inside

medicine

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"Measles death must be turning point"

EXCLUSIVE The death of a child in Liverpool after contracting measles is a "tragedy" that shows society is failing to protect children, the president of the Royal College of Paediatrics and Child Health (RCPCH) has told *The BMJ*.

Steve Turner said such a fatality "has to be a never event" and that the health community must redouble its efforts to ensure that all eligible children receive both doses of the measles, mumps, and rubella (MMR) vaccine.

He said, "This tragic event is the tip of the iceberg, because for this one child to have died meant many others had had measles and many others hadn't had the vaccine."

Turner, who became RCPCH president in March last year, was speaking after the *Times* reported that a child in the intensive care unit at Liverpool's Alder Hey Children's Hospital had died while severely ill with measles, as well as other serious health problems.

After the reports Alder Hey issued a statement saying that, while it could not comment on individual cases, it was concerned about an "increasing number of children and young people who are contracting measles." Since June it had treated 17 children for the effects and complications of the disease, it said.

UK Health Security Agency data show that from 1 January to 23 June England recorded 529 laboratory confirmed cases of measles, 12% of which occurred in the north west. In 2024 there were 2911 confirmed cases, the highest number since 2012.

In 2023-24 coverage of both doses of the MMR vaccine at age 5 in England fell to 84%, the lowest since 2009-10. In Liverpool the uptake of both doses of MMR vaccine is only around 73%, far below WHO's recommended 95% to achieve herd immunity.

Turner said the MMR vaccine had made a "profound difference" in reducing the spread of the disease. "The simple message that vaccinations save lives is as important now as it was 20, 30, 40 years ago. So, it saddens me to hear about this case, not just for the family but also because of what we're failing to do as a society to protect children. Hopefully, this tragic case will be seen as a turning point."

In an open letter from Alder Hey, the UKHSA, and the public health directors for Liverpool, Sefton, and Knowsley, parents were urged to vaccinate their children.

As cases rise, some nurseries have brought back infection control measures similar to those used in the covid pandemic to try to protect children, the *Guardian* reported.

Gareth Iacobucci, *The BMJ*

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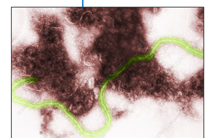
Steve Turner, RCPCH president, said the death in Liverpool was a result of society failing to protect children sufficiently

LATEST ONLINE

- Doctor and her husband jailed for selling stolen NHS PPE online
- FDA approves marketing of formerly banned Juul vapes, saying they help smokers
- RSV: single injection of monoclonal antibody to be offered to premature babies



MEDICAL NEWS

NHS strike plans risk patient safety, BMA warns

NHS England's plans for the latest resident doctor strikes will put patient safety at risk, the BMA has warned. In previous strike action the NHS agreed that non-urgent procedures would be postponed to allow consultants to provide cover in emergency and urgent care.

But for the five day action that was due to begin on Friday 25 July, after *The BMJ* went to press, NHS England's chief executive, Jim Mackey, told hospitals not to cancel elective non-urgent care.

After a meeting with NHS England on Monday 21 July, BMA council chair Tom Dolphin and deputy chair Emma Runswick wrote to Mackey warning that this approach was putting patients at risk. Their letter said, "It is vital hospital care must adapt on strike days to the levels of staff available. Your decision to instruct hospitals to run non-urgent planned care stretches safe staffing far too thinly and risks not only patient safety in urgent and emergency situations but in planned care too."

Meghana Pandit, NHS England's co-national medical director for secondary care, said, "The safest thing for patients is for the NHS to maintain as much urgent and planned care as possible during strikes, and we would encourage the BMA to work with us constructively to achieve this in the event industrial action goes ahead."

Gareth Iacobucci, *The BMJ* **Cite this as: *BMJ* 2025;390:r1542**

Training

Trainees "uncomfortable" about raising concerns

More than a quarter of medical trainees in some specialties reported feeling apprehensive or hesitant about escalating a patient to the supervising clinician, showed this year's General Medical Council national training survey, completed by more than 50 000 doctors in training and 21 000 trainers. A fifth (21%) of doctors in training reported feeling uncomfortable at raising concerns with their senior colleagues. The figure was even higher among trainees in certain specialties: 26% of trainees in emergency medicine, 27% in obstetrics and gynaecology, and 29% in surgery.

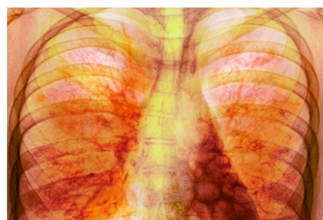
David Fuller inquiry

"Appalling" sex abuse could happen again, report warns

The "appalling" sexual abuse of dead bodies in NHS hospital mortuaries by a necrophiliac killer could happen again unless the sector is regulated by law, an independent inquiry concluded. David Fuller abused at least 100 bodies of women and girls over a 15 year period. He worked as an electrical maintenance supervisor for Maidstone and Tunbridge Wells NHS Trust, with a swipe card that allowed him to access all areas in Kent and Sussex Hospital and Tunbridge Wells Hospital. The inquiry chair, Jonathan Michael, said that arrangements to protect the security and dignity of dead people were inadequate.

Cystic fibrosis

New home treatment is fast tracked to patients



A once daily triple drug treatment for cystic fibrosis is set to be "immediately funded" by NHS England after a recommendation by NICE. Vanzacaftor-tezacaftor-deutivacaftor, marketed as Alyftrek and made by Vertex, works by combining three active components that target the transmembrane conductance regulator (CFTR) protein that is faulty in cystic fibrosis. The at-home treatment will be available for people aged 6 years and over who have at least one F508del mutation in the *CFTR* gene, meaning that around 89% (9790) of 11 000 English patients with the condition are eligible for it.

Mortality

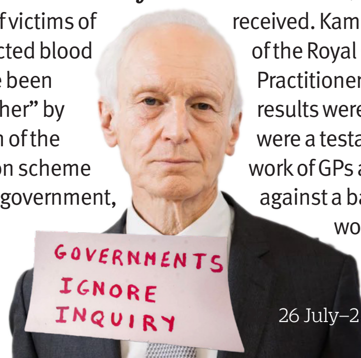
Death rate in England and Wales hits historical low

A report from the Continuous Mortality Investigation (CMI) found that overall mortality in England and Wales in the first half of 2025 was lower than in the first half of any other year recorded. Around 2300 deaths involving covid-19 were registered in the first half of 2025, down from around 5300 in the first half of 2024 and from 11 700 in the first half of 2023. The CMI's Cobus Daneel said, "For most age groups the last 24 months have seen stable low levels of mortality. A notable exception to this is males aged 45-64, whose mortality remains above pre-pandemic levels."

Infected blood scandal

Victims "harmed further" by compensation delays

Thousands of victims of the UK's infected blood scandal have been "harmed further" by the operation of the compensation scheme set up by the government, concluded the former High Court judge who chaired the public inquiry. Brian Langstaff (below), who delivered his main report in May 2024, issued an additional report after being inundated with complaints about delays and difficulties in getting payments from the Infected Blood Compensation Authority. His 2024 inquiry report concluded that the NHS and successive governments had hidden the truth for decades and had left people without justice.



General practice

Patient satisfaction results improve in England

The latest GP patient survey in England showed that 75% of respondents had a good overall experience of their general practice, up from 74% in 2024. And 70% of those surveyed had a good overall experience of contacting their practice on the last occasion, up from 67% in 2024. Some 2.7 million surveys were sent out and 702 000 responses received. Kamila Hawthorne, chair of the Royal College of General Practitioners, said that the results were encouraging and were a testament to the hard work of GPs and their teams against a backdrop of intense workload and workforce pressures.

