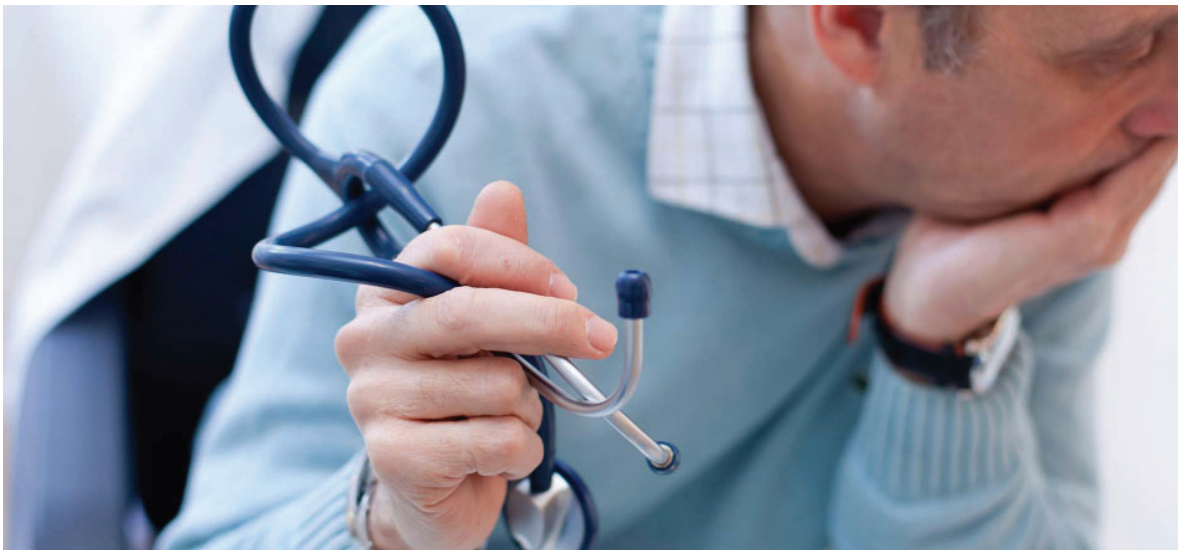
this week

DRUG REGULATION page 424 • **PEANUT ALLERGY** page 424 • **PENSION CHANGES** page 426



BURGER/PHANIE/ALAMY

UK GPs are more stressed than peers

Out of 10 countries, the UK's GPs were among the most stressed, least satisfied, and most concerned about time spent with patients

General practitioners in the UK experience the highest stress and lowest job satisfaction when compared with colleagues in nine other high income countries, an analysis has found.

The Health Foundation report analysed data from the Commonwealth Fund's survey of 9526 GPs in 10 high income countries, including 1010 in the UK. In all countries most GPs reported dealing with higher workloads than before the pandemic, and many said that they had experienced greater stress and signs of emotional distress.

But UK GPs reported higher levels of emotional distress and bigger rises in workload than those in nearly all other countries. Some 71% said that they found their job "extremely" or "very stressful," the highest of the 10 countries surveyed and similar to Germany (68%). Stress among UK GPs was up 11 percentage points on 2019.

The analysis also found that UK GPs were among the least satisfied at work, with just 24% "extremely" or "very" satisfied, similar to colleagues in France (27%) but lower than all other countries. They were also among the least satisfied with their work-life balance and the time they spent with patients.

Hugh Alderwick, the foundation's director of policy and coauthor of the report, said the results should "ring alarm bells." "Just a decade ago, UK GPs were among the most satisfied of any country in the survey, now they are the least satisfied. Decisive policy action is needed to improve working lives—including to boost capacity, reduce workload, and make use of wider primary care staff. The promise of new doctors will be little good if the NHS cannot retain the ones it has."

More positively, GPs in the UK are more confident in palliative care (96%) and dementia (95%). The UK also performed well on online access, using electronic medical records, and using data to inform care.

The report noted that, despite repeated government pledges to increase the workforce, the number of fully qualified, full time equivalent GPs in England had fallen since 2015. Shortages are estimated at 4200 and could grow to 8800 by 2031, it said.

Kamila Hawthorne, chair of the Royal College of General Practitioners, said, "The college has long warned that without urgent action general practice in the UK will become unsustainable—this report reveals just what a sorry state of affairs we are facing. The UK is further ahead than most other countries on some elements . . . but it does show, that as the foundation of the NHS, we are struggling."

Gareth Iacobucci, *The BMJ*

Cite this as: *BMJ* 2023;380:p676

LATEST ONLINE

- Doctor who sent explicit material to alumni is suspended despite asking to be struck off
- Climate change: window to act is closing rapidly, warn scientists
- Food tsar resigns saying voters are "fed up" with broken food system

SEVEN DAYS IN

Junior doctor strike led to 175 000 hospital postponements, data show

RON FASSBENDER / ALAMY

More than 175 000 planned hospital appointments and procedures were postponed during last week's 72 hour strike by junior doctors, show data from NHS England.

The release of the figures came as BMA leaders agreed to meet England's health and social care secretary, Steve Barclay, this week to try to resolve the dispute over pay and conditions that prompted the three day walkout.

Responding to the data on cancelled appointments, the co-chairs of the BMA's Junior Doctors Committee, Vivek Trivedi and Robert Laurenson, said, "Every day junior doctors despair as they see operations cancelled and treatment postponed for the millions on the waiting lists because our health services are in crisis. But rescheduling appointments as a result of the strike action could have been avoided if the health secretary had come to the table and negotiated an agreed settlement with us before any strike action was taken."

A Department of Health and Social Care spokesperson said the government deeply regretted the cancellations. "We want to find a fair settlement which recognises the crucial role of junior doctors and the wider economic pressures facing the UK, as we have done with other unions," they said.

Gareth Iacobucci, *The BMJ* Cite this as: *BMJ* 2023;380:p663

NHS pay

Deal is struck for nurses, paramedics, and other staff

The government and health unions agreed a deal for NHS staff in England including nurses and ambulance workers to get a 5% pay rise from April. The agreement, which does not cover doctors, would also give staff a one-off payment of £1655-£3789 to top up their 2022-23 pay award. Strike action will be paused while unions ballot their members. The Royal College of Nursing, which had asked for a 19% rise, is backing the deal, as are Unison and the GMB. Unite the Union said that it could not recommend the deal to members but would let them decide.

Pregnancy

Little evidence that IVF raises risk

Research has found little evidence that people conceived as a result of fertility treatment have a greater risk of pregnancy complications or worse birth outcomes than their naturally conceived peers when becoming parents, a study in *BMJ Medicine* reported. While IVF conception is associated with fewer pregnancies in adulthood, this may well be explained by social rather than clinical factors, the researchers said. They drew on the reproductive histories of more than a million Norwegian residents born from 1984 to 2002 who had a pregnancy registered with the Medical Birth Registry of Norway up to the end of 2021.

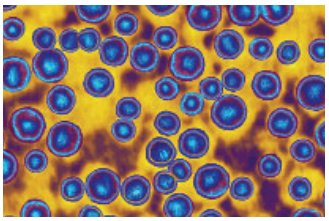
Traffic collisions increase risk of complications

Pregnant women involved in road traffic collisions—even those with minor injuries—have a greater risk of potentially serious birth complications, a study published online in the journal *Injury Prevention* found. Researchers in Taiwan examined information on 20 844 births among 20 739 women involved in a road traffic collision while pregnant in 2007-16. These women were 31% more likely than their peers to experience prolonged contractions, 51% more likely to experience placental abruption, 19% more likely to bleed very heavily before birth, and 5% more likely to need a caesarean section delivery.

Sexual health

Gonorrhoea cases surge since pandemic in England

The UK Health Security Agency urged people with new or multiple sexual partners to get tested, as data showed that gonorrhoea (below) cases had surged again since covid-19 restrictions were eased in 2021. Provisional data indicate that gonorrhoea diagnoses reported from January to September 2022 (56 327)



were 21% higher than in the same period in 2019 (46 451). In the first nine months of 2022, gonorrhoea cases were higher than those reported over the same period in each of the past three years.

Pollution

Most of world breathes air exceeding WHO target

The UK, along with 117 other countries, exceeded the World Health Organization target on fine particulate matter in 2022, a report on world air quality found. Only 12 countries were within the guideline value of 5 µg/m for annual $PM_{2.5}$ concentrations, said the fifth annual study by IQAir, a Switzerland based air technology group. These included Australia, New Zealand, Estonia, and Finland. The report is based on data from 30 000 air quality monitoring stations in more than 7000 cities. WHO estimates that poor air quality accounts for seven million preventable deaths a year.

