PrEP, finds survey



JONATHAN BRADY/PA/ALAMY

The government's ambition to end new cases of HIV by 2030 is under threat because of problems in access to pre-exposure prophylaxis treatments, charities have warned. A survey of 1120 people who tried to get an appointment to access PrEP at sexual health clinics in England between October 2021 and July 2022 found that 68% encountered problems. More than a third (35%) waited 12 weeks to be seen, and 57% waited more than 12 weeks, found the survey, by a coalition of HIV and sexual health charities.

Of the 79 clinicians who responded, 47% said there weren't enough staff to meet demand, and only 18% said there was adequate support and training to prescribe PrEP.

A total of 24 859 people enrolled in PrEP services in the 10 months reviewed, showed the findings, from a freedom of information request to which 134 (of 151) English local authorities responded. Latest figures from the UK Health Security Agency show that every day eight people in the UK receive an HIV diagnosis.

Deborah Gold (left), chief executive of the National AIDS Trust, said, "PrEP should be easy to give to anyone who needs it. It's the government's responsibility to fix this. Without action we cannot meet the national objective of ending HIV transmissions by 2030."

Shaun Griffin, London [Cite this as: *BMJ* 2022;379:o2667](#)

Covid-19

Pfizer and BioNTech test covid and flu vaccine

The drug manufacturers Pfizer and BioNTech have begun trialling a combined covid-19 and influenza vaccine. The single dose vaccine, which brings together the companies' omicron specific vaccine and mRNA based flu shot, is set to be tested in 180 volunteers aged 18-64 in the US. It is being evaluated for safety, tolerability, and immunogenicity. Ugur Sahin, BioNTech's chief executive officer, said, "The data will also provide us with more insights on the potential of mRNA vaccines addressing more than one pathogen."

Asian patients in England lost out in elective care

During the first year of the pandemic people of Asian ethnic backgrounds in England experienced a 49% fall in the number of elective procedures undertaken (equivalent to 23 000 missed procedures), which compared with a 44% drop among white and black groups (17 000 missed procedures). The largest variation was seen in cardiac care, where procedures fell by 45% in the Asian group, 35% in

the black group, and 28% in the white group. Reasons included epidemiology, deprivation, trust in health services and the government, and the shift to digital care, found an analysis by the Nuffield Trust and the NHS Race and Health Observatory.

Learning disabilities

Efforts to improve care remain slow, says CQC

People with a learning disability or autism are still not being given the quality of care and treatment they have a right to expect in hospital, a Care Quality Commission report concluded. The regulator identified "pockets of excellence and of great people doing great things," but added, "We have continued to find that staff often lack the skills, knowledge, and understanding to make sure they can provide people with the individualised care and treatment they need."

Medical training

Scottish government expands place numbers

Scotland's government announced 3152 additional medical training posts for trainee doctors in 2023. It said that the expansion, which will be funded by £37m over the next four years, equated to a 2.5%

rise in the whole time equivalent workforce of 6100 trainees, making it the most significant increase to date. NHS Education for Scotland recommended extra training places in specialties including general practice, core psychiatry, oncology, emergency medicine, intensive care medicine, anaesthetics, and paediatrics.

AMD

Diabetes and cholesterol drugs may cut AMD risk

A pooled data analysis of 38 694 people in Europe published in the *British Journal of Ophthalmology*



found that treatments to lower cholesterol or control diabetes were associated with, respectively, a 15% and 22% lower prevalence of any type of age related macular degeneration. The researchers said that longitudinal data would be needed to confirm the findings but that they pointed to a likely key role for metabolic processes in the development of AMD, which they said may offer potential new avenues for treatment and public messaging.

Winter pressures

Northern Ireland braced for "grim winter"

Patients attending emergency departments in Northern Ireland saw record long waits in July and September, with under half (43.3%) in July seen within four hours and admitted, transferred, or discharged. The latest figures also found that one in six patients attending a major department (26 752) waited 12 hours or more. Paul Kerr, vice president of the Royal College of Emergency Medicine Northern Ireland, said, "It is going to be a grim winter."

Breast cancer

New drug option for triple negative disease

Final draft guidance from NICE has recommended pembrolizumab (Keytruda) as an option with chemotherapy for neoadjuvant treatment and on its own as adjuvant treatment, for adults with triple negative early breast cancer at high risk of recurrence or locally advanced breast cancer. In trials, adding pembrolizumab to chemotherapy before surgery and continuing with it alone after surgery increased the chance of remission and increased the time before recurrence. An estimated 1600 patients in England will be eligible for the treatment.



MEDICINE



SIXTY SECONDS ON... THE JUNGLE

JUNGLE FEVER?

It soon could be for England's former health secretary Matt Hancock (below), who has inexplicably signed up to fly to an Australian rainforest to participate in the latest series of ITV's reality TV show *I'm a Celebrity... Get Me Out of Here*.

NICE WORK IF YOU CAN GET IT

It depends on how you define "nice." Contestants are ushered out to a harsh terrain where they must survive in extreme conditions and engage in challenges to win treats that would make most of us squirm.

SOUNDS A LOT LIKE WORKING IN BORIS JOHNSON'S GOVERNMENT

Maybe Hancock fancies a busman's holiday. The estimated £400 000 fee he will be getting probably helps too.

AH, SO IS IT JUST TO BOOST THE BANK BALANCE?

Hancock insists not, saying he will be making "a donation" to St Nicholas Hospice in Suffolk and charities supporting dyslexia, a matter he has focused on since resigning from government after he breached covid rules by having an affair with one of his aides. He also has a book coming out, incidentally.