IN BRIEF

Patient safety

Drug company breached industry code

Jazz Pharmaceuticals was found to have breached the Association of the British Pharmaceutical Industry's code of practice by failing to include important information relating to the concomitant use of Epidiolex (cannabidiol) and valproate in online, educational, and promotional presentations. The omitted information concerned the risks related to hepatic impairment. The panel said patient safety was of the utmost importance and that health professionals should be able to rely on materials produced by companies being complete and unambiguous in this regard.

Epidiolex information breached code by not mentioning risk of hepatic impairment if taken with valproate

Electronic discharge summary "fails patients"

A report from the Health Services Safety Investigations Body found that patients were being harmed by the way critical information was electronically communicated on discharge from hospital. Vital information about diagnoses, medicines, and follow-up care was often delayed, incomplete, or omitted in the discharge summary, leading to incidents of patient harm. The report highlighted how gaps in coordination between hospitals, GPs, pharmacies, and community care providers were contributing to unsafe transitions.

PFI contracts

Spending watchdog issues warning over build quality

The Public Accounts Committee warned that badly managed private finance initiative contracts could result in poor quality assets, including hospitals, being handed back to the public sector. Its report said that 665 PFI contracts were ongoing and that half were set to expire in the next decade. Public bodies are set to pay £136bn in charges until 2052-53, and the committee warned that careful management was needed to ensure that private sector firms complied with their contractual obligations and that "only quality assets are handed back."

Vaping

Vapes are "underused" in quitting smoking

The estimated proportion of people in Great Britain who vape has stalled in the past year at 10% among adults and 7% in 11-17 year olds, showed data from Action on Smoking and Health. The charity said this indicated a lack of progress in reducing vaping among children, as well as its potential underuse for smoking cessation. Public confusion about the risks of vaping is growing: 56% of adults and 63% of young people now wrongly believe vaping is at least as harmful as smoking.

Trump administration

Medical associations sue over vaccine policy changes

Leading US medical associations opened two lawsuits against the Trump administration to try to stem health policy politicisation. In one lawsuit the American Academy of Paediatrics and five national associations backed the suit of an unnamed plaintiff working in a Massachusetts hospital, who was denied a covid-19 vaccine after a new recommendation that pregnant women and children should not receive one.

Cite this as: *BMJ* 2025;390:r1509

UTIs

Hospital admissions related to urinary tract infection in England totalled 189 756 in 2023-24, up **9%** on the previous year. However, admissions were still lower than in the three years before the pandemic

[UK Health Security Agency]

SIXTY SECONDS ON . . . ALCOHOL AT FOOTBALL

IS IT ALL KICKING OFF?

That's been the concern—which is why, for the past four decades, the UK has prohibited football fans from drinking in the stands. But in Scotland, at least, the ban is being lifted as part of a pilot scheme.

SHOW PROHIBITION THE RED CARD

A handful of Scottish football clubs, including Arbroath, Ayr United, and Queen of the South, have been permitted to allow a select few home fans to raise their glasses as well as their scarves in designated areas at League Cup fixtures.

WHAT'S THE PITCH?

The Scottish Professional Football League says it hopes the pilot will improve the "match day experience" for fans. Some people think it unfair that football supporters are treated differently from those at other events such as rugby or cricket, who are permitted to drink alcohol.

REFEREE!

The UK has had strict rules on drinking in football stadiums since the 1980s, when bans were introduced in response to hooliganism and civil disorder. Since then, fans have been able to gulp their pints only before the match or at half time, away from the view of the pitch.

AREN'T WE TRYING TO CUT DRINKING?

The charity Alcohol Focus Scotland has made this point, warning that, with Scotland's high rate of alcohol related deaths, the policy is an "own goal" that could result in rising consumption, reduced fan safety, and increased public disorder.

EXTRA TIME AND PENALTIES?

Others have argued that allowing supporters to take their drinks to their seat would be preferable to them binge drinking at half time. But it's not clear whether this would have an overall, net positive, impact.

IS THE POLICY A KEEPER?

We'll have to wait and see. Scotland's first minister, John Swinney, has said he's "not sympathetic" to lifting the ban. In the wake of the pilot scheme Maree Todd, minister for drug and alcohol policy and sport, said the government's position hadn't changed, adding that it was up to local licensing authorities and the police to be satisfied the pilots were permissible "within the current legislative framework."

Gareth Iacobucci, *The BMJ*

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TOM DOLPHIN: **There is potential for many thousands of unemployed doctors**

As the NHS faces one of the most turbulent periods in its history, the BMA has elected a new chair. **Rebecca Coombes** spoke to him about his priorities and his vision to empower grassroot members

Tom Dolphin, consultant anaesthetist and trade union stalwart, steps into the role of BMA council chair at a moment of industrial unrest, deep uncertainty about medical roles and training, and a government promising reform but facing huge financial challenges.

Dolphin, aged 46, is seen to represent generational change at the BMA. He now leads an organisation reshaped by the rise of the grassroots Doctors Vote organisation and younger activists galvanised by declining pay and working conditions.

"I don't think there's going to be a huge change in direction," he says, but he points to a need to bring the union "closer to the local membership."

Too centralised for too long, he says, the BMA must do more to train and support grassroots representatives. "We're just not particularly facilitating the work of local negotiating committees and regional reps. We need to empower them—so they know their rights, how to run a campaign effectively, how to find allies."

Why is Wes Streeting talking about valuing doctors and not actually valuing them in any way that counts?

Hotbed of radicalism?

With more Doctors Vote members being elected as representatives, the BMA has been criticised in the press for being too radical. Dolphin calls this "overblown." He says, "There's certainly a shift towards a much younger feel to council, reflecting how at the most recent elections a large number of resident doctors were very angry and motivated.

"The trade union side of the BMA had diminished in effectiveness. All that we've done really is rebalance that."

Dolphin was speaking after the BMA's Resident Doctors Committee had voted for six months of strike action in demand for a 26% pay rise. Less than 50% of eligible doctors voted in favour of strikes, and public support for the resident doctors' strike has halved, polling has shown. Are the BMA and its members at risk of losing the argument?

"I think the public understands our pay has dropped," he says. "If anybody had a pay cut of 30% in value, they'd want to do something about it."

Low vote turnout should be taken in the context of the record turnout for industrial action in 2023, Dolphin explains. "This is more of a reversion to the mean than a sign the campaign is not succeeding. I'm not too worried."

Last year's strikes secured a deal worth 22.3% more on average over two years, but restoration of real terms pay has stalled. "The journey has come to a halt," he says. "We've given [health secretary Wes Streeting] plenty of opportunities to negotiate. He didn't take them. That's why resident doctors have voted to strike again." A strike was due this week, as *The BMJ* went to press.

As council chair, Dolphin is not directly involved in pay negotiations, but it is clear that the BMA remains open to a deal. Frustration is mounting over the government's lack of progress on the non-pay elements of last year's settlement.

"Why is [Streeting] talking about valuing doctors and not actually valuing them in any way that counts? They talk about non-pay elements: exception reporting, the way rotas are constructed. That work just hasn't materialised. It's been months and months of difficult discussions that don't progress."

Dolphin praises the BMA's outgoing council chair, Phil Banfield, for transforming the association and pushing forward the pay campaign. But he has his own agenda: "There's lots of other work I want to do around the value of the profession—not just pay, but the deprofessionalisation we've seen." He is no stranger to politics, playing an active role in the Labour Party, and was disappointed not to have been selected as a candidate to fight last year's general election.

Physician associates: misleading patients

A flashpoint is the BMA's legal challenge to the GMC over physician associates (PAs) and anaesthesia associates (AAs). "They are being used to replace doctors," Dolphin says. "And patients don't always realise they're not seeing a doctor. They are being misled.

"The GMC has facilitated this and hasn't taken responsibility for who should set the scope of practice and what their name should be.