Anaphylaxis risk

UK withdraws all pholcodine medicines

Cough and cold medicines containing pholcodine have been withdrawn from the UK market after an investigation into the risk of allergic reactions by the MHRA. The opioid medicine, which is used in 20 common over-the-counter cough medicines such as Day & Night Nurse and Boots Day Cold & Flu Relief, is understood to increase the risk of "very rare" allergic reactions to neuromuscular blocking agents used in general anaesthesia during surgery. The review found that, while the absolute risk was "very small," the benefits of these medicines did not outweigh the increased risk.

MEDICINE

HRT

Cheaper access for women with menopause symptoms

From 1 April women with a prescription for hormone replacement therapy will be eligible for a scheme enabling access to a year's worth of menopause prescription items for the cost of two prescription charges, currently £18.70. The HRT prepayment certificate is being launched to reduce costs for HRT prescription items. It can be used against an unlimited number of HRT items, such as patches, tablets, and topical preparations.

Women will pay only two prescription charges a year for an unlimited number of HRT items

International news

Five cities get cash prize in public health awards

The first Partnership for Healthy Cities Summit awarded five cities $150 000 (£123 000) to continue work in preventing non-communicable diseases and injuries. Athens was awarded the money for increasing access to naloxone for opioid overdoses; Bengaluru, for reducing smoking in public places; and Vancouver for online tracking of population health indicators. Mexico City was recognised for introducing a bike path on a busy road (above) that led to a 275% rise in cyclists, and Montevideo was rewarded for introducing nutritional food standards in government offices and some public universities.

Syria's women lose access to reproductive healthcare

Earthquakes and attacks on healthcare facilities in northwest Syria have left 2.3 million women and girls without access to medical care, particularly sexual and reproductive healthcare, leading to the deaths of children and mothers, a report found. The earthquakes that struck southern Turkey and northern Syria on 6 February killed 4500 Syrians and injured 8700. The disaster has pushed the region's already fragile healthcare system closer to collapse and has further reduced access to healthcare.

US maternal mortality rose during pandemic

Data from the US Centers for Disease Control and Prevention showed that 1205 women died of maternal causes in the US in 2021, up from 861 in 2020 (a 40% rise) and from 754 in 2019. The maternal mortality rate in 2021 was 32.9 deaths in 100 000 live births, which compares with 23.8 in 2020 and 20.1 in 2019 and was much worse among black women (69.9 deaths in 100 000 live births) than white women (26.6).

Public health

Grants in England are "too little, too late"

The government's award of a £3.53bn public health grant to English local authorities for 2023-24 just two weeks before the start of the financial year is "far too little, far too late," said Jim McManus, president of the Association of Directors of Public Health. Ministers said the grants would give each local authority a 3.3% cash terms increase. But McManus said the money did not make up for years of funding reductions and that some services would still have to be cut despite strong evidence for their effectiveness.

Cite this as: *BMJ* 2023;380:p664

HEALTH GAP

Babies born this year in Hampstead, north London, can expect to live to **88**, compared with those born in Glasgow, who have a life expectancy of **76**

[Health Equals]

SIXTY SECONDS ON . . . **POOLS**

IN AT THE DEEP END?

Public swimming pools are struggling to stay afloat, with soaring energy costs putting hundreds in danger and risking a knock-on effect on people's health. But some are being offered a potential life raft through an innovative new scheme to heat their water.

DIVE IN, TELL US MORE

The technology start-up company Deep Green has been making a splash after setting up a small computer data processing centre underneath a local swimming pool in Devon. The energy from the centre heats the water, saving Exmouth Leisure Centre money.

WATER GOOD IDEA

Indeed. Deep Green's chief executive Mark Bjornsgaard (below) said that in most cases, data centres waste the heat that their computers generate. "We capture ours and we give it free to heat the swimming pool," Bjornsgaard told BBC Radio 4's *Today*.

DEEP HEAT

The scheme is mutually beneficial: the heat from the computers warms the water, saving leisure centres money and reducing the amount of carbon they use, while the transfer of heat into the pool cools the computers, allowing the data company to offer cheaper services because it doesn't have the cooling costs.

A STROKE OF GENIUS?

It looks like there could be a butterfly effect. The boss of Swim England, Jane Nickerson, said that she had been flooded with requests from other pool managers asking to be included in the scheme, which she said could be "an absolute gamechanger" for hard pressed leisure centres.

ARE POOLS BEING OFFERED OTHER HELP TO KEEP THEM AFLOAT?

The chancellor Jeremy Hunt has attempted to play lifeguard by making £63m of new money available to help struggling pools in his budget. Local authorities will be able to apply for funding for leisure centres with pools that face immediate cost pressures such as high energy bills and maintenance costs.

Gareth Iacobucci, *The BMJ*

Cite this as: *BMJ* 2023;380:p638

Novo Nordisk is suspended from industry body over serious breaches

The Danish drug company Novo Nordisk has been suspended as a member of the Association of the British Pharmaceutical Industry for two years because of "serious breaches" of the association's code of practice. The company failed to disclose clearly its sponsorship of a weight management training course for healthcare professionals which included positive information on its obesity drug Saxenda (liraglutide). It is only the eighth time in 40 years that the ABPI has suspended a member.

The course, promoted on LinkedIn, was offered by a third party training provider, and Novo Nordisk said it had supported it "at arm's length." ABPI said, however, that it was concerned that Novo Nordisk did not recognise that this was a large scale Saxenda promotional campaign that the company had knowingly paid for and which was "disguised."

Novo Nordisk also covered the cost of provision of a patient group direction (PGD) to prescribe Saxenda to those health professionals who had completed the course. PGD is a legal framework that allows health professionals, including dietitians, nurses, and pharmacists, to supply drugs to a specific group of patients without them having to see a doctor or nurse prescriber.

The funding was an inducement to prescribe, supply, administer, or recommend Saxenda
Appeal board panel

Over 13 000 health professionals were to be trained over two years on how to set up a weight loss service, with each delegate provided with a one year PGD with financial support from Novo Nordisk to a maximum contract value of £357 500. As of 1 July 2021, 4399 health professionals had completed the training and 599 PGDs had been activated.

The appeal board panel said covering the cost of a PGD was a benefit being offered to individual health professionals and "was an inducement to prescribe, supply, administer, or recommend Saxenda."

ABPI said the arrangements between Novo Nordisk and the training provider, particularly in relation to the PGD, "brought discredit on, and reduced confidence in, the pharmaceutical industry."

The appeal board said the attendance of Novo Nordisk representatives at the webinars and their subsequent follow-up with delegates meant it could not be considered an arm's length sponsorship.

Jacqui Wise, Kent

Cite this as: *BMJ* 2023;380:p634

UK to give "near automatic sign-off" for treatments approved by "trusted" overseas regulators

The UK government has announced £10m funding for the country's medicines and devices regulator to help fast track patient access to innovative drugs and technologies.

Under a new approach MHRA would give "near automatic sign-off" for treatments already approved by "trusted" regulators in other parts of the world such as Europe, Japan, or the US.

Announcing the move in his spring budget, the chancellor, Jeremy Hunt, said that from 2024 MHRA would put in place the "quickest, simplest regulatory approval in the world for companies seeking rapid market access."

The MHRA would still be responsible for approval of all "recognition route applications" and ensuring all products are of sufficient quality to be licensed in the UK under a robust patient safety process.

June Raine, MHRA chief executive, said the £10m cash injection would help it deliver an "ambitious vision for patients across the UK."

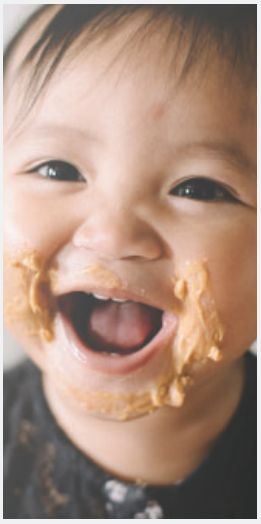
Hunt said swifter approvals systems would also quicken access to groundbreaking technologies such as cancer vaccines and artificial intelligence therapeutics for mental health and make the UK a global centre for their development.

Faster regulatory reviews will inevitably introduce greater uncertainty about drug benefits and harms Huseyin Naci

The government has accepted all the recommendations from a review into "pro-innovation" regulation of digital technologies by Patrick Vallance, the UK's outgoing chief scientific adviser.

Vallance said there were areas where the UK was "slower than the EU average" in making innovative medicines available to patients and this could contribute to poor health outcomes. "A major focus for UK regulators should therefore be to enable

Give babies peanut products between 4 and 6 months



Researchers have called on the government to change weaning advice, saying peanut products should be introduced into babies' diets between 4 and 6 months of age to reduce the risk of allergy.

The incidence of peanut allergy has tripled in recent decades and now affects around 2% of the UK's children.