HE'S USED TO SQUIRMING

True. But the move has gone down like a cockroach milkshake with the Conservative Party, which has removed the whip from him, just as they did with fellow Department of Health and Social Care alumnus Nadine Dorries when she appeared on the same show back in 2012.

STRENGTH, MATE

Andy Drummond, deputy chairman (political) of West Suffolk Conservative Association in the "celebrity's" local constituency, was among those to take a dim view of Hancock abandoning his MP duties. "I'm looking forward to him eating a kangaroo's penis," he said. "You can quote me on that."

HANCOCK'S HALF HOUR?

Who knows how long he'll last, but, as ever, he's not short of self-confidence or enthusiasm.

"While some will say reality TV should be beneath a politician, I think we've got to go to where the people gather," he said.

Gareth Iacobucci, *The BMJ*
Cite this as: *BMJ* 2022;379:o2671



Alcohol harms account for more lost years of working life than the 10 commonest cancers combined

Alcohol

Call for national strategy to tackle health crisis

The Alcohol Health Alliance, parliamentarians, and experts have called on the prime minister to commission a review of alcohol related harms to inform a new national strategy. They said alcohol was the leading risk factor for death, ill health, and disability in 15-49 year olds, caused more lost years of working life than the 10 most common cancers combined, and cost society at least £27bn a year. Dan Carden, a Labour MP, said, "After a decade of inaction, alcohol harm has reached crisis point—doing its worst damage in our most deprived communities—and requires immediate government intervention."

2022 for introducing a range of targets to tackle environmental decline and its effect on human health in various areas, including air quality. In a letter to the environment secretary, Thérèse Coffey, 10 leading health organisations, including the Royal College of Physicians, warned that action to improve air quality was being delayed despite clear evidence of toxic air harming human health. They urged the government to publish the environmental targets as soon as possible.

WHO: COP27 must focus on health and act urgently

As the 2022 United Nations Climate Change Conference (COP27) began in Egypt the World Health Organization said that health must be at the core of critical negotiations. It warned that climate change was already affecting people's health and would "continue to do so at an accelerating rate unless urgent action is taken." WHO's director general, Tedros Adhanom Ghebreyesus, said, "Climate change is making millions of people sick or more vulnerable to disease all over the world, and the increasing destructiveness of extreme weather events disproportionately affects poor and marginalised communities."

Cite this as: *BMJ* 2022;379:o2682

Environment

Horn of Africa sees rise in climate crisis events



Seven countries in the Greater Horn of Africa—Djibouti, Ethiopia, Kenya, Somalia, South Sudan, Sudan, and Uganda—have recorded 39 disease outbreaks, flooding, and other acute public health events so far in 2022, the World Health Organization said. This is the highest annual reported number since 2000. Outbreaks of infectious diseases accounted for more than 80% of events reported, while drought, flooding, and other disasters accounted for 18%. WHO's regional director for Africa, Matshidiso Moeti (above), said, "We are the least responsible for global warming but among the first to experience its tragic impact."

Government must publish targets, say health leaders

The UK government has missed its legal deadline of 31 October

Ethnic minority doctors found to have less chance of entering public health training

While we acknowledge the strengths of the system, which correlates well with future performance, we must recognise its deficiencies

Report authors

Action is needed to tackle differential attainment in recruitment to public health specialty training, a report has concluded. Imperial College London analysed four years of application data to determine the extent to which differential attainment may be present and, if so, how it could be mitigated.

The work was commissioned by the UK Recruitment Executive Group of Health Education England and the Faculty of Public Health after routine monitoring indicated that some groups, including applicants from minority backgrounds, may be “systematically disadvantaged” in the current recruitment process.

The researchers cited a 2020 analysis in *The BMJ* (BMJ 2020;368:m479) that had shown widespread ethnic inequalities among specialty training applicants, the

greatest of which was in public health, saying this had prompted the decision to look in more detail at the issue.

“Our findings provide strong evidence that differential attainment is present in the current public health specialty training recruitment process,” the report concluded. “While we acknowledge the strengths of the system in providing a scalable, multi-point assessment of candidate potential which correlates well with future performance, we must recognise its deficiencies.

“The existing process appears to select strong candidates. Yet at the same time, it appears to disadvantage candidates from several groups: those from minority backgrounds, those who are older, and those from international medical graduate backgrounds and backgrounds other than medicine.”

The analysis looked at recruitment data from 2018 to 2021 covering more

than 3000 applications. After taking into account age, sex, socioeconomic status, and professional background, it found that black applicants were around 10 times less likely to be successfully appointed to the public health training programme than their white counterparts (odds ratio 0.10 in 2018-20; 0.17 in 2021), followed by Asian candidates, who were three times less likely (0.24 in 2018-20; 0.36 in 2021).

In 2021 almost half of applicants were from non-white backgrounds, but only a fifth were successfully appointed. White British candidates had a 22% success rate, compared with 4% and 6% among black and Asian candidates, respectively.

The report also found evidence of differential attainment by age, with success rates declining with age, and people with backgrounds other than medicine were less likely to be

Scotland’s social care reform plan raises questions

Ambitious plans to create a national care service in Scotland face mounting opposition, as warnings have been made that the costs could rise significantly.

The Scottish government wants to consolidate social care services under a national organisation in what has been described as the biggest public service reorganisation in Scotland since the NHS’s foundation in 1948.

Legislation to establish the service, planned to be introduced at the end of 2026, is being scrutinised by Scottish parliamentary committees.

Written evidence submitted by Audit Scotland warns that cost estimates of £644m to £1.2bn for the service over the next four years may “significantly understate” what is needed.