"Breaking down medicine into individual tasks and handing them out like an assembly line: that doesn't work. The benefit of having that in one person—the doctor—is immense. But we don't value that any more."

He welcomes the Leng review (p 62, 64, 83, 86) and says a name change for PAs (from "associate" to

LAST YEAR'S strikes secured a deal worth **22.3%** more on average over two years, but restoration of real terms pay has stalled

"assistant") would help clarify their role. "But there also needs to be a national scope of practice, perhaps by the royal colleges, not local employers," he adds. "Otherwise, you end up with people doing work they're not trained or safe to do.

"The risk is that employers say we're a bit short of, for example, urology trainees, let's put PAs on the rota and they can do things that urologists can do. Evidently, that's not safe.

"If we don't get it right, we'll end up with two tier care. People in well-off areas get to see a doctor, those in less well-off areas can see a PA."

Medical training

The government's newly published 10 year NHS plan, with its announcement of 1000 new specialty training posts, is not enough to fix medical training, Dolphin thinks.

"The 1000 training posts are nowhere near enough to deal with the problem. There is the potential for many, many thousands of doctors to find themselves either underemployed or unemployed or certainly out of training in a very short time.

"And that's going to create a huge problem for the government, because they're going to have a large number of resident doctors who are not progressing in their training."

He says that large groups of resident doctors, "when they're angry, can be a very powerful force that can be a real problem for the government. So they need to get a grip."

IMGs versus UK graduates

The BMA has successfully campaigned for UK graduates to take priority over international medical graduates for training places. "The problem here is not IMGs versus UK grads—it's that the workforce system has been allowed to set everybody up so that they're competing for an inadequate number of training places"

Dolphin is also concerned about the rise of "non-training training programmes" for locally employed doctors, often IMGs, where "local hospitals band together to set up rotations in effect for LEDs. They look like training programmes, but they're not funded by the government."

Polarised views

On the issue of antisemitism, which surfaced at the BMA's annual representative meeting, Dolphin says, "Antisemitism has no place in the BMA and we don't tolerate it."

He adds, "Where allegations are made, we investigate, and we take disciplinary action as needed. As a profession, we have more in common than divides us. Part of the role of the chair of council—when those debates get difficult, when people have strongly polarised views—is to try to get people to hear each other."

Dolphin has also spoken out in support of trans rights and against the government's handling of Hilary Cass's review of gender services for children and young people. He has said that the BMA's refusal to endorse Cass's findings was "one of many steps" needed, a view that has alienated some of the membership.

The BMA is currently carrying out its own evaluation of the evidence—an exercise Dolphin is "staying very clear of"—the outcome of which will be out soon. For his part, Dolphin says the government was wrong to ban puberty blockers and to criminalise people importing the drugs. "It went beyond what Cass had recommended," he says. Cass's recommendations included confining prescription of puberty blockers and hormonal treatments to research settings, but trials are yet to start enrolling.

"Trans people are among the most marginalised in our society. They just want to live their lives. What's happening to them is dehumanising," he says.

As the BMA enters a new chapter, Dolphin must balance the anger and ambition of a younger, more activist membership with the need to win public trust and influence the government.

"Success for me is the union being as strong in the workplace as it is nationally in terms of achieving wins for its members. Doctors want to go to work and look after patients and not have to worry about all the other things that we've been talking about," he says.

Rebecca Coombes, *The BMJ*

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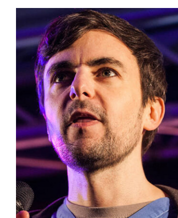

Resident doctors, when they're angry, can be a very powerful force that can be a real problem for the government. They need to get a grip

To listen to the full interview visit bmj.com

GUY BELL/ALAMY

Recommendations are attempt to "reset the hostility," says Leng

The roles of physician associate (PA) and anaesthesia associate (AA) should not be abolished but be renamed "physician assistants" and "physician assistants in anaesthesia," Gillian Leng's independent review has recommended.

Leng acknowledged her "pragmatic" solution "won't be universally popular." She said she found "no convincing reasons" to abolish the roles but that changes were needed to embed them into the NHS workforce effectively.

Leng's 18 recommendations, based on the "best available evidence," aim to represent a "pragmatic, sensible way forward that will provide clarity and enable effective change" (see box, below right). Her report must be an opportunity "to reset the hostility" in the debate and stimulate effective collaboration for the future, she said.

As much evidence as possible

Leng said in her report that she had gathered as much evidence as possible on the safety and effectiveness of PAs and AAs. This included a systematic review of research, an analysis of NHS trust "never events" by professional groups, and references in NHS GIRFT (Getting it Right First Time) reviews. The Care Quality Commission also analysed mentions of PAs or AAs in coroners' reports, such as regulation 28 reports (to prevent future deaths), whistleblower files, and the Learn from Patient Safety Events system. The review also surveyed 8558 frontline staff (PAs, AAs, and healthcare professionals who work with them) and carried out patient focus groups and visits to hospital trusts and general practices.

THIS WILL PROVIDE CLARITY AND ENABLE EFFECTIVE CHANGE
Gillian Leng

Leng concluded that research on the safety and effectiveness of PAs and AAs was limited, generally of low quality, and either inconclusive or giving a mixed picture. She said that "significant gaps in our knowledge remain" but that, given the urgency of current workforce challenges, now was not the time to defer to the wisdom of future research. The review recommended that safety systems should routinely collect information on staff groups to facilitate monitoring and interrogation at a national level, against agreed patient safety standards.

A key concern expressed by doctors was the time needed to supervise PAs and AAs, the absence of training to do this well, and a lack of understanding about how supervision should work in practice. Doctors also said that potential safety incidents were regularly picked up and prevented by supervising doctors.

The review recommended that doctors should receive training in line management and leadership and be allocated extra time to ensure that they can fulfil their supervisory roles.

Jacqui Wise, Kent Cite this as: *BMJ* 2025;390:r1482

NEWS ANALYSIS

PHYSICIAN ASSOCIATES Doctors' leaders warn that Leng review fails to protect patients fully

Gillian Leng has acknowledged that her "pragmatic" solution to the PA matter "won't be universally popular." **Jacqui Wise** summarises the reactions

The BMA has criticised Gillian Leng for not recommending a nationally defined scope of practice for physician associates (PAs) and anaesthesia associates (AAs) and has warned that her review does not go far enough to protect patients adequately.

Leng's review, published on 16 July, makes several recommendations for clarifying the safety and scope of the roles of AAs and PAs (box), including that PAs be renamed physician assistants to avoid confusing patients and that they should not see undifferentiated patients except within clearly defined national clinical protocols.

The government has accepted all the review's recommendations.

The health and social care secretary, Wes Streeting, commissioned Leng, president of the Royal Society of Medicine and former chief executive of the National Institute for Health and Care Excellence, to head the rapid review following growing anger among the medical profession about the way PAs were being deployed and regulated.

In her report, Leng said she carefully considered a set scope of practice for AAs and PAs. But given feedback she thought this would be unworkable and unenforceable and was not a feature of other professional health roles. She added that there was now added clarity regarding training of AAs and PAs following the approval process put in place by the GMC.

Instead of a national scope of practice, Leng said there should be defined national initial job descriptions for PAs in primary and secondary care and for AAs when they first qualify. This would be coupled with opportunities for further training through a national credentialling programme.

Tom Dolphin, chair of the BMA council, said, "Despite the alarming way these roles were introduced and expanded unsafely, there are significant gaps in the report where strong patient safety recommendations should have appeared. Most worryingly, a major opportunity has been missed to end the postcode lottery of what PAs can and can't do.

An opportunity has been missed to end the lottery of what PAs can and can't do
Tom Dolphin

"By failing to recommend authoritative, nationally agreed scopes of practice, Professor Leng has ignored the most urgent demand of the medical profession and left patients at the mercy of local decisions by employers who can still choose where and how assistants can work. This is deeply disappointing, and we call again on NHS England to act now and adopt the BMA's safe scope of practice guidance as an interim measure until this can be properly addressed."