THE EPIDEMIC OF ALLERGY IS BECAUSE OF THE DELAYED INTRODUCTION OF PEANUTS
Graham Roberts

An analysis by Graham Roberts, professor in paediatric allergy and respiratory medicines at Southampton University, and Gideon Lack, professor of paediatric allergy at King's College London, found that peanut allergy could be cut by 77% if peanut products were added to all babies' diets at 4-6 months. Their modelling, published in

Headquarters of MHRA, which was given £10m by ministers to fast track new drugs

the best innovations to be delivered safely and rapidly to patients through the creation of innovation pathways for MedTech, diagnostics, and drugs," Vallance said.

He said the model of mutual recognition for products already approved by trusted international partners should be paired with a "rigorous surveillance process" allowing MHRA to monitor effects in clinical practice and take proactive action as necessary.

Small market

Martin Landray, professor of medicine and epidemiology at Oxford Population Health, Oxford University, said the UK was a small market for new products and consequently "of lower priority for developers" than many other territories, including the EU, Japan, and the US.

"A default position of adopting an approval that has been made by another sophisticated regulator such as FDA or EMA makes sense—and frees up resources to focus on drugs that have particular scientific or clinical issues or where approvals in other countries seem inappropriately slow for non-scientific reasons," he said.

But Huseyin Naci, associate professor of health policy at the London School of Economics, said that expediting patient access to new drugs "can have unintended consequences."

"For example, evidence from the US suggests that drugs receiving accelerated approvals and drugs approved near regulatory deadlines are more likely to have post-marketing safety events," Naci told *The BMJ*. "Faster regulatory reviews will inevitably introduce greater uncertainty about drug benefits and harms. Such uncertainty can complicate decision making for organisations like NICE as well as for patients and clinicians."

Matthew Limb, London

Cite this as: *BMJ* 2023;380:p633

Risk of neurodegenerative disease 50% higher in elite male footballers

Elite male footballers were 1.5 times as likely to develop neurodegenerative disease as population controls, found a study of Sweden's top division from 1924 to 2019.

The observational study, in *Lancet Public Health*, found that 8.9% of players (537 of 6007) and 6.2% (3485 of 56 168) in the control group were given a diagnosis of a neurodegenerative disease.

The study, which used Sweden's national health records, reported footballers had a 1.6% (95% confidence interval 1.47 to 1.78) higher risk of Alzheimer's disease and other dementias than the controls, with 8% of footballers, and 5% of controls receiving these diagnoses. It found no significantly increased risk of motor neuron disease and the risk of Parkinson's disease was lower. Mortality was slightly lower among footballers (40%) than the control group (42%).

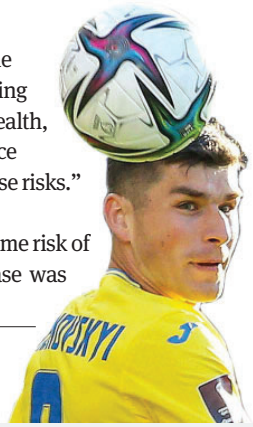
The findings supported those from a Scottish study which found footballers were around 3.5 as likely to develop neurodegenerative disease.

Peter Ueda, assistant professor at Karolinska Institute and author of the latest study, said, "As there are growing calls for measures to protect brain health, our study adds to the limited evidence base and can be used to manage these risks."

The authors added that, as most participants were still alive, the lifetime risk of developing neurodegenerative disease was likely to be higher.

Elisabeth Mahase, *The BMJ*

Cite this as: *BMJ* 2023;380:p641

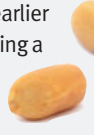


PEANUT ALLERGY has tripled in recent decades and now affects around 2% of the UK's children

the *Journal of Allergy and Clinical Immunology* found that peanuts should be introduced at 4 months for babies with eczema and at 6 months for those without.

Advice used to say that peanut products should be avoided until a child is older than 3 years. The most recent guidance is for exclusive breastfeeding or first infant formula for the first six months, with peanuts introduced between 6 and 12 months.

"The government last reviewed the data in 2018, and it is time to relook at the evidence," said Roberts. "The old advice was based on intuition. It was made in good faith, but looking back it appears that the epidemic of peanut allergy in the UK is because of the delayed introduction of peanuts to the diet," he told a briefing at the Science Media Centre in London. He said that there was now much evidence for earlier introduction, including a large Scandinavian study in 2022 which found that exposure to allergenic foods from 3 months cut food allergy at 36 months in a general population.



The new analysis showed the greatest benefit can be achieved if the whole population is targeted. Targeting only the highest risk infants with severe eczema reduced the population disease burden by only 4.6%. The estimated fall in peanut allergy diminished with every month of delayed introduction. Waiting to introduce peanuts until 12 months would lead to only a 33% reduction. Most peanut allergies have developed by the time a child turns one. "There is a narrow window of opportunity to prevent an allergy from developing," said Lack.

Mary Feeney, paediatric dietitian at King's College London, emphasised that breastfeeding should continue while peanuts are being introduced. "It's not either or," she said. She told the briefing that babies should be developmentally ready to take solids with small amounts of pureed vegetable, fruit, or cereals such as baby rice introduced first. Once this was established then smooth peanut butter loosened with a little baby milk or peanut puffs can be tried, but not whole or chopped peanuts. She recommended a heaped teaspoon of peanut butter three times a week.

Jacqui Wise, Kent

Cite this as: *BMJ* 2023;380:p645

NEWS ANALYSIS

PENSIONS **Doctors welcome government's decision to abolish lifetime allowance**

The chancellor made major changes to pension taxation to try to stem the exodus of senior doctors. **Gareth Iacobucci** examines the details

In his spring budget the chancellor Jeremy Hunt unveiled a major policy for tackling the number of senior NHS doctors reducing their hours or taking early retirement because of high taxation charges on their pensions.

In a surprise move, Hunt announced a package of measures, including scrapping the lifetime allowance on how much can be saved tax free in an NHS pension and raising the threshold for the annual allowance.

What changes were announced?

From April 2023 the lifetime allowance on how much can be saved tax free in an NHS pension will be removed. It will be abolished entirely from April 2024 in a subsequent finance bill.

Hunt had been expected to lift the cap on how much can be saved tax free from £1 073 100, but he instead opted to scrap the charge. The maximum Pension Commencement Lump Sum (the amount you can take out as a tax free lump sum when taking benefits) will stay at the current level of £268 275 and will be frozen thereafter, the Treasury added.

Alongside this, the annual allowance (the amount of money that can be put in a pension pot tax free each year) will increase from £40 000 to £60 000 from April. Individuals will continue to be able to carry forward unused annual allowances from the three previous tax years.

The money purchase annual allowance, which applies to those who take money from a defined contribution pension pot, will increase from £4000 to £10 000.

The tapered annual allowance (which limits the amount of tax relief a high earner can claim on their pension savings by reducing their annual allowance depending on their level of taxable income) is being retained but will rise from £4000 to £10 000 from 6 April. The BMA had asked for this to be scrapped. The adjusted income threshold for the tapered annual allowance will also increase from £240 000 to £260 000 from 6 April 2023.

This means that for every £2 a person's adjusted income goes over £260 000, their annual allowance for the current tax year will reduce by £1. As a result of the threshold rising, the expectation is that fewer doctors will have their annual allowance for that tax year restricted.

In addition, the government said that it would be linking open and closed public service pension schemes for the purposes of calculating annual allowance charges, to tackle negative pension input amounts that affect how much tax an individual has to pay.

The linking of schemes means only real growth above inflation is measured
Tony Goldstone

This will help us to retain our most senior doctors who have a vital role
Vishal Sharma

The change will allow members "to offset any negative real growth for annual allowance purposes in legacy public service pension schemes against the annual allowance."

Posting on Twitter, Tony Goldstone, deputy chair of the BMA pensions committee, said that this was a positive step, as it meant that negative growth in one scheme such as the 1995 benefits scheme can be combined with positive growth in 2015 so "only real growth above inflation is measured."

Why has the government chosen to act now?

The Treasury said that the move had been made "to incentivise highly skilled individuals such as NHS clinicians to remain in the labour market by reducing the risk of incurring significant pension tax charges."

The number of senior doctors reducing their hours or retiring because of punitive taxation on their pension has been exacerbating the NHS workforce crisis. The NHS has just had one of the toughest winters on record and is struggling to tackle the huge backlog in treatment that worsened during the covid-19 pandemic, so it cannot afford to shed further staff.

Hunt spent more than six years as health secretary between 2012 and 2018, which has given him an understanding of the problem. He also chaired the House of Commons Health and Social Care select committee from 2020 to 2022, during which he produced a report acknowledging that action is needed to tackle the "national scandal" of doctors feeling forced to retire to avoid facing punitive tax bills on their pensions.

What will be the impact of the changes?