Inflation, transition costs, wages, and pensions may all rise above what has been estimated. “In some of these, the potential for additional cost is significant and taken together it is likely that the overall cost of the measures will be significantly above the amounts currently assessed,” said Audit Scotland.

Priorities

Scotland’s local councils, which currently run social services, have called for the plans to be redrawn. They say that 75 000 council staff have been left uncertain about their future and that the uncertainty risks years of disruption rather than contributing to service improvements.

Paul Kelly (left), health and social care spokesman for the Convention of Scottish Local Authorities,



Significant organisational change will not add the biggest value Ralph Roberts

said, “Instead of investing to improve services now, the government is choosing to prioritise unnecessary expensive structural reform which will disrupt services, staff, and communities who rely on support.”

The plans would involve establishing regional boards directly answerable to Scottish ministers, similar to the current NHS structure.

In its written evidence Audit Scotland stated, “It is not yet feasible to forecast if a national

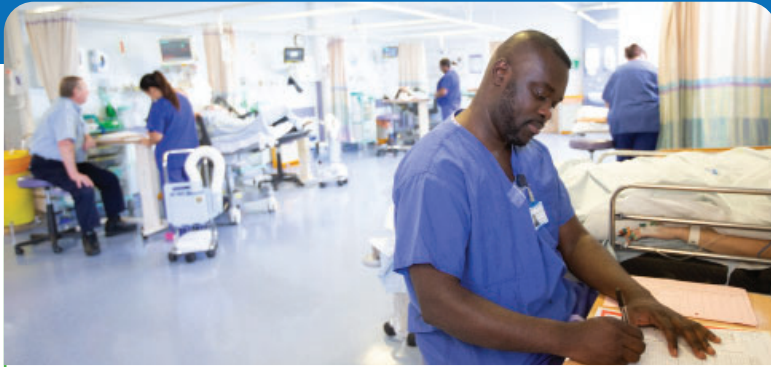
care service, as set out in the bill, will be successful in delivering improvement in the quality and consistency of social work and social care.” It added that work to establish the new service may also distract from the ongoing recovery of the NHS.

The Scottish parliament’s finance committee was told that the benefit to the NHS may be limited. Ralph Roberts, chair of the group of NHS board chief executives in Scotland, said spending money on organisational change was the wrong choice at a time when the NHS was struggling.

“I don’t believe that significant organisational change is what will add the biggest value at the moment,” he said. “I think there are other things that are a higher priority.”

Bryan Christie, Edinburgh
Cite this as: *BMJ* 2022;379:o2645





In 2021 almost half of applicants to public health training programmes were from non-white backgrounds, but only a fifth were successfully appointed. White British candidates had a **22%** success rate, which compared with **4%** among black candidates and **6%** among Asian candidates



appointed than medical applicants (0.38 in 2020-21; 0.2 in 2021).

The recommendations included commissioning an external organisation with expertise in recruitment and in equality and diversity to review each component of the process. This should involve refreshing the job analysis—last reviewed in 2009—to update the person specification and then review the selection process, it said.

Shorter term actions might include providing universal information and advice at the point of application and giving targeted support to candidates

from disadvantaged groups, the report added. Any options pursued should be monitored and evaluated to assess their effect on differential attainment and to identify “any unintended consequences.”

“Future improvements must take care to avoid losing the positives in attempts to mitigate the negatives,” it said. “However, action is needed to create a more level playing field and ensure that the public health specialty can deliver on its commitment to a fairer and more equal future.”

Gareth Iacobucci, *The BMJ*
Cite this as: *BMJ* 2022;379:o2636

“Only talks can end strike plans”

Another strike by junior doctors is now a “realistic possibility,” but Rishi Sunak’s government still has time to avert it, the former co-chairs of the BMA’s Junior Doctors Committee have said.

Speaking to *The BMJ* in an exclusive interview (p 262), Sarah Hallett and Mike Kemp, JDC’s co-chairs until 1 October, said they had raised pay concerns with “increasing urgency” throughout the pandemic but the government had refused to “meaningfully engage.”

After junior doctors were excluded from the NHS 4.5% pay rise, Hallett and Kemp issued an ultimatum to England’s health secretary, Steve Barclay, during his first stint in the role in August, to commit to full pay restoration or prepare for industrial action. They wrote, “Junior doctors in England have experienced a sustained and continued real terms cut of more than a quarter of our salaries since 2008-09.” Pay restoration would

equate to a rise of around 30%.

“We found we were just being ignored,” said Hallett, a paediatric registrar. “We had no choice other than to issue the ultimatum.”

Since then political turmoil has led to England having had two changes in prime minister and health secretary.

However, the co-chairs said there was still time to avert the crisis. Issuing a message to Sunak’s government, they said, “Listen to frontline staff.

Invest in the workforce, more staff, fair pay, and better conditions; it makes sense for the NHS, patients, and the economy.”

Nurses, physiotherapists, pharmacists, paramedics, and ambulance workers are among NHS staff who have also voted or will soon do so on industrial action, with reports that consultants could follow suit.

Elisabeth Mahase, *The BMJ*
Cite this as: *BMJ* 2022;379:o2572

PAY restoration would equate to a rise of around **30%**

NHS cancer plan is “no longer fit for purpose,” says expert

The NHS Long Term Plan, which promised “extraordinary improvements” in cancer diagnosis and survival, should be “torn up and redrafted,” a leading researcher has said.

Richard Sullivan, director of the Institute of Cancer Policy at King’s College London, said there was a “total disconnect between politics and the reality of what’s happening on the ground.”