Training concerns

The Doctors Association UK (DAUK) also criticised the Leng review for insufficient safety safeguards and unclear scope boundaries.

Matt Kneale, its chair, said, "While Professor Leng's report contains some welcome proposals, we are alarmed

We are alarmed by the endorsement of role extensions that lack necessary protections
Matt Kneale

We welcome a strong focus on national consistency, patient safety, and clarity of role and scope
Hilary Williams

by its endorsement of role extensions that lack the necessary protections."

DAUK is concerned that the review suggests ongoing modular training for PAs—potentially including prescribing rights and ordering non-ionising radiation. It argues that critical skills in pharmacology and radiology cannot be adequately covered by short credentialling modules, given the stark difference in baseline training in comparison with medical doctors.

DAUK warned that unclear scope boundaries without explicit limits risks PAs undertaking advanced interventions such as sedation for invasive procedures, without the underpinning medical training traditionally required.

"We support innovation that enhances patient care," Kneale said, "but these recommendations, as they stand, place workforce convenience above the need for safety."

The BMA welcomed Leng's recommendation that assistants shouldn't be the first to see patients in GP surgeries or in emergency care, but it said the report contradicted itself by saying that PAs can act as a first point of contact in primary care for minor and common conditions. "It is not clear how these two recommendations can coexist, and this must be clarified," said Dolphin. "Minor complaints are only minor in retrospect, and serious conditions can present in subtle or unusual ways."

The Royal College of Physicians (RCP) welcomed the recommendation of a change in job title from associate to assistant—something that it and the BMA have long called for. Hilary Williams, the RCP's incoming clinical vice president, said, "This is a thoughtful, detailed, and thorough review of a complex matter, and we want to thank Professor Leng and her team for their hard work and balanced approach. This report is clear that reform is needed to ensure safe multiprofessional teamworking in the NHS, and we welcome a strong focus on national consistency, patient safety, collaboration, and clarity of role and scope."

Doctors protest outside the Houses of Parliament against use of PAs in February 2024

The United Medical Associate Professionals, a body representing PAs, broadly welcomed Leng's review but warned that some recommendations could limit patients' access to care. The union's general secretary, Stephen Nash, said, "We object to the recommendation that PAs only treat 'differentiated patients'—those who have already received a diagnosis. We believe this will compound the backlog of appointments with GPs and consultants and entirely negates the benefit of having such highly trained medical professionals available on wards and in local surgeries."

Speaking on BBC Radio 4's *Today* programme, Leng disagreed with Nash. "There is an appropriate role that PAs should play. But we must maintain safety and ensure that PAs are not doing more than they are trained for."

Leng pointed out that the BMA said her report had not gone far enough and that Nash said it had gone too far. "That probably means it is balanced and I got it right," she said.

"The recommendations are clear about providing an important role for PAs. It gives them a career path, gives them opportunities to develop, but it is also clear that they shouldn't be doing the same as a doctor, that they don't have the same level of training."

"Much needed clarity"

Charlie Massey, chief executive of the GMC, said, "The review brings much needed clarity and offers a timely opportunity for a reset across healthcare. The findings of the review will be pivotal to how we work with others and continue to improve our regulatory practices. We look forward to working on the aspects of the report that relate to the GMC and with others where there is a shared responsibility to deliver change."

Streeting said, "Legitimate concerns about patient safety have been ignored for too long. We're accepting all the recommendations of the Leng review, which will provide clarity for the public and make sure we've got the right staff, in the right place, doing the right thing. Patients can be confident that those who treat them are qualified to do so.

"Physician assistants, as they will now be known, will continue to play an important role in the NHS. They should assist doctors, but they should never be used to replace doctors."

COMMENT, pages 86-87

Jacqui Wise, Kent

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LENG'S KEY RECOMMENDATIONS

- PAs should not see undifferentiated patients except within clearly defined national clinical protocols
- Newly qualified PAs should gain at least two years' experience in secondary care before taking a role in primary care or a mental health trust
- A named doctor should take overall responsibility for each PA as their formal line manager
- Standardised measures, including clothing, lanyards, badges, and staff information, should be used to distinguish PAs from doctors
- PAs should have the opportunity for ongoing training and development within a formal certification and credentialling programme
- A permanent faculty should be established for AAs and PAs to provide provisional leadership, with standards for training set by relevant medical royal colleges
- GMC requirements for regulation and reaccreditation of AAs and PAs in *Good Medical Practice* should be set out separately from those for doctors

Gillian Leng led NICE for 20 years and is now president of the Royal Society of Medicine. Her landmark review into physician and anaesthesia associates proposes a new direction for their integration in the NHS. Here, she speaks to **Kamran Abbasi,** BMJ editor in chief, about what the evidence showed, how she approached the task, and what must happen next

GILLIAN LENG: **There wasn't enough evidence to recommend halting recruitment**

Patients were very keen that the word assistant was used—they felt "associate" sounded like a grand title

KA: How did you go about the review and what did you find?

GL: "I wanted it to be based on the best available evidence. I wanted us to be comprehensive in looking at that evidence base, informed as much as it could be by engagement with all the relevant groups: the physician associates and anaesthesia associates themselves, the doctors, patients and their families, and managers, so very, very comprehensive. I think that's the most important thing to emphasise."

What did the published evidence you examined show?

"It was sadly not as helpful as it might have been. It didn't provide a definitive answer. It was limited in terms of the quality—and in terms of most quality classifications that were used it was either low or very low quality. It was limited in terms of the scope that it covered and generally inconsistent.

"For instance, in the evidence base in secondary care there was nothing for anaesthesia associates. In terms of physician associates, what there was was limited to the emergency department. So it wasn't possible to say the evidence says this, so we're going to do this. It had to be triangulated with professional opinion, patient feedback, and workforce requirements."

What could you conclude?

"There was nothing in the evidence base that said these two professions are so unsafe that we have to completely abandon them. But equally there was nothing that said we can be 100% confident these roles are safe.

"What that did mean was that we needed to particularly clarify how the roles were going to work moving forwards, because there was all sorts of feedback, confusion, and concern from patients, professional groups, and managers."

How about safety data?

"We got some data from the Care Quality Commission—helpful but again limited—and audit data from the anaesthesia community, again limited."

You also surveyed professionals. What did that show?

"Confidence in the roles among doctors is much higher if you're actually someone who is working with a PA or AA. And the expectation of what roles are appropriate differed between doctors and PAs and AAs.

"In things like carrying out audit, research, prevention, immunisation programmes there was much more agreement. [But when it comes to] seeing undifferentiated patients and making diagnoses, there's more difference."

You also interviewed stakeholders and bereaved families?

"Yes, including the GMC, CQC, BMA, and medical royal colleges. I spoke to the relatives of the small number of people who sadly died where the role of a PA was implicated in the coroner's report. They hadn't understood that the role was not the same as a doctor."

What are the key recommendations of your report?

"The first is clarity of recognition of the roles, changing the name from associate to physician assistant. Patients were very keen that the word assistant was used—they felt 'associate' sounded like a grand title."

Was that discussed with PAs?

"I didn't consult them specifically. The recommendation was based on conversations with doctors,

Consistency, clarity, and identification across the NHS would make it safer and would make it easier for patients to navigate

medical royal colleges, patients, and patient groups."

You also made recommendations on visibility and identification?
"Name badges, lanyards, national level uniforms, clearer signage in GP surgeries or wards . . . it matters, it's part of that safety profile.

"I think consistency and clarity and identification across the NHS [generally] would make it safer and would make it easier for patients to navigate, especially bearing in mind the number of roles that we have. You often see photographs of the staff, but with that photograph let's have the name, the role, and a sentence about what that person does. Basic information.