The Treasury has estimated that the pension changes will mean that 80% of NHS doctors "will no longer face

HUNT had been expected to lift the cap on how much can be saved tax free from **£1 073 100**, but he instead opted to scrap the charge

an unexpected tax charge, with respect to any accruals under the 2015 career average NHS pension scheme."

Abolishing the lifetime allowance would remove barriers to remaining in work and simplify the tax system by taking thousands out of "the complexity of pension tax," it added.

How have doctors responded?

The BMA hailed the announcement as potentially transformative in terms of stemming the exodus of senior doctors.

In a statement, Vishal Sharma, BMA pensions committee chair, said, "We are pleased that, after many years of BMA campaigning, the chancellor has finally taken meaningful steps to tackle the impact of punitive pension taxes.

"The scrapping of the lifetime allowance means that doctors will no longer be forced to retire early because of pension tax. This will help us to retain our most senior doctors who have a vital role to play not only in providing care for patients but in teaching and mentoring their junior colleagues. The rise in the annual allowance to £60 000 will mean that far fewer doctors receive large unexpected tax bills and will significantly reduce the perverse incentive to reduce hours."

Sharma said that while the changes were "an important step forward," some doctors will still face additional tax bills. He said that, because the tapered annual allowance has only seen minor changes, doctors close to or above the thresholds will still need to be cautious before taking on extra shifts or doing overtime. "The tapered annual allowance needs to be scrapped," he said.

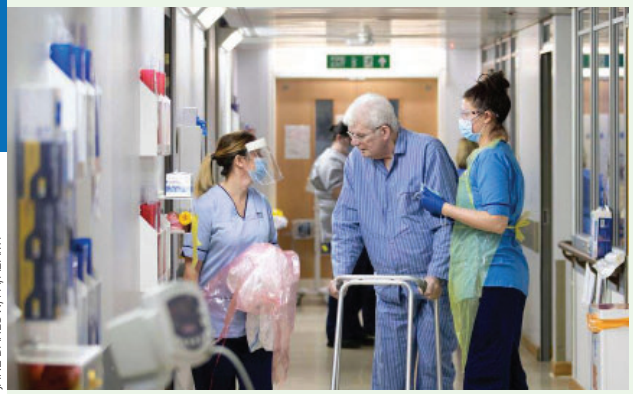
Will sorting out pensions solve the NHS workforce crisis?

Matthew Taylor, chief executive of the NHS Confederation, said, "Lifting the lifetime and annual allowance will help incentivise more medical staff to carry out extra shifts—this is vital if we are going to reduce waiting lists.

"But we are facing a staffing crisis in the NHS and this budget does not provide any further clarity on how the government is going to tackle it."

Gareth Iacobucci, *The BMJ*

Cite this as: *BMJ* 2023;380:p625



JANE BARLOW/PA/ALAMY

It is incredibly disappointing the NHS workforce crisis was not acknowledged
Eve Byrne

Chancellor failed to tackle workforce shortages and NHS funding, say critics

Leading doctors, patients' groups, and health analysts have rounded on the chancellor, Jeremy Hunt, for ignoring critical pressures on NHS staffing and funding in his spring budget.

They said that Hunt's failure to publish an NHS workforce plan on 15 March, alongside a financial statement that was billed as boosting work in the wider economy, was a damaging own goal.

Hunt announced measures to support people in moving into work, targeting barriers he said were preventing those on benefits, older workers, and those with health conditions who wanted to work. He signalled 30 hours of free childcare for every child over the age of 9 months with working parents by September 2025 and scrapped the cap on the amount that workers can accumulate in pensions savings over a lifetime before they have to pay tax.

The Royal College of Physicians said that, although the childcare and pension interventions would help to retain staff, the long term sustainability of the workforce required a detailed NHS plan with "solutions" for retention and recruitment, including an expansion of medical school places and measures to reduce demand for healthcare.

The college's president, Sarah Clarke, said, "We need to increase the number of doctors and retain those earlier on in their careers by ensuring they have good working conditions and feel supported and valued.

"Today's budget was an opportunity to deliver that plan in full."

Eve Byrne, director of advocacy at the charity Macmillan Cancer Support, said Hunt had missed a chance to "throw a lifeline" to people with cancer. "It is incredibly disappointing that the NHS workforce crisis was not acknowledged," she said. "Despite hardworking NHS staff doing everything they can, there is a chronic shortage of cancer professionals, leaving cancer patients without the care and support they deserve."

The Nuffield Trust said its own analysis of Department of Health and Social Care spending and inflation projections showed the budget left the NHS in England with a £2bn real terms funding cut from next month. It said the NHS had been left with little certainty over how it will meet growing demand or tackle the workforce crisis.

To retain doctors they need to have good working conditions and to feel supported and valued
Sarah Clarke

Sally Gainsbury, senior policy analyst at the trust, said, "The chancellor made this a budget about boosting the workforce across the economy, but the lack of the long promised, fully funded workforce plan for the NHS continues to delay meaningful action. The government remains silent on any funding to shore up a social care workforce eroded to near collapse.

"Abolishing the lifetime cap on pensions is a broad measure and isn't NHS targeted. It will address the concerns of some senior clinicians, but it does not address the significant concerns over pay and working conditions of the majority of staff."

Back to work

Hunt announced £406m funding to tackle the "leading health causes" that are keeping people out of work, with investment targeted at services for mental health, musculoskeletal conditions, and cardiovascular disease. He announced a new fitness-to-work testing regime to determine eligibility for health related benefits.

But Sarah Hughes, chief executive at the charity Mind, said, "Many people who are long term sick have mental health problems. If the government is looking to get these people 'back to work,' they should adequately fund the clinical services that support people before their mental health problems get more severe."

Hughes added mental health ward staffing was consistently at unsafe levels "so we urgently need a fully costed plan to address this."

Matthew Limb, London

Cite this as: *BMJ* 2023;380:p629

THE BIG PICTURE

Starry love letter to the NHS

Judi Dench, Derek Jacobi, Jennifer Saunders, Russell Tovey . . . the stars gathered together for a film that aims to pay tribute to the deep humanity of NHS staff battling with limited resources and ever growing demand.

Allelujah, based on the Alan Bennett play, celebrates the spirit of elderly patients and NHS staff who, when their ward in a small Yorkshire hospital is threatened with closure, fight back by galvanising the local community.

Jacobi told BBC Radio 4's *Today* programme that the film reflects the times he had spent in hospital. "The nurses and doctors are just amazing. They work so hard. They care for you not just physically but mentally."

The film, directed by Richard Eyre, opened across the UK this week.

Alison Shepherd, *The BMJ*

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PATHÉ UK

EDITORIAL

Controlling avian influenza

A One Health approach that links human, animal, and environmental health is essential

Global reports of highly pathogenic avian influenza A(H5N1) in birds are increasing, with cases reported from every region except Australasia and Antarctica since 2020.[1]

The global spread of these avian influenza outbreaks is unprecedented, exacting large economic losses to poultry industries and tourism, and posing a substantial threat to global health security and animal ecology.

On 24 February, an 11 year old girl died from an H5N1 avian flu infection in Cambodia and her father was admitted to hospital with the same infection.[6] On the same day, China reported another human H5N1 case: in a 53 year old woman from Jiangsu province who became ill after exposure to poultry.[7] Genetic analysis showed that the strain in the Cambodian cases belongs to the localised clade 2.3.2.1c, whereas the strain in the Chinese case belongs to clade 2.3.4.4b, which has been causing the recent poultry outbreaks across the world.[6-9]

These new cases in Asia were probably the result of transmission from poultry, not between humans, but they do highlight the importance of a "One Health" approach to viral threats. This approach understands and jointly considers human, animal, plants, environment, and planetary health as fundamentally connected.[10]

Investigating outbreaks

Outbreaks need to be investigated using bespoke techniques to decipher the transmission dynamics and identify underlying driving forces of evolution.[11 12] Furthermore, all data and virus isolates should be shared widely among expert laboratories so that the potential threat of evolving strains to global health can be comprehensively assessed. A pilot One Health programme implemented in Thailand in 2016 showed that transparent sharing of human, animal, and environmental surveillance data among all stakeholders is essential for effective surveillance and control.[13]

IMAGINECHINA LIMITED/ALAMY

The longer the virus circulates among animals, the more likely is the emergence of a strain that can transmit between mammals, including humans

Epidemiological studies can characterise the interplay between wild birds and the live poultry markets that act as reservoirs of avian influenza viruses and inform the design of interventions to control transmission and spill-over. For example, after an outbreak of H5N1 in 1997, Hong Kong developed and implemented a multipronged approach, including monthly closures of live poultry markets for deep cleaning, a ban on keeping live poultry overnight in both wet markets and wholesale markets, and continued viral testing of poultry and market samples.[14 15] Since then, no major avian influenza outbreaks have been reported in Hong Kong, and similar control measures have been implemented in other affected South East Asian countries.[16]

Vaccinating poultry

Several countries are now vaccinating poultry or considering vaccination to help control avian influenza. Although existing vaccines reduce deaths among infected birds, vaccinated birds can still be infected and transmit the virus.