Speaking at the Westminster Health Forum on cancer prevention, diagnosis, treatment, and care in England on 7 November, Sullivan added, “Morale, stress, burnout are being reported by almost 100% of heads of services . . . To be blunt, we are in a crisis. The long term plan may no longer be fit for purpose.”

The plan, published in 2019, outlined a vision of England’s health system in 10 years. It promised that by 2028 75% of cancers would be diagnosed at stage I or II and that outcomes would improve to the extent that 55 000 more people each year would survive cancer for at least five years after diagnosis. It also said that within 28 days of an urgent referral 75% of patients would know their diagnosis.

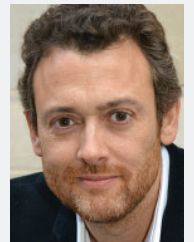
However, last year MPs on the Health and Social Care Committee warned that England would miss the targets set out in the plan, without major investment. This came as the BMA also reported that England was 50 000 doctors short and so far worse off than similar European countries.

Now, Sullivan has said that, unless the government commits to a “massive” funding injection, much of the plan may need to be scrapped. “I think political reality tells us [the funding boost] is not going to happen,” he said.

“There do have to be some hard decisions. We’re not going to have all the money we need. And I think the challenge is really going to be putting the money where it’s going to deliver the best outcomes. There’s going to have to be some really hardnosed dialogue, and it’s going to potentially take some of the long term plan to be torn up and redrafted as we go along in the next two to three years.”

The NHS is reporting record high waiting times, from ambulances to bed occupancy, and, coupled with the workforce crisis, research suggests it could take the service more than a decade to clear the cancer backlog resulting from the pandemic. The charity Cancer Research UK has warned that every month more than 65 000 people in England are waiting beyond the 28 day target to find out whether they have cancer.

Elisabeth Mahase, *The BMJ* Cite this as: *BMJ* 2022;379:o2694



THERE’S GOING TO HAVE TO BE SOME REALLY HARDNOSED DIALOGUE

Richard Sullivan

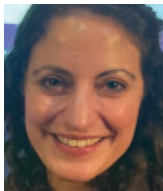
PATIENTS' ACCESS TO MEDICAL RECORDS: What is happening with the rollout in England?

Plans to let people see their GP records on the NHS app have been paused. **Matthew Limb** asks why



Practices are worried they cannot safely assess records that are added to at a rate of 1.3 million consultations a day

David Wrigley



Fears about a surge in patients seeking explanations or disputing entries have not been borne out

Kiren Collison



I do not believe it is safe for us to switch on the access without checks and balances in place

Amir Hannan



Information in medical records is about an individual, and that person should have every right to see it

Rachel Power

? What is being rolled out?

Patients in England, but not the rest of the UK, are being promised automatic access to all their new GP records through the NHS app by the end of the month. That includes results, vaccination history, medication lists, hospital letters, and consultation notes made by healthcare staff during appointments with a GP or practice nurse.

? Are things on track?

There's been confusion and delay. The Accelerated Citizens' Access programme, led by NHS England, was meant to start on 1 November. EMIS and TPP, companies that supply IT systems to general practices, announced a pause until there was full confidence in it. The BMA's General Practitioners Committee had called for a halt to give practices more time to prepare to offer patients the scheme in line with the Data Protection Act and safeguarding measures.

? What does NHS England say?

For practices that asked EMIS and TPP not to enable the change, NHS England has instructed both to pause until the end of the month.

Practices needing more support should engage with local commissioners and agree plans to prepare before their systems are "automatically enabled" from 30 November 2022. For all other practices that had not informed EMIS and TPP to pause by 5 pm on 4 November the change will go ahead as planned, "with prospective data entered into patient records from 1 November 2022 automatically becoming visible in a phased way," NHS England said.

? Does this approach suit everyone?

Concerns remain in some quarters over patient safety, clinical liability, timing, resourcing, and handling of the rollout. Under

the Data Protection Act, GPs bear responsibility for this information as data controllers. "Many practices are worried they're not in a position to be able to safely assess patient records that are being added to at the rate of 1.3 million consultations a day, nor keep track of all the different data sources inputting into the GP record," said David Wrigley, deputy chair of the BMA's GP Committee.

Worcestershire Local Medical Committee has proposed a motion to be debated at England's national conference of local medical committees later this month saying that the scheme poses "unacceptable risks" and should be paused "until all outstanding issues have been addressed."

"We've been told this will all get rolled out at the end of November, whether or not we've sent that instruction as the data controller," Gill Farmer, a GP and secretary of Worcestershire LMC, told *The BMJ*. "If we're not giving permission to the provider to release it, I find that an interesting legal question as to how that can be overridden."

? What are the professed benefits?

Health officials say that giving patients access to their personal health information will give them greater control over managing their health, by allowing them to monitor and review information about themselves. Many health practitioners endorse that in principle. Kiren Collison, NHS England's interim medical director for primary care, said the experiences of general practice staff at 16 early adopter sites told a "positive story" and may help to allay some of the concerns. For example, she said evidence indicated that fears about a surge in patients seeking explanations or disputing entries after reading their notes had not been borne out.



? What are GPs' concerns?

Some worry that, although access to GP records may greatly benefit some patients, it could harm others. Loss of privacy of medical information is a concern.

"This is particularly true of our more vulnerable patients, such as those with mental health issues or who are in abusive and coercive relationships," said Wrigley. Patients under safeguarding or child protection may potentially put themselves at risk if they read things about them that health professionals have been writing, it is feared.

? How should practices prepare?

GPs must identify patients who could be at risk of serious harm from having automatic access to their records and put the right safeguarding processes in place to support access to all future data. But GPs' leaders said that many practices don't have the resources needed to identify, review, and if necessary redact sensitive data in patients' records, especially when the redaction software used is "not fit for purpose."