"Healthcare is complicated these days. There's so much that can be done, so many different treatments, and I think we need to help the patients and patients' relatives as they walk through that."

And clarity in relation to doctors?
"There have been some great examples where you see PAs working in a complementary way to doctors. However, there has been some substitution where PAs are working in [place of] doctors. I've recommended a number of things: template standard job descriptions for PAs and AAs in secondary and primary care—that scopes out for everyone, for the avoidance of doubt, what those roles are about at the start of their careers. That's more straightforward than writing out a scope of practice, because it's a practical tool that the system can use. And within that there's an important caveat: that PAs should not see undifferentiated patients unless they've been triaged as adult patients with minor ailments.

"I've drafted those job templates with input from the colleges– they are in the appendix [of the report]."

You also suggest two years in hospital before primary care?
"[There were] quite a few concerns that the training that PAs receive is limited. It didn't seem logical to go straight into primary care. Two years in a clinical environment helps provide confidence."

You mention the need for named supervision. What does that mean?
"Each PA needs a senior doctor—a consultant, a GP—who is their named supervisor, making sure the PA is working in a role for which they are appropriately trained."

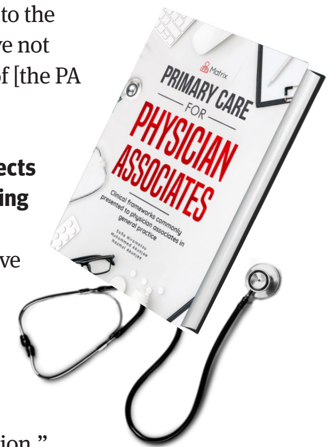
In terms of regulation what do you recommend?
"It was out of scope to review whether the GMC was the right regulator. But the way they present regulation should be clearer and more distinct—like the NMC [Nursing and Midwifery Council] does for nurses and midwives."

That is contentious. Can the GMC be trusted to make the distinction?
"That's the recommendation. They should present PAs as distinct and complementary to doctors. But the choice of regulator was not within scope."

PAs should not see undifferentiated patients

And what about further training?
"They need accredited training modules and appropriate standards. We need a faculty, ideally with oversight from the medical royal colleges, and to ensure doctors shape it."

Why did you take different views on prescribing and diagnostic tests?
"There are many professions that can now prescribe. With appropriate training and checks, there shouldn't be an absolute bar. Where it involves ionising radiation, the risks to the patient are higher, and I have not recommended that as part of [the PA and AA] portfolio."



Some feel this all reflects poor workforce planning
"Workforce planning is complex. What we didn't have [at the time the PA and AA roles were created] was a clear vision for how these roles were going to work in practice. If we'd had that, we'd have had less substitution."

Did you consider recommending the halting of recruitment of PAs?
"I did. But there wasn't sufficient evidence to say we should do that. We need more staff in the NHS. But we need clarity around how they work."

Kamran Abbasi, editor in chief

Mun-Keat Looi, international news and features editor, *The BMJ*

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THE BIG PICTURE

Gaza protesters demand end to atrocities

Healthcare workers join protesters to form a red line in Parliament Square to demand the UK government take action to stop the destruction of Gaza's healthcare system.

Israeli military attacks have killed tens of thousands of Palestinians and destroyed most of the region's hospitals. More than 1500 doctors and other health workers have been killed or kidnapped.

The protest on 10 July, one of many across the world, featured placards with photographs of killed and missing doctors. It was organised by a coalition that included Médecins Sans Frontières, the BMA, War Child, and Oxfam.

Natalie Roberts, executive director of MSF UK, read out a message from Mohammed Abu Mughaisib, a doctor who has worked with the organisation in the Gaza Strip for more than 20 years: "I carry the screams, the faces, the unanswered prayers . . . Nothing prepared me for this war. We hope the world hears the voices of Gaza's medical staff. We hope someone listens."

Alison Shepherd, *The BMJ*

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GUY BELL/ALAMY

EDITORIAL

Decline in UK childhood vaccine uptake

Coordinate action to improve confidence and convenience

In England, none of the childhood vaccine programmes attained the World Health Organization recommended 95% coverage target in 2023-24.[1] Coverage across all childhood vaccine programmes has been gradually declining since 2013-14,[1] but in view of its high infectivity, measles is a particular concern. Sustained high uptake (95%) of two doses of measles, mumps and rubella (MMR) vaccine is needed to prevent outbreaks; uptake of the first dose of MMR vaccine at age 2 years was 92.7% in 2013-14 and 88.9% in 2023-24.[2] This decline is resulting in nationwide outbreaks disproportionately affecting children in disadvantaged areas.[3 4] There were 2911 confirmed measles cases in England in 2024, the highest number in over two decades, and a child died in July 2025.[5]

The drivers of declining uptake are complex. The covid-19 pandemic disrupted services and raised public concerns about vaccine safety.[6] Public confidence in childhood vaccination is generally high in the UK; 84% of over 3000 parents of young children surveyed in 2025 trusted childhood vaccines.[7] However, confidence levels have declined since 2015.[8]

Infrastructural problems predating the pandemic have affected delivery, suggesting that confidence may not be the primary issue.

Austerity caused public health spending cuts and worsening child health.[13-15] Vaccination coverage is sensitive to deprivation: in Italy austerity measures correlated with a decline in MMR coverage in 2014, with substantial attrition in the areas most harmed by reduced public health investment.[16] In England, "Sure Start" children's centres were launched in 1998 to consolidate early years services with the aim of giving the most deprived children equitable opportunities to thrive.[17] The centres' broader commitment to

Committing to family centred delivery strategies offers potential to reverse the decline

Ben Kasstan-Dabush, lecturer of global health policy, University of Edinburgh
ben.kasstan-dabush@ed.ac.uk

Tracey Chantler, associate professor of public health evaluation, London School of Hygiene & Tropical Medicine

Helen Bedford, professor of children's health, UCL Great Ormond Street Institute of Child Health, London

health and family wellbeing provided a trusted environment to recommend and receive vaccines. Government spending cuts have resulted in over 30% of centres closing since 2009.

In July 2025, the Department for Education announced plans to roll out "Best Start" family services across England to reintegrate support for the most deprived families.[18] Health visitors are reported to be the most likely to discuss vaccines with parents,[7] but their numbers have been reduced by over 40% since 2015 and their role in immunisation delivery diminished.[19] The Best Start approach will enhance vaccine access through health visiting,[18] indicating potential to improve what works for parents. Universalist policy approaches improve the prospects of all children and help reduce health inequalities across the social gradient.[20]

Reversing the decline

Multipronged solutions are required. The covid-19 pandemic showed the need for a robust approach to routine vaccination delivery that can be pivoted in an emergency to attain high and equitable coverage. The covid-19 vaccination programme offers lessons for achieving greater vaccine equity, showing how responsibility for health protection could be shared with underserved communities to foster a sense of public ownership over progress.[21]

However, there are strong indications that lessons for preparedness are not being applied in England. Integrated care boards, the NHS organisations that plan and commission health services for their local populations, are expected to reduce operational costs by 50%,[22] which will affect strategies for vaccine coverage recovery and community engagement. Fragmentation will persist if funding is directed to Best Start pathways but scaled back in other arms of the immunisation system. Improving vaccine equity in these circumstances requires recommending or offering vaccines opportunistically, making every contact with health services count for children.[21]

Reporting adverse events through the Yellow Card system is critical for monitoring vaccine safety. Patient reporting of vaccine adverse reactions has increased since 2005-07, probably because the routine schedule has expanded and public awareness of self-reporting procedures has increased.[23] Healthcare professionals should always take patient concerns of adverse reactions seriously to help protect confidence in vaccine recommendations. Health professionals should have annual vaccine training, but provision remains sparse or difficult to attend.