Nevertheless, vaccination of poultry against H5 and H7 avian influenza has been compulsory in China since 2017, and there have been no nationwide outbreaks for several years.[17 18] Authorities in Mexico approved emergency vaccination of poultry against H5N1 in November 2022, and the US will shortly begin testing new vaccines in response to its worst ever H5N1 outbreak.[19]

"Silent circulation"

Without systematic viral testing in poultry, imperfect vaccine effectiveness means that ongoing viral transmission might be difficult to detect if symptoms are mild or absent. "Silent circulation" of the virus under selective pressure might facilitate mutations and increase the risk of a variant emerging that can transmit between humans. Scientists are already testing mRNA poultry vaccines that might reduce infections and transmission[20] and calling for the development of more effective human vaccines.[9 21]

A One Health approach to surveillance and control of avian influenza needs high level commitment and substantial investment. In particular, eliminating vulnerable bird populations would be costly for the poultry sector and damaging to human food supply.

Although there is currently no evidence that H5N1 transmits efficiently between humans, the longer the virus circulates extensively among poultry and other animals, the more likely it is that a strain will emerge with the ability to transmit between mammals, including humans.

The current global outbreak warrants increased and strengthened surveillance and preparedness measures, and a renewed commitment to a One Health approach to controlling all pandemic threats, including avian influenza.

Kathy Leung, assistant professor ksmleung@hku.hk
Tommy T Y Lam, associate professor
Joseph T Wu, professor, University of Hong Kong

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EDITORIAL

Resolving the NHS workforce crisis

Retention of ethnic minority staff is critical

The English NHS is facing the biggest workforce crisis in its history with nearly one in 10 positions vacant.[1] A 2022 report from the World Health Organization identified the UK as having the lowest number of medical doctors, nurses, midwives, and dentists per 10 000 population in western Europe and the third lowest in northern Europe after Latvia and Estonia.[2] Staff gaps lead to poorer patient outcomes, and replacing doctors and nurses with other clinical staff may affect patient satisfaction.[3 4] High turnover is also costly.[5]

Current efforts to reduce NHS staff shortages have a strong focus on recruitment, including from overseas.[6] However, WHO estimates a projected shortfall of 10 million healthcare workers by 2030, particularly in low and middle income countries.[7] Although there are also calls to increase numbers of "homegrown" staff, the government has stated this would have a "significant financial implication,"[8] and little is said about how universities and the NHS will find the capacity to provide high quality training for them.[6]

Finding effective ways to reduce the number of staff who leave (attrition) and increase the number who stay (retention) is crucial to reduce the pressures of understaffing and ensure good patient care.

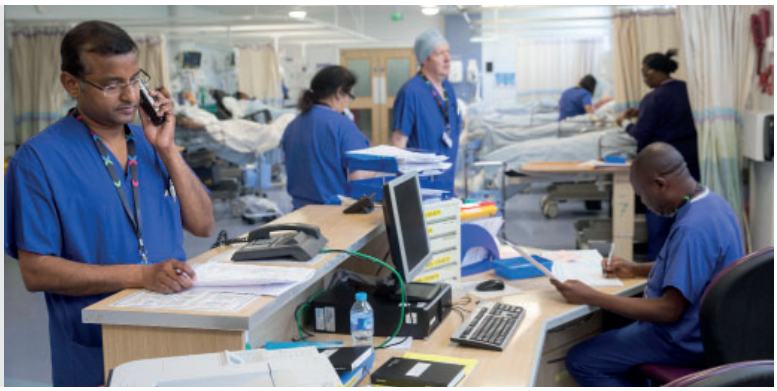
51% of ethnic minority NHS leaders have said racial harassment made them want to leave

Katherine Woolf, professor of medical education research, UCL Medical School, London
k.woolf@ucl.ac.uk

Padmasayee Papineni, consultant in infectious diseases and acute medicine, London North West University Healthcare NHS Trust

Susie Lagrata, advanced nurse practitioner, UCLH NHS Foundation Trust, London

Manish Pareek, professor of infectious diseases, University of Leicester



MARK THOMAS

Tackling attrition

Staff from ethnic minority backgrounds make up 24% of all NHS staff[9] and 42% of doctors.[10] This includes international staff, but also reflects the ethnic diversity of UK healthcare students: in 2019 a third of those accepted to study nursing and half of those accepted to study medicine were from ethnic minority groups.[11]

Empirical evidence is lacking on how staff attrition rates and reasons for leaving vary by ethnicity and on effective ways to encourage and enable staff from diverse backgrounds to stay. We know the main reasons staff leave the NHS are workload pressures, poor work-life balance, mental ill health, and poor development opportunities. These have been worsened by understaffing and the pandemic.[13-15] Pay and pensions are clearly important too, although increasing pay is unlikely to be enough to encourage staff to stay if working conditions are not improved.[16] It is also clear that staff from ethnic minority groups and international staff are more likely than their white British colleagues to experience many of the predictors of attrition, and have also been disproportionately affected by the pandemic.[17-19]

Racial harassment

Staff from ethnic minority and international backgrounds are much more likely to experience racial harassment, which can cause poor physical and mental health.[20 21] It is important to find out whether NHS staff from ethnic minority groups are experiencing greater ill health and, if so, to address this, and also to find out whether they experience higher sickness absence, as this is a strong predictor of attrition.[22]

In a recent survey 51% of ethnic minority NHS leaders said racial harassment made them want to leave.[23] Tackling these inequalities is important for both staff and patients: in NHS trusts where staff experience discrimination and harassment patients are also likely to experience unsatisfactory care.[24]

The NHS also urgently needs to find ways to increase retention that are effective and appropriate for staff from diverse backgrounds, and the evidence needs to be included in retention efforts and guidance, such as the NHS Employers retention guide.[25] The guide currently includes a chapter on welcoming international staff, but it does not have any specific information about staff from ethnic minority groups, many of whom are from the UK. The guide does not explicitly state the problems known to affect international staff and staff from ethnic minority groups.

The 2022-23 business plan sets out NHS England's work in leading and supporting the service to respond to the challenges it faces. First in its list of key commitments is to "support the NHS to attract and retain more people, working differently in a compassionate and inclusive culture."[26] To achieve this laudable aim the NHS urgently needs to ensure efforts to understand why staff are leaving include an intersectional analysis of whether and why the large proportion of staff from diverse ethnic minority groups may be more or less likely to leave.

The NHS needs to understand how well retention efforts are working for staff from different ethnic groups, and to ensure that evidence based ways of encouraging and enabling them to stay are found and embedded within all NHS organisations.

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INDUSTRIAL ACTION

Junior doctors strike: What consultants learnt from picking up the slack

How did consultants, other non-striking doctors, and staff maintain services last week—and did the experience offer any lessons for the future?
Emma Wilkinson reports

While thousands of junior doctors picketed outside hospitals last week during the three day strike action, consultants and other members of the team held the fort, in some cases doing tasks they hadn't done for a decade or more. On one level the NHS did keep running, patients were seen, decisions were made—some have noted, more quickly than usual—but elective care had to be cancelled, and hospitals were forced to throw many resources at the problem.

Julian Hartley, chief executive of NHS Providers, says that the full extent of the disruption is still emerging but that it's "very clear" that this must not happen again, for the sake of patients and staff.

"There is a very real human cost for patients in terms of treatment deferred, pain prolonged, and continuing uncertainty," he says. "Consultants and other staff have stepped into the breach. But the NHS was already overstretched. Morale is slipping and staff are exhausted." He adds that paying for strike cover has diverted resources from other priorities.

Vicky Barradell, consultant in the care of older people at Doncaster and Bassetlaw Teaching Hospitals NHS Trust, says that things ran "incredibly smoothly" but only because so many consultants and advanced clinical practitioners "pulled out all the stops." No bed waits or delays were seen, but most elective activity was cancelled—"and there may well be consequences down the line," she explains. "We recognise that huge decline in working conditions for juniors alongside the financial issues."

Barradell believes that it has also highlighted the need to invest in advanced clinical practitioners alongside junior doctors. She says, "Having senior practitioners brings another skill mix, and they have really stepped up this week."

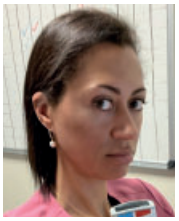
Humbling and exhausting

Rebecca Gibbs, consultant obstetrician and gynaecologist at the Royal Free Hospital in London, volunteered to do night shifts on call. The best way to show her support for pay restoration was to take on the job that "no one else wanted to do," she says, remembering how supportive her consultant colleagues were during the 2016 strikes.