"It's a huge amount of work to make sure these notes are safe for patients: that we've redacted the necessary information," said Farmer. "If you have a patient who you know is an adopted child, do they know they're adopted? How do we know what's safe to reveal and what isn't?" she asked.

A patient will be able to see a GP's notes just as they've been typed up. This means that GPs will have to think carefully about how they make their notes clear and accurate records of consultation discussions and strip out confusing medical jargon.

? What other steps are needed?

More should be done to prepare patients for what to expect and to support them, some doctors and researchers have argued. A study of online access to medical records in 10 English general practices showed patients had difficulties interpreting information.

Amir Hannan, a GP in Manchester who has enabled his patients to have access to the full electronic health record since the mid-2000s, said staff can use

A STUDY of online access to medical records in 10 English general practices showed that patients had difficulties interpreting information

questionnaires to gain prior consent and to prepare the ground with patients so they know how to respond and make appropriate choices if they are exposed to concerning details in their records.

"That doesn't happen with the current [NHS England] proposal. I do not believe it is safe for us to switch on the access without those checks and balances in place," Hannan recently told the BBC podcast *Inside Health*.

The BMA has called for a public campaign to let patients know that the NHS app may suddenly become a portal to their detailed health records. Jackie Applebee, a GP in Tower Hamlets, east London, and chair of Doctors in Unite, who supports patients' access to medical records but opposes an "automatic switch on for everybody," told *The BMJ* she was concerned over a lack of proper consent procedures. In addition, "A lot of our colleagues in secondary care have no idea this is happening. They don't realise their letters will be available for patients to see online when they send them," she added.

A lot of our colleagues in secondary care have no idea this is happening
Jackie Applebee

? What do patients say?

Rachel Power, chief executive of the Patients Association, said, "Quite clearly there is a desire among patients to see their medical records, and we support NHS England's efforts to make this happen with GP held records. Callers to our helpline often tell our advisers that they're surprised they cannot access their GP records through the NHS app. This suggests most patients will welcome being able to access their notes

this way when that functionality is rolled out at the end of November.

"At the end of the day, information in medical records is about an individual, and that person should have every right to see it."

? What resources are available?

Webinars for practices and commissioners are available from NHS Digital. The BMA has also issued its own guidance.

? How long has England been trying to enable access to records?

The NHS has a poor track record when it comes to adopting digital technologies at scale, such as the 1992 national IT strategy for the NHS and the National Programme for IT that ran from 2002 to 2011. This failed to create a single electronic health record system and connect primary and secondary care IT systems and was criticised for being overcentralised and not understanding of users' needs.

? What happens in other countries?

Many countries have a policy guaranteeing accessible electronic health records to patients but differ over access procedures, age restrictions, and other factors.

A study of 10 countries (Australia, Denmark, Estonia, Finland, France, the Netherlands, New Zealand, Norway, Sweden, and the US) found all had some type of mandatory patient access but "none mandated continuous patient access to complete EHR data." US patients have "near complete" access to their records, said Helen Haskell, a member of *The BMJ's* patient advisory panel, who is based in South Carolina. "There were lots of fears but no complaints once it became reality. Transparency is seldom a bad idea," she said.

Matthew Limb, London

Cite this as: *BMJ* 2022;379:o2677





PRECIOUS PHOTOS/ALAMY

THE BIG PICTURE

“Climate crisis puts every child in the world at risk”

Children in countries such as Mali (left) and Kenya (below) already suffer from brutal climate conditions that have depleted water and food sources, and the number of the world’s children exposed to such conditions is set to rise, warns a new report.

The Unicef report, published in the run up to the COP27 climate change conference, which opened this week in Egypt, raises concerns about the lack of progress on tackling the climate crisis. It said heatwaves were becoming longer, stronger, more widespread, and more frequent. Climate change was also creating a child rights crisis and was already taking a heavy toll on children’s lives and futures, the agency warned, not just because food and water were becoming scarcer but from the impact on children’s health solely from extreme heat.

By 2050, in both low and very high emission scenarios, the authors warned that almost every child on the planet would be exposed to high heatwave frequency—namely, living in areas where the average yearly number of heatwaves is 4.5 or above. Currently around 559 million children live in such areas.

“The implications for children’s health and wellbeing and the need for adaptation are dramatic,” said the authors. “The more heatwaves children are exposed to, the greater the chance of developing health problems including chronic respiratory conditions, asthma, and cardiovascular diseases.”

Heatwaves also presented health risks for pregnant and breastfeeding women, they added, because extreme heat was harmful to children in utero and could lead to stillbirth, complications from gestational diabetes, and preterm birth.

Adrian O’Dowd, London

Cite this as: *BMJ* 2022;379:o2598



1. Brothers in Mali share water from a well

2. Women and children from Turkana in Kenya search for water that seeps out of the sand and collects in wells dug into a riverbed



TONY KARUMBA/AFP / GETTY IMAGES

Doctors are “thwarted” by politicians’ mismanagement, say junior leaders

With 12 years’ combined experience of representing their colleagues at a national level, the former BMA Junior Doctors Committee co-chairs **Mike Kemp** and **Sarah Hallett** talk about pay erosion, flexibility in training, and giving the government an ultimatum

QUICKFIRE QUESTIONS

Sarah Hallett

What was your first ever job?

I worked in retail as a shop assistant. It definitely helped me with learning to interact with the public.

Most cringeworthy moment during your medical training?

When I was a medical student on the labour ward there was an incident involving a tidal wave of amniotic fluid, which meant needing to shower afterwards. That was probably up there.