Attaining high and equitable vaccine coverage requires sustained investment. Coverage recovery can be advanced by enabling parents to draw confidence about vaccine safety from consensus. Service fragmentation can be reduced by coordinating system-wide action that clearly allocates responsibility and funding entitlements. Committing to family centred delivery strategies offers potential to reverse the decline in child health caused by austerity but will be most effective as part of a strategy to ensure vaccines are within arm's reach of every child throughout their life course.

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EDITORIAL

Ethnicity and childhood cancer survival

We need high quality data to analyse outcomes

Evidence suggests ethnic inequalities in cancer outcomes among children in the UK. A study of children with cancer between 1981 and 1996 showed no significant difference in survival overall when comparing white and non-white children but found higher mortality for children of South Asian origin with acute lymphoblastic leukaemia and for black children with neuroblastoma compared with white children.[1]

A historical regional study of patients under 30 with cancer between 1990 and 2005 concluded poorer survival outcomes for South Asians compared with non-South Asian children and young adults with leukaemia and lymphoma but better outcomes for South Asian children and young adults with other solid tumours, independent of socioeconomic deprivation.[2]

A study from Yorkshire examining survival from 1997 to 2016 revealed long term improvement in survival rates for all cancers combined, including in children from South Asian backgrounds, whose five year survival for all cancers rose from 64.4% to 80.7%.[3] Although the survival gap between South Asians and other ethnic groups for leukaemia and solid tumours outside the central nervous system (CNS) narrowed, persistent inequalities remained for lymphoma and CNS tumours, whereby South Asian children had a 15% increased risk of death within five years after diagnosis compared with their non-South Asian peers.

These differences were not explained by access to specialist care, with a similar proportion of South Asians (90%) and non-South Asians (89%) being treated at paediatric oncology centres.[4,5] Socioeconomic or cultural barriers delaying diagnosis and treatment, and potential biological differences affecting treatment efficacy, may contribute to these differences, although these were not investigated in this study.

New studies are needed to reflect a changing population

In the US, survival differences remain across different ethnic groups in all major diagnostic categories of childhood cancer, even for children participating in clinical trials.[6-9] One study described provider bias favouring high socioeconomic status and European American ethnicity in decisions about enrolling children into cancer trials.[11]

In the UK, most studies on ethnicity and childhood cancer have been regionally focused or diagnosis specific. It is therefore timely to investigate survival outcomes within a changing population, rather than rely on old studies with different population distributions.

Improving the data

Robust epidemiological studies and assessment of health inequalities are needed to measure differences in care quality or access, particularly within subgroups. Ethnicity can often be a proxy for other aspects of care quality or experience rather than a measure of biological variation. For example, financial and social barriers for families from ethnic minorities or lower socioeconomic backgrounds may delay or prevent them accessing and navigating care.[12,13] Assessment of ethnicity and cancer outcome needs to account for these nuances.

Studies of ethnicity and outcomes require high quality data to enable measurement of population level differences in access to care, quality of care, and outcomes. NHS organisations are mandated to record ethnicity data, and best practice states that this should be collected in agreement and collaboration with the patient.[14] However, the data are often inaccurate, incomplete, and unvalidated.[15-17]

Studies show hospital recorded ethnicity for adults is less accurate than self-reported ethnicity, particularly for non-white groups.[18-20] For children, discrepancies exist between hospital records and parental reporting of ethnicity.[21,22]

Unique challenges of recording ethnicity in children include the age from which to collect demographic information, changing preferences over time, and the limitations of traditional healthcare databases, which may not include options to reflect the changing population diversity.[23]

Further investment and resources are needed to capture more complete and accurate data on ethnic groups within existing national cancer datasets. We must also quality assure historical data on ethnic group in the National Cancer Registration and Analysis Service, a database of cancer patients in England, with validation through linkage to Hospital Episode Statistics and primary care databases when ethnicity is recorded as missing or unknown.[24,25]

NHS England established the Core20PLUS5 framework, a national approach to support the reduction of child health inequalities, but cancer is not one of its core components.[26] Data and research are needed to inform policies that better align with the Department of Health and Social Care's national cancer plan, which aims to reduce cancer related health inequalities and improve outcomes for children with cancer.[27]

Jessica Bate, consultant paediatric oncologist, Southampton Children's Hospital Jessica.Bate@uhs.nhs.uk

Neil Ranasinghe, parent with experience of childhood cancer, UK

Gita Patel, parent with experience of childhood cancer, UK

Richard G Feltbower, professor of epidemiology, University of Leeds

On behalf of the Childhood Haematology and Oncology Research on Disparities Group (CHORD)

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BMJ INVESTIGATION

Questions raised over safety of self-test health kits on supermarket shelves

Studies suggest some commercial products are inaccurate and unsuitable for the public to use at home. **Rebecca Coombes**, **Hristio Boytchev**, and **Gareth Iacobucci** ask if regulators are protecting consumers

In the health aisle of your local supermarket, a range of self-testing kits—including for male fertility, vitamin D deficiency, and menopause—now sit between sleep aids and pregnancy tests.

This plethora of tests offer to provide simple answers to complex problems—but experts warn the reality is far more nuanced, and that the tests are potentially misleading.

"Why is it that a 15 year old can walk in and buy one of these tests?" asks Jackson Kirkman-Brown, director of the Centre for Human Reproductive Science at the University of Birmingham. "There is no support or understanding of what they are looking at."

The male fertility tests typically measure sperm count or activity but offer no insight into other clinically relevant factors—laboratory tests also look at sperm shape, for example, and clinics will take details from a partner into account. "More than half of couples with fertility problems are thought to have a male factor, but many men would not be abnormal by evidence of one of these tests," Kirkman-Brown says. A normal result may falsely reassure, and an abnormal one might cause anxiety, and unnecessary treatment.

Availability of self-testing kits has expanded in recent years, especially since the universal use of lateral flow tests during the pandemic, with the UK market for self-tests expected to reach a projected revenue of £660m by 2030. But studies published in *The BMJ* this week have raised serious concerns about their accuracy, clinical value, and regulation.

All the tests evaluated met European requirements for in vitro diagnostic medical devices and are cleared for sale in the UK. Researchers say this shows that urgent regulatory reform is needed to protect the public from potential harm. The Medicines and Healthcare Products Regulatory Agency (MHRA) says it will investigate allegations of self-tests that do not comply with the regulatory standards.

It is important the evidence upon which health decisions are made can be scrutinised
Jon Deeks

New evidence of risks

Birmingham University researchers assessed 30 tests for 19 health conditions in 2023, and found 60% had at least one high risk usability problem. Despite claims of accuracy, supporting evidence was often unavailable or flawed—based largely on poorly designed lab studies. Reports for only 12 of the 30 tests could be obtained, and many lacked robust data.

The tests, which have CE marks—to signify products have met European standards—are sold in major retailers such as Tesco and Superdrug and retail at £1.89 to £39.99. They require samples from a range of body fluids, including nasal and oropharyngeal secretions, capillary blood, urine, seminal fluid, vaginal secretions, and stool.

Many of the kits assessed had poorly written instructions that failed to clearly explain how to collect samples and interpret results, researchers found. Some had instructions clearly not suitable for home use, such as suggesting a centrifuge to clear a cloudy urine sample. Key information about test limitations was omitted, as were details about follow-up actions and when to seek medical advice.

Of the 30 tests, eight had guidance on the box about who should use the test, seven indicated any follow-up needs, and 10 provided quantitative information about the test's accuracy.

Jon Deeks, professor of biostatistics at Birmingham and the studies' corresponding author, says: "Our research raises concerns about the suitability, accuracy, and usability of many of the self-testing products available that require users to sample, test, and interpret results themselves."