She describes the experience as both humbling and exhausting, but what stood out were all the small things that had changed since her time as a junior doctor. For example, the hospital lost its gynaecology ward in the pandemic and now has patients spread over 12 floors, making it harder to review them and respond to calls.

Gibbs tweeted about a night time sandwich delivery, which was a "lovely gesture by the trust" but not something the juniors experience.

Morale is slipping and staff are exhausted
Julian Hartley



We are simply not paying our junior doctors enough
Rebecca Gibbs

"Indeed, the hospital restaurant does not open out of hours," she adds. "I cannot imagine how demoralising the disparity must have felt to any juniors on the picket line."

Taking over the bleep is absolutely something Gibbs would do again if more strikes were needed. She says, "We are simply not paying our junior doctors enough. This is a mentally and emotionally challenging job requiring round-the-clock working. I genuinely worry that we are reaching a situation where pay in the earliest years of a medical career is so poor that renting in the major cities of the UK will become unaffordable without parental support."

Higher pressures

Robert Fleming, specialist (SAS) anaesthetist at Sherwood Forest Hospitals NHS Foundation Trust, held the first on-call "SHO" anaesthetist bleep and says that things have definitely changed since he was a trainee over a decade ago. "My reflections would be that the level of complexity and the volume of work have both increased," he says. "Being an anaesthetist in training was never easy, but it has got harder."

This anecdotal perspective is backed up by recently published national audit data, adds Fleming, showing that age, body mass index, and comorbidity in a typical patient undergoing anaesthesia have all increased in the past decade.

Junior doctors on the picket line outside University College Hospital, on 13 March

RICHARD H SMITH

"The demand for the expertise of our junior doctor colleagues has increased, and retaining them within the NHS should be a priority," he says. "In any other industry this would be recognised, and it should be no different for these doctors."

One consultant paediatrician from the north of England who asked not to be named told *The BMJ* that work pressures over the past five years have meant that she is used to clerking, cannulating, requesting investigations, chasing results, and writing notes and discharge letters, but she did notice that her more specialist colleagues found some practical aspects of strike cover more challenging.

"The big impact on the service is going to be if this is repeated and we have to keep cancelling outpatient work," she said. "On a personal level, the major impact has been on my ability to keep up with non-clinical work. I'm horribly behind on letters, emails, and service development work."

Jo Mannion, consultant paediatrician and care group director for family health at York and Scarborough Teaching Hospitals NHS Foundation Trust, covered a resident night shift and also worked an evening shift as a paediatrician SHO. Her main take home message was that new doctors are given so many tasks that don't need six years' training at medical school.

The impact on the consultant team was significant, she says, and not everyone pitched in because the trust had refused to pay the BMA's consultant rates for extra-contractual work, £262 an hour. "They paid £150-£188 [an hour], and several consultants felt on principle they shouldn't cover. Most of my consultant colleagues were not happy to have clinics cancelled due to the effect on patients, so they've just moved them into Saturdays or SPA [supporting professional activities] time."

Mannion was still expected to do her management role despite having been up all night. "People kept inviting me to meetings," she says. "I attended one with the camera off and told everyone it's because I wasn't dressed, and there were a few raised eyebrows."

Well planned—but that won't always happen

Last week was always going to run smoothly, notes Louella Vaughan, consultant acute physician at the Royal London Hospital, considering the thought and resources that went into it. She tweeted a photo of the hospital's chief executive Neil Ashman, a nephrologist, "leading from the front" by spending three days doing the TTA ("to take away") discharge summaries and medicines—a time consuming but necessary bit of admin to keep things moving and patients safe.

"It's an incredibly important task because, if it's not done right, everything that you have done while the patient is in hospital has been a waste of time," says Vaughan. Consultants at the hospital were paid £250 an hour for the night shifts, and clinical pharmacists and tech support were on hand to help with prescribing and IT issues. "It was an enormous amount of resource that was mobilised, and they had been planning for quite a long time."

She's seen lots of comment that the strikes showed the need for quick senior decision making near the front door and that they raise the question of whether consultants should also work 24/7.

Yet the evidence doesn't support this, even if it was affordable—which it definitely is not—says Vaughan, who is also a clinical fellow at the Nuffield Trust. "Saying it should be like that all the time is a bit silly, as there is no way that is sustainable," she says.

This time around, the response from her clinical colleagues was "heartening," she concludes, with no doubt that everyone would step up even before pay rates had been agreed. But she wonders whether this will continue in the same way should there be further strikes.

"The question is what happens after this," says Vaughan. "My suspicion is that the goodwill could erode rapidly."

Emma Wilkinson, freelance journalist, Sheffield emmalwilkinson@gmail.com

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Being an anaesthetist in training was never easy, but it has got harder
Robert Fleming

The question is what happens after this
Louella Vaughan

PUBLIC HEALTH

Why health experts are fighting to end daylight saving time

As evidence for the health hazards of twice yearly time switching grows, countries must decide which of two time systems is preferable. **Chris Baraniuk** reports

DWINDLING DAYLIGHT SAVING TIME AROUND THE WORLD

On 30 October 2022, Mexico dropped daylight saving time entirely—most of the country had observed it since 1996. Iran, Jordan, and Syria all gave up on seasonal daylight saving time completely last year, too.

They followed Fiji and Samoa, who moved away from daylight savings in 2021, and Brazil, which did the same in 2019.

Seasonal daylight saving time remains in place in much of North America, Europe, New Zealand, and south eastern Australia although there are numerous campaigns in such regions to end the convention.

Many nations have never observed modern daylight saving time at any point in their history—including Afghanistan, Angola, Indonesia, North Korea, Saudi Arabia, and Venezuela.

There's a showdown brewing in Tennessee. Beth Ann Malow, professor of neurology at Vanderbilt University Medical Center, is one of many health experts campaigning for an end to daylight saving time. She wants her state, and six neighbouring southern states, to secede on this matter together and enshrine permanent standard time into law.

"Once they agree to go to standard time as a region we wouldn't need the federal government to tell us what to do," she explains. Among the neighbouring states she hopes would join such a movement are Alabama, Arkansas, and Mississippi. If all seven states moved together, people travelling around this region wouldn't have to adjust to different times, she adds.

Malow and other health experts argue that permanent standard time increases people's exposure to morning sunlight, which is associated with improved sleep.

A string of studies published in recent years suggests that a twice yearly time shift is bad for us for lots of reasons. The loss of one hour of sleep in spring, in particular, has been linked to an increase in heart attacks, strokes, road accidents, and negative mood.

Modern daylight saving time was first introduced in two Canadian towns in 1908, to allow residents to gain an hour of sunlight in the evening. The idea soon spread around the world, largely through colonial empires. It has, however, since vanished from many of the territories on which it was imposed during the twentieth century.

Although daylight saving remains common in Europe and North America, most countries in Africa, Asia, and Latin America do not observe seasonal clock changes. And some nations have recently ditched the practice (see box)—Russia adopted standard time permanently in 2014. Mexico also took up standard time in 2022. The European parliament, meanwhile, voted to end seasonal clock changes in 2019, but no plan to implement this has yet arrived, so the 27 member states of the European Union continue to observe daylight saving time for now.

If you're going to switch to a permanent time system, you generally have two choices: year round standard time or year round daylight saving time—with health experts tending to favour the former.

Growing evidence

It might not seem plausible that seasonal clock changes can have such a significant impact on public health. "I was sceptical in the beginning," says Christian Cajochen, head of the Centre for Chronobiology at the Psychiatric Hospital of the University of Basel.

But a 2019 US study convinced him. The paper, published in the *Journal of Health Economics*, suggested that people living at the western edge of US time zones experienced more light in the evening and were also more likely to have health problems associated with disruption to their circadian rhythms. These health problems ranged from obesity and diabetes to breast cancer.

Many other studies have also linked health risks to seasonal clock changes. The loss of an hour in spring in the US is associated with a 24% increase in heart attacks in the days following these transitions, according to a 2014 paper (although, importantly, the authors did not claim that daylight saving time was causing an overall increase in heart attacks, merely that it seemed to affect their timing). Similarly, a study in Finland published in 2016 found that strokes were more common during the week following a seasonal clock change, with women and people over 65 worst affected.

The pattern of road traffic accidents in the US is also impacted by daylight savings, a 2020 paper published in *Current Biology* reveals. The authors estimated that the spring change causes a 6% rise in the risk of a fatal road traffic accident and that around 28 fatal accidents could be prevented every year were daylight saving time transitions to be abolished. The team also found evidence of the western edge effect—with traffic accidents more likely the further west one lives in a time zone.