Favourite part of your job?

I think one of the major things for me as a paediatric registrar is seeing babies who are born extremely premature and then meeting them again as children, seeing the progress that they’ve made. I find that incredibly rewarding.

Mike Kemp

When did you know you wanted to be a doctor?

About three or four weeks into my AS levels I changed my mind. I had wanted to be an architect, and then my dad died. It was something I’d been thinking about for a little while, that I was interested in medicine, and I decided then that this was what I wanted to do.

Most cringeworthy moment during your medical training?

I went to examine a patient and didn’t notice there was a urine bottle on the table, and I managed to knock it so that it tipped up over my shoe. So, then I was wearing one soggy shoe... that was at the beginning of a night shift.

Favourite part of your job?

It’s the situations where I’ve been able to take skills that I’ve got from work and relate them to a friend or family member who’s been unwell. Being able to help and support them.

Giving people back some control over their lives will make a huge difference



“I’ve basically been working in crisis mode for the past six years,” says Sarah Hallett, a paediatric registrar who has been on the BMA Junior Doctors Committee for nearly a decade, including three years as deputy chair and three as chair.

Hallett and her co-chair Mike Kemp, a neurology registrar, sat down (virtually) with *The BMJ* a few weeks after finishing their BMA roles on 1 October, to reflect on what they had achieved and what was left to do.

“The workload is huge, and it’s all consuming,” says Kemp, who joined Hallett as co-chair in 2021 after serving a year as deputy co-chair. “Many of the things we’ve achieved are things junior doctors starting today will see as being the norm, but they weren’t when we started. I think that gradual, incremental change has been so important, but there’s always more that you can be doing.”

Biggest achievements

Giving junior doctors more control over their training and lives has been a key motivation for these co-chairs.

“We’ve made some huge strides when it comes to flexibility in training,” says Hallett. “I’ve often

felt, going back years, that there was quite a paternalistic approach to our training. But I do think many in Health Education England and the medical deans are now not that way.”

During their tenure they have campaigned for—and seen implemented—a number of changes, including removing the need to give a reason to move to less than full time training, preferential applications for specialty training if applicants have caring responsibilities or a disability, and the ability to move deanery within the national Inter Deanery Transfer system without needing to give a reason.

They also worked on supporting return to training and contractual shared parental leave. Kemp, who was one of the first junior doctors to take up the shared parental leave option after his daughter was born, says that this work is crucial for retaining doctors.

He says, “These are the things that make a difference to how people value, enjoy, and feel valued in their job. We hear a lot about junior doctors feeling burnt out, the fatigue that goes with their role. And that’s partly because the intensity of every hour of work done in the NHS these days is far more intense than it was 10 years ago.

Working conditions are worsening, and I think that affects how we view remuneration



“I think a huge contributor to that is the fact that people have felt less control over their working lives, and by giving people back some of that control it will make a huge difference, because it allows people to make their working life work for them.”

Desperate need for staff

However, while Hallett is very proud of the work the committee has done, she says that it has been “limited by the political environment and by choices that are made by the government more widely.”

One such area is the workforce. “We all want to be able to provide excellent care, and we all want to be able to train to be the best doctors that we can be,” she says. “I currently feel as though that’s being thwarted by the mismanagement of the NHS and workforce strategy by politicians. That is essentially where this lies. And I would say it’s unfortunate that the lobbying we’ve done thus far, I haven’t seen make improvements on the ground.”

She adds that junior doctors don’t have “breathing space” and that their training has been “markedly reduced,” with trainees and trainers alike coming under incredible strain. “I think that loss

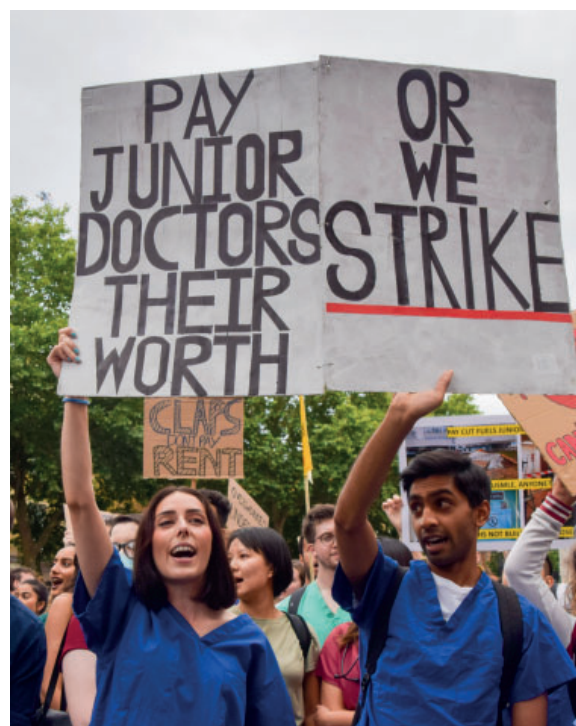
of mentorship, and that loss of the ability to have that thinking space, affects burnout and also that sense of the loss of autonomy a lot of junior doctors feel.”

The pandemic, says Hallett, has truly highlighted how fragile the system is, especially when it comes to staffing levels. “We are able to cover what’s needed for patient safety, but no more,” she says. “This means that when something like a pandemic happens or if there’s a lot of sickness, or even if someone just goes on holiday, it often leaves our rotas understaffed. We desperately need better staffing. That’s not just for doctors but across the board.”

Doctors on the picket line

Alongside the workforce, pay has become a leading issue for junior doctors in the past few years.