NICK ROBINSON

Most self-test manufacturers either refused to provide study reports to support claims, stating they were commercially confidential, or didn't respond to requests, says Deeks. "Legally, they do not need to share this information. However, for matters of health, it is important the evidence upon which decisions are made is available and can be scrutinised."

When studies were available, they were of low quality and lacked details, such as the populations in which the tests were evaluated. When these were described, some were unrepresentative of the intended user. A usability study for one of the menopause tests, for example, included a majority of women whose last menstrual period was within two months and therefore not fitting the menopause criteria.

"Freeze at –20°C"

Researchers found many examples of poor instructions for consumers, some completely unsuitable for home use. In one case, instructions were printed directly onto the faecal sample collection sling and became unreadable when in use. Several urine tests gave unrealistic instructions for freezing samples, sometimes at temperatures as low as –20°C. Others warned that, as specimens might be a potential biological hazard, the use of disposable gloves and face masks (not supplied) was advised to prevent exposure.

Nearly all tests recommended follow-up with a healthcare professional—and not only when results were positive. Fourteen of the 30 tests recommended seeking support if results were negative. Bernie Croal, president of the Royal College of Pathologists, emphasised the knock-on effects for the NHS. "There are significant risks to patients when poor quality tests are carried out inappropriately, with both false reassurance and unnecessary consequences for the NHS to repeat tests or take additional action," he told *The BMJ*.

Four self-tests with the most identified problems

The BMJ has focused on four types of test that researchers said seem to raise the most problems. They were all distributed by one of two companies, Newfoundland and Suresign.

Vitamin D tests (Vitamin D Rapid Test Cassette; Vitamin D Test)

The colour chart omitted a shade, and subtle differences made it hard to read. Pipette blood collection often failed. Suresign, a test distributor, says the human eye can distinguish subtle shades and that the test and chart were updated in 2023 and 2024.

Bernie Croal, president of the Royal College of Pathologists, says that Vitamin D tests are "very much overused" in the UK, "with hundreds of millions of pounds spent every year in the NHS on both testing and prescriptions for vitamin D supplements. Direct to consumer testing, chosen and carried out by patients and pushed by the commercial sector, remains largely unclear when such issues around quality, regulation, and appropriateness are considered."

Microalbuminuria Rapid Test Kit (Colloidal Gold) for the diagnosis of chronic kidney injury

This test had the most usability issues of all the tests examined, including sampling challenges and unclear result interpretation. The instructions mention laboratory equipment and leave it unclear whether the test is for chronic kidney disease or acute injury. Faint colour charts make results hard to read.

Paul Stevens, co-chair of the Kidney Disease: Improving Global Outcomes 2024 guidelines for the evaluation and management of chronic kidney disease, says that doctors are trying to move away from using the confusing term "microalbuminuria," because it sounds like a different kind of protein, when it actually just means a small amount of albumin (a normal protein) is showing up in urine. Detecting this can be an early sign of kidney disease, but the amount needs to be measured accurately using the albumin-to-creatinine ratio.

He says that point-of-care tests should provide this ratio, not just a simple positive or negative result, and they need to be checked against high quality laboratory tests to make sure they're reliable.

Follicle stimulating hormone (FSH) menopause tests (Menopause (FSH) Rapid Test; FSH Rapid Menopause Test Midstream)

Seven high risk concerns were raised for the FSH menopause tests. One usability study mostly included women younger than 40 with recent menstruation. Instructions mention laboratory steps such as freezing or refrigerating urine samples and using a centrifuge.

Lynne Robinson, a consultant gynaecologist at Birmingham Women's Hospital, says: "Women under 40 years old can be menopausal, but including women with their last menstrual period in less than two months does not fit the criteria for menopausal. These women may be perimenopausal, but as FSH levels fluctuate, [the tests] need to be done on day 2-5 of the cycle or anytime if they are not having periods. Otherwise, it is very difficult to interpret the results." Suresign, a distributor, says the tests could be purchased by professionals or used by pharmacists for in-store testing, both of whom may have access to centrifuges or filters.

TSH Rapid Test Cassette to detect underactive thyroid

In the instruction for use leaflet, the text and figure muddle steps 6 and 7 in the opposite order, so consumers are told to add the buffer first in the figure, and to add blood first in the text. The text instructions state to use two drops of blood, but the pipette could hold more than this.

Kristien Boelaert, professor of endocrinology and consultant endocrinologist, tells *The BMJ*: "I have a problem with screening for thyroid disease because there is no need. Symptoms of abnormal thyroid function are notoriously vague . . . tiredness, weight changes, a bit of anxiety. And NICE guidelines recommend going on one symptom is generally not enough. GPs and clinical practitioners will have clear trigger points for doing a test, so I don't see how it would help patients to do a test that is going to say, 'yes, you are above a certain thyroid stimulating hormone' or 'no you're not,' because the 'no you're not' doesn't mean that everything is okay."

Hangzhou AllTest Biotech, manufacturer of the menopause, Vitamin D, and thyroid tests, and Hangzhou Singclean Medical Products, manufacturer of the microalbuminuria test, both based in China, did not respond to *The BMJ*'s invitation to comment

Kristien Boelaert, professor of endocrinology at Birmingham University and a consultant endocrinologist, goes further. Speaking about self-tests for thyroid disease, she says, “I actually think it’s dangerous. I would like there to be central UK-wide regulation . . . that prevents these things from coming on the market. I think the biggest potential harm is a false reassurance that, if it’s not positive, everything is fine.”

Regulatory issues

Clare Davenport, clinical associate professor at Birmingham and coauthor of the studies, echoes the need for greater regulation: “The same consideration given to pharmaceuticals should be given to self-testing where some, such as pregnancy tests, could be sold over the counter and others that carry greater risk of misuse are sold only with the support of a pharmacist.”

New medicines must undergo a stringent regulatory process, including clinical trials and registration with the MHRA. By contrast, self-tests are subject to much less stringent tests by notified bodies, the European companies that award CE marks. This has allowed certain self-tests to be sold in the UK, despite them raising concerns. Many of the branded tests sold in UK supermarkets and pharmacies originate from a small number of manufacturers and notified body approvals. So, although it looks like there are many different brands, most are clones that originate from those manufacturers.

The MHRA tells *The BMJ* that tests with CE marks will be recognised in Great Britain up to 2030. It added that this month, post-market surveillance regulations came into force requiring manufacturers to monitor self-tests use, and to report significant incidents.

All within the rules

Newfoundland Diagnostics distributes many self-tests in the UK, including the four tests with the largest number of problems (box), and was one of the few companies to provide supporting documents when requested. A spokesperson says it is “committed to high standards of performance, transparency, and user safety, with kits meeting all European requirements for in vitro diagnostic medical devices and MHRA guidelines.”

They added: “As

Tests that carry greater risk of misuse should be sold only with pharmacist support
Clare Davenport

part of our continuous development, we regularly work with new and existing suppliers to improve product quality. Previous tests, of which these reviews seem to refer, have gone through extensive quality and usability overhauls to ensure they are as easy to use as possible, whilst also being sustainable and affordable.”

Suresign, which distributes tests in the UK, including two of those that researchers said seem to raise the most concerns (see box), says that the tests should be used for “screening” and “not for taking medical decisions.” A spokesperson tells *The BMJ*, “They are not intended to replace tests carried out by professionals. Currently it is difficult to get an appointment with a GP, and therefore these tests provide information to enable users to actively seek a medical opinion if necessary.” The menopause and vitamin D tests were updated in 2023 and 2024.