Separately, Cajochen and colleagues have studied how latitude affects sleep patterns. Such research, he explains, makes clear that geography can have an effect on sleep and overall health. It follows that daylight saving time would also have an impact, he reasons, but the phenomenon remains mysterious. "We don't know the exact mechanism," says Cajochen.

Malow notes that light's impact on brain regions including the amygdala could have something to do with it. And light might affect the production of certain hormones in the body in such a way as to alter one's susceptibility to certain diseases.

Remaining questions

There remain questions about what other factors could influence seasonal spikes in health conditions or accidents. Andrey Rzhetsky, professor of medicine and professor of human genetics at the University of Chicago, says that there are diseases that characteristically become more or less prevalent depending on the time of the year. Sometimes researchers have an idea of why that is, but not always, and it could be difficult to establish whether

Almost all research in this area tends to emphasise the health benefits of avoiding seasonal transition

a move away from daylight saving would affect these patterns, if at all.

It's also not easy to study the effects of ditching daylight saving time given that it is impossible to conduct a blind trial—by definition—on exposure to daylight. Few studies have explored the effect on health outcomes when one group of people in a sample observe daylight saving time while another group doesn't, or the consequences when a whole country switches to a permanent time system.

To complicate matters further, some research indicates that there could be benefits to keeping daylight saving time (or making it permanent). A 2014 paper described a sample of 439 children in Europe and Australia who wore accelerometers that tracked their physical activity before and after seasonal clock changes. The researchers behind the experiment found a modest increase in the children's activity once evenings became lighter. Permanent daylight saving time might improve overall public health, the authors suggested.

Almost all research in this area tends to emphasise the health benefits of avoiding seasonal transitions, however. Joan Costa-i-Font, professor of health economics at the London School of Economics, says that he does not have an opinion on whether countries should choose permanent standard time or permanent daylight saving time—but that changing the clocks twice a year is evidently a problem.

He and colleagues published a discussion paper in 2021 (currently being peer reviewed) which suggested that these seasonal transitions have a detrimental effect on people's happiness. The authors based this on household surveys conducted in Germany, which revealed how clock changes impact people's sense of life satisfaction. The team estimated this in financial terms, valuing it as an average loss of €393 (£344) a person each year. Interestingly, the autumn gain of one hour was found to be beneficial—but did not compensate for the loss in happiness caused by changing the clocks in the spring.

"You sum the two, the effect is negative," says Costa-i-Font.

MALCOLM WILLETT

Standard or daylight saving time?

From a scientific perspective, standard time is better for health, according to experts. "At the heart of it is science," says Kathy Sexton-Radek at the American Academy of Sleep Medicine. "Sufficient sleep is one of the three pillars of health, along with nutrition and exercise."

People's annoyance at having to adjust routines, together with the growing evidence of health and social impacts, makes it no surprise that many western governments are now looking to abandon the tradition. It's worth noting that the US did introduce permanent daylight saving time briefly during the 1970s, although it proved unpopular when reports of early morning traffic accidents involving children emerged. (Data later suggested that the increase in morning accidents was modest, and that accidents during the afternoon had actually fallen.)

Today, a debate rages in the US over which of the two alternative permanent time systems to go for. Two US states, Arizona and Hawaii, already observe permanent standard time and, technically, any US state can decide to do so too under current law. In March 2022, however, the US Senate voted through the Sunshine Protection Act, which aims to make daylight saving time permanent across the other 48 states. This federal action, being tied up in the House of Representatives, is not yet law but has been accompanied by a flurry of supportive bills at state level. Tennessee, for one, introduced legislation in 2019 intending to make daylight saving time permanent.

Malow argues that, while things remain fluid, there's still a chance to convince politicians and members of the public across those seven neighbouring states in the south to choose permanent standard time instead. "We just have to get the message out to people," she says.

At the time of the European parliament's vote in 2019, it was expected that national governments would be able to choose whether to go for permanent standard time or permanent daylight saving time. Elsewhere, various motivations have prompted an end to spring and autumn clock adjustments. Mexico opted for permanent standard time citing health reasons, whereas Jordan chose permanent daylight saving time to make "most use of the daytime."

Whatever way you look at it, the clock seems to be ticking down on daylight saving time. In those places where it lingers on, health experts hope their arguments will convince legislators and members of the public to stick up for permanent standard time, protect morning sunlight—and abandon what Malow calls a twice yearly "jolt to the system."

Chris Baraniuk, freelance journalist, Belfast
chrisbaraniuk@gmail.com
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WORK-LIFE BALANCE

Improving flexible working in the NHS

Gareth Iacobucci reports on the problem and the debate on how the health service needs to tackle it

At the Nuffield Trust's 2023 summit this month, The BMJ hosted a roundtable discussion examining the NHS's institutional intolerance towards flexible working. Participants discussed the damaging effect this is having on retention and what the service needs to do to become a truly flexible employer

EMIL HOLBA

THE PANELLISTS

Rachel Hutchings Nuffield Trust fellow, and co-author of *Future Proof*, which explored the impact of caring responsibilities on surgical careers

Farzana Hussain GP in Newham, east London

Thea Stein chief executive of Leeds Community Healthcare Trust, and a Nuffield Trust trustee

Sarah Sweeney interim chief executive of National Voices, a coalition of health and care charities

Where is the NHS going wrong on flexible working?

CULTURE Panellist Rachel Hutchings, a fellow at the Nuffield Trust and co-author of a report on the challenges of combining a career in surgery with parenting, kicked off the discussion. She said that, although surgery had a particular problem with inflexibility, the "negative culture" around working less than full time that she and colleagues documented also exists more generally in the NHS. Perceptions that people who work less than full time are "less dedicated or less committed to their career" often permeate conversations around flexible working, she said.

Employers often fail to provide sufficient information to people about flexible working in terms of what they can request and what they might be entitled to, she added. "People feel that if they ask for something like an amended working pattern during pregnancy, for example, they will be perceived as weak [and] unable to do their job," she said.

"I think that's just really shocking. We shouldn't have a situation where people aren't asking for things that they are entitled to ask for."

Fellow panellist Farzana Hussain, a general practitioner in Newham, east London, identified culture as the key barrier to flexible working. "If people are even afraid to say, 'I need an amendment or a change in my work pattern because I'm pregnant,' and they don't feel safe to say that, that's going to have a direct negative impact on patient care," she said.

ORGANISATION OF TRAINING Hutchings said there were "practical challenges" to flexibility in surgery and in other specialties because of the length of training, with some people concerned that working less than full time would stall their career and cause them to miss out on training.

She said childcare was "an absolutely huge" barrier to flexibility. Respondents to the Nuffield Trust's report, particularly those in training, identified on-call requirements, receiving rotas with insufficient notice to organise childcare, and needing to move around the country for particular placements, again with little notice, as major issues.

We've got to look at all carer responsibilities
Simon Gregory

Speaking from the floor, Simon Gregory, a GP and Health Education England's medical director for primary care, described the challenges facing the "squeezed generation" of doctors, who have dual caring responsibility for their children and their older parents or relatives. "We've got to look at all carer responsibilities," he said.

POOR SUPPORT FOR NON-CARERS On the panel, Thea Stein, chief executive of Leeds Community Healthcare Trust, said that, aside from issues facing parents and carers, "the NHS is a poor employer of people with mental health and physical disabilities. We're a poor employer of people with long term conditions, which is appalling, absolutely appalling."

Gregory agreed, arguing that, although general practice is ahead of other specialties in supporting people who work less than full time, "it's not great for those with health conditions or long term disabilities."

"There are GPs with long covid who are now out of work because the model [of flexibility] that works well for less than full time works less than well for other things," he said. "We've got to improve how we value and support diversity across all characteristics."

What can the NHS do to become more flexible?

PROACTIVE SUPPORT In the Nuffield's report, the top three things that survey respondents thought would improve the experience of people with parental responsibilities were flexible working patterns, more flexible training pathways, and a better culture, Hutchings said. "Greater acceptability [and] encouragement of some of those working options would be really helpful to improve that culture," she said.

"People need to know what their options are. They need to know what they can ask for [and] who to go to for support if they don't get it or they don't feel like they're being supported." Training programmes should support people who want flexibility so they "don't feel penalised by the fact that they might take a bit more time," she added.

For their report, Hutchings said she and colleagues observed positive examples and experiences of people who were surrounded by supportive teams and colleagues. Proactive support to navigate challenges such as organising a job share during surgical training is "really valuable" she added.

The NHS should also focus on implementing programmes to support people returning to work (such as after maternity leave) that are "tailored to individuals and tailored to specialties," Hutchings said.

Addressing the panel, Victoria Tzortziou Brown, vice chair of the Royal College of General Practitioners and research and innovation lead for North East London Integrated Care Board—said the onus shouldn't be on individuals to have the confidence to come forward but on employers to reach out to say they welcome people with disabilities who may require flexible and adjusted working. "It's the culture you create that makes it a positive and welcome choice," she said.