Hallett explains, “The erosion of our pay has been significant, and we have medical students who are graduating into an NHS that’s incredibly under strain and only getting worse. The working conditions are worsening, and I think that affects how they view that remuneration, how they view that pay erosion.” She adds that students are also conscious of leaving



Ministers must commit to full pay restoration or prepare to face industrial action

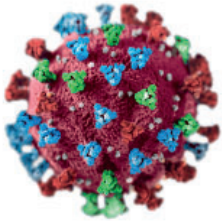
medical school with significant and increasing levels of debt.

While junior doctors had a multi-year pay deal agreed before the pandemic, it included room for a review at a later date should the situation change. As a result, Hallett says that she has been raising the issue with increasing urgency since 2020 but that the government has refused to “meaningfully engage.” This was what led to the Junior Doctors Committee issuing an ultimatum to the government in August: commit to full pay restoration or prepare to face industrial action. “We had no choice,” says Hallett.

However, both former co-chairs emphasise that there is still time to avoid a strike. “The door to discuss these matters is open, and the government should take that opportunity if they want to avoid more industrial action and junior doctors on the picket lines again becoming a reality,” says Hallett. “I think the government is going to have to respond because this is not just affecting one branch of the NHS—this is a whole NHS issue. Staff members will be standing together and saying that enough is enough.”

Elisabeth Mahase, *The BMJ*

Cite this as: *BMJ* 2022;379:o2648



CORONAVIRUS

How similar is covid-19 to the flu?

Chris Stokel-Walker asks whether the comparison is fair and correct



Influenza kills 290 000 to 650 000 people globally each year



SARS-CoV-2 seems to sometimes trigger a more substantial immune response
Cheryl Walter

How have people compared the viruses?

For those who sought to downplay the severity of the disease caused by SARS-CoV-2, “just like the flu” was a way to express how they thought that lockdown measures were over the top.

As the pandemic progressed, groups of experts began talking about the possible evolution of SARS-CoV-2 into something more “flu-like”—the natural extension, as some virologists thought, of a virus getting less deadly so that it could continue to propagate in the population. By killing fewer hosts, there is a higher chance that the virus will be transmitted to others.

Emma Thomson, professor in infectious diseases at the MRC-University of Glasgow Centre for Virus Research, told *The BMJ* in a video, “I learnt at medical school that viruses generally get less severe. But I think that’s probably one of those statements that’s made with very little evidence behind it.

“We’ve never watched evolution like [SARS-CoV-2] on such a large scale and with so much sequencing of the [viral genome being done]. So we now have much better evidence to show that there’s a real heterogeneity [in the way that viruses evolve].”

Finally, there’s the disease covid-19 itself and the way that we are coming to “live with the virus” in the same way that each year we live with influenza, which kills 290 000 to 650 000 people globally each year, according to the World Health Organization.

What do the viruses target?

Both SARS-CoV-2 and the influenza virus target the respiratory epithelium, so in that respect the target cells they’re infecting are quite similar, says Wendy Barclay, head of the Department of Infectious Disease and chair in influenza virology at Imperial College London.

There are differences in what each virus requires, however, to infect people. Influenza requires haemagglutinin and neuraminidase, whereas SARS-CoV-2 uses protein S to infect humans, a 2020 study found.

How do their symptoms differ?

There are similarities when it comes to acute infection, says Cheryl Walter, a virologist and lecturer in biomedical science at the University of Hull—people generally get a sore throat, a runny nose, and perhaps a general sense of fever and achiness. But, as is well documented, covid-19 has caused a range of

symptoms not usually seen with flu. We’re still trying to understand why people lose their sense of smell and taste, she says.

One difference between the two is that SARS-CoV-2 seems to sometimes trigger a more substantial immune response, which makes some people very ill. “The immune response can be different from one person to the next, and we see that can mean the difference between life and death,” says Walter.

How does mortality compare?

In the early days of the pandemic, covid-19’s infection fatality ratio (IFR)—the proportion of people who died after contracting the disease—was much higher than the flu’s. How to calculate covid’s IFR has been the subject of academic debate, with estimates varying from 0.49% to 2.53% in one study.

Factors that affect the IFR of covid are thought to include a person’s age, location, and ethnic background, as well as where they live and work. In one study that analysed disease mortality across 190 countries, IFRs for the same disease varied by a factor of more than 30, showing how variable mortality can be.

Another important variable that affects IFR is the extent to which people are vaccinated. As the vaccine rollout has progressed, covid-19 has become less fatal. Likewise, the rise of new covid variants has helped reduce covid’s IFR. One non-academic analysis indicated that covid-19’s IFR has now become equal to or less than flu’s (around 0.04%), whereas in mid-2020 covid-19 was 20 times more likely to kill people than the flu.

What about variants?

As we now know, SARS-CoV-2 mutates and evolves, forming new variants that have been fuelling fresh waves. This pattern of behaviour is similar to what happens each year with new variants of influenza, which is why the flu vaccine must be reformulated each year, based on variants that emerge in the southern hemisphere’s earlier winter months.

A big difference with SARS-CoV-2 is that it has evolved much faster—this year alone has seen at least four omicron “subvariants under monitoring” as the World Health Organization calls them, including BA.4 and BA.5 that are currently responsible for most of the world’s infections. Unlike influenza, this has continued even through warmer months, posing a challenge for vaccination efforts to keep up.

Most people under the age of 50 will not be offered an autumn covid booster this year, in line with the flu jab



P. MARAZZI/SPL

How is vaccination handled?

The pandemic is now centred around new variants and waning immunity, with an emphasis on regular booster jabs, particularly tweaked to the new variants, to top up immunity. This is not dissimilar to the yearly flu jab, although the speed at which new covid variants are emerging is a problem for the development of new booster vaccine formulations.