LESSONS FROM PRIMARY CARE Primary care offers more flexibility than other specialties, suggested Hussain, citing her practice's decision to facilitate GPs who want to work evening or weekend sessions to fit around childcare responsibilities. "As an employer I had a salaried GP who needed to be back home at 5.30 pm to pick up her little one from nursery. Generally our surgeries finish at 6.30, but I was able to make that change for her, and she actually said, 'I would have left you if I couldn't have had that and I wouldn't be working.'

"There are a lot of small changes that can be made, but I'd like to see more at scale as well."

Increasing flexibility has helped Health Education England increase GP training numbers in England, Gregory said, because this was what younger doctors said they wanted. But he said there has been some resistance. "We had a backlash from older members of the profession, saying, 'You're failing because you're not producing enough full time GPs.'

"But what we hear from the younger ones is, 'If you don't offer that, we'll walk.' So what's better, a valued colleague who is working the time they want to and can work, or nobody?"

It's the culture you create that makes it a positive and welcome choice
Victoria Tzortziou Brown

ROLE MODELS Hussain stressed the importance of role models for doctors who want a career alongside their caring commitments.

Stein also picked up on this point, highlighting that a senior director in her trust is a job share between two women who both have young children. "Role models are incredibly important, and it's also very important in the way you recruit," she said. "Go out, very obviously and upfront [and say], 'We welcome flexible working—that's what we want and that's what we will encourage.'"

EMBRACE THE CHALLENGE The NHS should see flexibility as beneficial for the workforce rather than something that's challenging, Stein said. "We can't afford not to do this for the clear reason that we won't have a workforce if we don't do it, but I also think we should look at it as a really exciting opportunity.

"People are offering us a new way of inventing work. We did that during covid... we're doing it now with a generation who are demanding a better work-life balance," she said. "We should see this as an exciting time, embrace the complexity, and try to work it out."

Stein's trust encourages staff to have what it calls "itchy feet" conversations. "If you're thinking about leaving us, we say, 'Come and have a conversation with us first,'" she explained. The trust then explores with employees how they could put a flexible working package together, Stein said, which in turn "is what makes people stay with us."

"We do as much as we can to break the mythology that it is impossible to run a shift system if you allow people to be flexible," she said. "It's not. It's really hard, but it's not impossible. You have to be very open, to work collaboratively, and to have a culture."

Any unintended consequences need to be considered
Martin Marshall

BETTER PLANNING Speaking from the floor, Kiran Patel, chief medical officer and deputy chief executive of University Hospitals Coventry and Warwickshire, urged the NHS to embrace "the fact that we need to plan better."

"Too often we get into impulsive planning rather than saying, 'I've got 12 500 staff and I've got to deliver a million outpatient appointments, but I can plan that and slot people into what they want to do,'" he said.

Patel said integrated care systems potentially offer the chance for people to work across sectors, if organisations are willing. He also talked about the need to be more compassionate and "fleet of foot" when building an agile workforce, citing his trust's international graduates who have been able to take sabbaticals to return to their home countries "to recharge and avoid burnout."

Stein said some employers had a "tremendous fear" that allowing flexibility will open the floodgates to a wave of requests for extended periods of leave, but she takes a different view. "I say, if we set the precedent of compassion, of kindness, of individualistic care, we will be fine," she said.

THINK ABOUT PATIENTS Martin Marshall, Nuffield Trust chair and former chair of the RCGP, asked the panellists whether there were "unintended consequences" to working less than full time that needed to be considered, such as patients' trust and the perception that their doctor is always there for them.

Panellist Sarah Sweeney, interim chief executive of National Voices, a coalition of health and care charities, said surveys from her organisation show that the public is aware of the pressures on the NHS and of societal shifts towards inclusive employment practices.

The key for healthcare providers, Sweeney said, was "treating people as adults, being clear about what is possible and what's not possible." She gave the example of a general practice that offers patients the opportunity either to see any clinician on the day or to wait to see the person that they'd like at a time when that clinician is available.

Improving flexibility for the workforce is "absolutely linked to patient safety," Hussain concluded. "A flexible workforce or no workforce is where we are at the moment."

Gareth Iacobucci, assistant news editor, *The BMJ*
giacobucci@bmj.com
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MEDICINE AND THE MEDIA

Semaglutide: should the media slim down its enthusiasm?

When the drug gained NICE approval for weight loss last week, the press response was largely positive. **Margaret McCartney** reports

The BBC's *Science Focus* magazine read, "Hollywood's favourite skinny jab is coming to the NHS," calling it a "weight loss game changer." The *Times* said it "could trim benefits bill." The *Economist*'s cover story said the excitement was justified: "Eat, inject, repeat—curing obesity, worldwide."

NICE's approval last week of the Novo Nordisk drug semaglutide (Wegovy) for weight loss led to a slew of positive headlines. Already available on the NHS for the treatment of type 2 diabetes, semaglutide is now recommended for weight loss alone in England and Wales (as a different brand and dose). A glucagon-like peptide-1 (GLP-1) that reduces appetite, semaglutide is for prescription by specialist NHS weight management services for people at high risk of complications of obesity.

The news lands in a febrile social media landscape. On Twitter, Elon Musk confirmed that he uses Wegovy, while other celebrities have issued denials that they don't. TikTok has exploded with brand name hashtags by those using and prescribing it.

So what to make of the coverage of a drug that is reasonably well studied but also known to come with significant side effects?

Silver bullet?

The STEP-5 trial showed that, over two years, patients (mainly white and female) on semaglutide lost an average of 15.2% of their body weight, compared with 2.6% in the placebo group. In the *Times*, Steve Barclay, England's health secretary, was keen to use GLP-1 drugs as "a way of preventing illness without resorting to 'nanny state' measures," having set up a £20m fund to research further obesity treatments. The *Economist* said that "these new drugs mean that the world's fight against flab may eventually be won."

There was very little coverage on the causes of obesity

Pharmacological interventions that turn the heads of politicians towards supporting industry rather than public health deserve interrogation. The *Economist* acknowledged that "states should keep pressing other anti-obesity measures, such as exercise, healthy eating, and better food labelling." And added that processed food and sedentary lifestyles are the main elements of today's obesogenic environment. But there was very little coverage in the media overall on the causes of obesity and how much of a difference semaglutide could make to large populations.

In England, 25% of adults are obese and 28% overweight. A strategy relying on jabs would mean a lot of people injecting themselves, potentially for life. And given that NICE is recommending a maximum of two years of treatment, it is uncertain what will happen after that.

The media gave a light touch to what happens after people stop the injections: weight gain, along with a reversal of other gains made in hypertension or hyperglycemia. This means that after a two year NHS prescription of semaglutide, many people taken off it would swiftly gain weight, unless they could afford to source it privately. Given the social gradient related to obesity, it might be that people most likely to benefit from the drug would not be able to afford it. Then there are the side effects, mentioned in several news stories—gastric problems, such as nausea, diarrhoea, vomiting, and constipation.

The Science Media Centre gathered reaction quotes and disseminated them to journalists. Experts that were quoted often had potential conflicts of interest. The centre asks commentators for their declarations of interest; Nick Finer, for example, medical consultant in obesity and endocrinology, declared he was an employee of Novo Nordisk until July 2022. But these declarations were often not reported alongside the media quotes. The *Observer* investigated some of the conflicts of individuals and organisations that were quoted in the avalanche of publicity. But readers were not made aware of such interests when one of the named individuals wrote a column in the *Observer*'s sister paper the *Guardian* about semaglutide just a few weeks before.

Jason Halford, head of Leeds University's school of psychology, is president of the European Association for the Study of Obesity, which was paid more than £3.4m by Novo Nordisk between 2019 and 2021. The *Guardian* has since added a footnote to include these details. Halford has undertaken research, talks, and consultancy funded by Novo Nordisk, with payments made to his university. Halford appeared on BBC Radio 4's *Today* programme on 8 March to call for greater access to semaglutide, beyond specialist clinics. No mention was made of his interests.

Hesitancy not hyperbole

There are other, more subtle problems with the coverage. Charities representing people with eating disorders have raised concerns about the increasing availability of these drugs outside the NHS, with many private clinics offering email only services. Hadley Freeman wrote in the *Times* about how, when she had anorexia, she would skip meals and how "it's scary there is a jab that lets you do the same."

The *Times* quoted government officials that these drugs will get "millions of people with joint problems and other illnesses caused by obesity back to work." We don't know that: the STEP-5 trial included questionnaires on quality of life, but isolated questions about paid work were not included.

An evidence based, reflective media response should be cautious around claims and report conflicts of interest and uncertainties.

Margaret McCartney, GP, Glasgow
mgtmmccartney@gmail.com
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