In terms of rollout, covid booster jabs are being tied in with the well established annual flu vaccination effort. The UK's NHS is running two vaccination schemes in parallel this autumn and winter, just as it did last year. The annual winter flu jab season will coincide with this autumn's seasonal covid booster campaign, which will see 26 million people in England eligible for the jab. The NHS is encouraging hospital hubs and general practices to try and vaccinate patients against both covid-19 and the flu simultaneously "where possible."

For covid, as with the flu, it is the most vulnerable people (older or immunocompromised people and those with certain conditions such as severe asthma) that are prioritised. In the early stages of the covid-19 vaccine rollout, it was given to those most in need of the jab ("priority groups") before being offered to people of all ages. This is different from the flu jab campaign, which targets vulnerable and older people. But the UK Joint Committee on Vaccination and Immunisation's latest advice indicates that most people under the age of 50 will not be offered an autumn booster this year, unless they are vulnerable, in line with how the flu jab is rolled out.

The increasing similarity with the flu jab campaign is likely to continue, says Paul Hunter, a virologist and professor in medicine at the University of East Anglia. "I suspect that the current over 60s might well continue to be vaccinated pretty much forever, whereas younger people probably won't," he says, much like the flu. Unlike the flu, we are not yet at the stage where vaccination is available or recommended for everyone. But that could, of course, change depending on whether a more potent variant arises.



We've never watched evolution like SARS-CoV-2 on such a large scale and with so much sequencing
Emma Thomson



I think we live with deaths from seasonal flu and we will live with deaths from covid as well
Wendy Barclay

Mid and South Essex Health and Care Partnership

NHS

Flu Vaccination – Keep Calm and Carry On

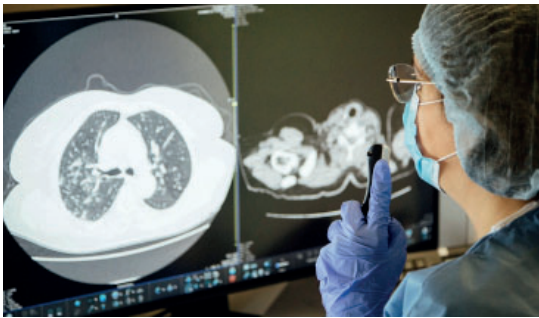
For more information about flu, visit: www.nhs.uk/flu

What about treatments?

Besides vaccines, we now have a range of treatments for covid-19, including antivirals. In large part, the knowledge we now have about how to treat covid-19 comes from the Recovery trial, which tested various interventions and their efficacy. But, says Barclay, although many of these treatments have been “tried here and there with the flu, it’s not really ever been used.” The much prophesied influenza pandemic has yet to arrive—instead we’ve had covid-19. As such, it’s difficult to compare the rapid rise and use of covid-19 interventions with flu treatments that are rarely used.

Steroids like dexamethasone, for example, are now a core first line therapy for covid-19. But if a patient comes into hospital with severe flu, we don’t give them steroids in the UK, says Barclay. “People have not been convinced with flu that this intervention was helpful.” There doesn’t seem to be much of an appetite to change that either, even though such interventions proved to be positive with covid. The Recovery trial proposed an extension to its remit to explore treatments for severe influenza, but this was rejected.

This is a missed opportunity, says Barclay. “There are lots of things we can learn about what to do with flu from SARS, and what some people have been thinking about is using these small molecules more like prophylactics, getting them into people very quickly,” she says; for example, monoclonal antibodies could be used to treat flu just as we have with covid-19.



Most knowledge about covid treatments we now have come from the Recovery trial



The pandemic should make us less tolerant of the toll of airborne diseases
Deepti Gurdasani

How are the two diseases perceived?

Before the pandemic, England and Wales, along with other countries, would “accept” between 10 000 and 25 000 deaths a year caused by influenza. And it’s arguable that countries opening up and living largely as if the pandemic is not ongoing signals a similar acceptance of the still high numbers of deaths from covid-19—as of 23 September, 44 341 deaths in England and Wales this year were marked as caused by or involving covid-19.

Whether this is acceptable or abhorrent is a matter of debate. But given what the world has gone through in the past two years, we must take lessons, says Deepti Gurdasani, a clinical epidemiologist and senior lecturer in machine learning at Queen Mary University of London. She says the pandemic experience should make us less tolerant of the toll of airborne diseases “because now we’ve learned that things like ventilation can massively reduce the mortality associated with all airborne diseases, not just covid.” In other words, we know we can save lives with simple interventions, so why don’t we?

Barclay, who sits on various UK government advisory bodies, is less certain the perception of the public—and of those in charge of mitigating risks—will change. “I think we live with deaths from seasonal flu,” she says. “And we will live with deaths from covid as well. I don’t think there’s any alternative to that. We will continue to try and strike the balance between the numbers, and how uncomfortable those numbers feel, and how uncomfortable the hospital situation is. Basically, everything will be predicated on whether the NHS can cope.

“What people forgot is that when SARS-CoV-2 first emerged into the human population, it was a brand new animal virus, which humans had not seen before,” Barclay says. That lack of precedence, and the lack of immunological priming for its effects in humans, is what caused such severity of disease in the pandemic’s early days. “The whole world was completely susceptible. A proportion of those people were going to get really quite ill because they had no immune backup to rely on.”

That’s not the situation many populations are in now. Though more frequent than flu, encounters with covid are becoming common, with some degree of immunity from exposure to prior variants, vaccination, or both helping to lessen their severity—so far.

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Cite this as: *BMJ* 2022;379:o2625