Tesco, the UK supermarket that sells a wide range of health kits, tells *The BMJ* that it complies with all the relevant regulations “and [the tests] are approved within Tesco’s normal supplier frameworks and processes before they are listed for sale.” Boots, another seller, says it conducts regulatory checks on the self-testing products it sells. “As the majority of our stores have a pharmacy, we are well placed to support customers with any queries or concerns they may have about the results of self-tests they complete,” it adds. Wells Pharmacy, one of the largest pharmacy chains in the UK, did not reply to *The BMJ*’s invitation to comment, and neither did Superdrug.

TÜV SÜD, a notified body based in Munich, Germany, which, according to the packaging, approved the four tests that researchers said seem to raise the largest number of issues, referred to the manufacturers when confronted by *The BMJ* with the problems found regarding the tests. “TÜV SÜD is subject to a legal duty of confidentiality as a notified body, and, as a service provider, we are also in a private law contractual relationship with the manufacturer

and are subject to corresponding confidentiality obligations,” it says. It will include the findings of *The BMJ* studies “in the monitoring programme for the manufacturer,” it adds.

Deeks criticised the body over its decisions to approve some of the tests, alleging a lack of detail when explaining those approval decisions. “TÜV SÜD has acted as the regulatory gatekeeper that has allowed the tests *The BMJ* investigation has focused on to go on the market,” he said. “The decisions that these tests are fit for purpose and safe to the public is their responsibility.”

Don’t use GPs as a default

Concerns in the wider clinical community continue. Kamila Hawthorne, chair of the Royal College of General Practitioners, which has campaigned for greater transparency around these kits, says that there are ethical concerns about making money out of people without the necessary health literacy. “With the risk of false positives and negatives, and no offer of an interpretation of the results or aftercare, self-testing kits can mean patients experience a significant amount of stress and anxiety—prompting them to seek guidance from their GP to interpret any results. This not only negatively impacts patients, but it can also intensify the enormous pressures that GPs and their teams are currently under,” Hawthorne says. “Commercial self-testing kits should not default to NHS general practice as the provider for next steps and aftercare, unless the test was initiated in primary care or as part of a commissioned NHS service.”

Since collecting their initial sample of tests in 2023, Deeks and his team have continued to track the market—and it’s booming. A repeat search of the same geographical area in December 2024 identified 63 tests, twice as many as the previous year, many of them clones of existing self-tests, rebranded and sold under different names by a range of distributors.

There is an urgent need for regulatory action and to harness the tests’ potential, says Deeks. “Self-tests have a clear potential to improve public health. However, for them to be beneficial, not harmful, they must be proven to be accurate, easy to use, and supported by clear instructions. We hope the MHRA will update the regulatory process to ensure self-tests are effective and safe for everyone.”

Rebecca Coombes, head of journalism
Hristio Boytchev, freelance investigations reporter
Gareth Iacobucci, assistant news editor, *The BMJ*
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RESEARCH, p 77

HEALTH POLICY

How Labour performed on health in its first year

The long awaited 10 year plan to "rewire" the NHS has been unveiled—so what is the government's record on delivering on pledges? More money does not guarantee progress, writes **Richard Vize**, who finds concerns over restructuring, poor industrial relations, and waiting lists

In his excoriating 2024 analysis of NHS performance for the new Labour government, surgeon Ara Darzi was clear: top-down reorganisation of NHS England and integrated care boards (ICBs) was "neither necessary nor desirable." Ministers are now pursuing both.

Claiming that the NHS was broken, Labour's manifesto, unveiled in June 2024, promised to cut waiting times by adding 40 000 more appointments a week, meet the referral-to-treatment target of 92% of patients being seen within 18 weeks, and double the number of cancer scanners. It also sought to rescue NHS dentistry, employ 8500 more mental health staff, reset relations between staff and government, deliver the new hospital programme, and ensure the "return of the family doctor."

The pledge of more appointments is on track, but progress on treatment waiting times is far short of what is required to hit the target. Some progress has been made on providing more scanners, but there's a long way to go. Access to dentistry remains below pre-pandemic levels, there is no clear evidence of more mental health staff, staff relations are still poor, and much of the new hospital programme is delayed until the 2030s.

Siva Anandaciva, policy director at the King's Fund, describes progress in Labour's first year as a mixed bag. "The early months were marked by action to resolve industrial action for some staff groups and completing a very quick audit of how the NHS was performing," he says. "One year in, waiting lists are coming down, but only sluggishly, [and] we are still waiting for more concrete action on adult social care reform and the government's health mission.

"The big story in health policy in 2025 so far has been the abolition of NHS England and the contraction of integrated care boards, which surely isn't what the government or patients and taxpayers would have expected one year into fixing a 'broken' NHS."

The health and social care secretary, Wes Streeting, has been aggressive in his approach to reform: naming and shaming poor performers, talking about sacking NHS managers, dismissing NHS England as the world's largest quango, and publicly humiliating a board chair of one of his local hospitals at a conference, accusing her of "really poor quality care."

Health Foundation chief executive Jennifer Dixon warns there is a whiff of "it's a blob, rip it up, start again, we have to destroy," in Labour's approach to NHS reform. "You can't be in combat mode, [US government] Doge-style mode, by saying everything is broken . . . We have to do something radical, but you also have to take people with you. The style is heavy handed and demotivating. This is very basic stuff."

Patients would not expect this a year into fixing a "broken" NHS
Siva Anandaciva

There is a whiff of "it's a blob, start again, we have to destroy"
Jennifer Dixon

NHS England axing "unnecessary"

Anandaciva questions the government's need to abolish NHS England to reduce duplication in the health system and achieve closer alignment with government, rather than simply enabling more effective collaboration.

Bill Morgan, who was health adviser to Rishi Sunak when he was prime minister, knows how much time and political capital ministers need to expend to deliver reform: Morgan was also adviser to health secretary Andrew Lansley when he was steering what became NHS England onto the statute books in 2012.

The difficulty of disposing of NHS England is, Morgan says, compounded by its absorption over the years of other bodies such as Health Education England, the regulator NHS Improvement, NHS Digital, and some parts of Public Health England.

"Where they've made an unforced error is in promising a formal abolition," he says, "because it isn't just the operational HQ, it's all the other functions that used to sit outside the department: digital, foundation trust licensing, deaneries, education, and training. All of this is now in scope.

"What [legislation] removes is ministerial bandwidth," he adds. "Ministers are sitting in the House trying to get it through . . . not using time on things that matter to patients."

LABOUR'S FIRST YEAR IN POWER: KEY MOMENTS IN HEALTH

2024

13 June Labour manifesto pledges "fundamental reform" to meet 18 week treatment target, improve illness prevention, provide more community health services, and reset staff relations

5 July Labour returns to government after 14 years of Conservative government

29 July Resident doctors are offered 22% rise to settle pay dispute

12 September Ara Darzi's NHS performance review warns that Labour is unlikely to hit waiting times target this parliament and says A&E services are awful, productivity is poor, and too much is spent on hospitals

16 September—Resident doctors accept pay offer

30 October Rachel Reeves, the chancellor, announces £22.6bn injection for NHS England over two years

12 December Treasury bans NHS from raiding capital budgets to fund revenue gaps

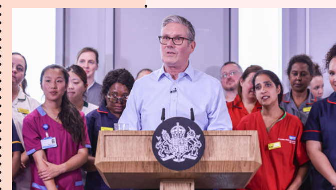
20 December Real terms funding for general practice is increased by 4.8%

2025

25 February NHS England chief executive Amanda Prichard quits

13 March Keir Starmer announces abolition of NHS England

3 July Government launches 10 year plan for NHS



Anandaciva doubts that ministers analysed the move in detail. "It was much more of a provocation [to the NHS]: here's a target to aim for, now figure out what you can do," he says.

Reorganisation of ICBs

Since their inception in 2022 ICBs have been buffeted by changes to their shape, size, and function. In November 2024 they were stripped of performance management of trusts, to focus on commissioning and local health services. Then in March 2025 new NHS England chief executive Jim Mackey told them to halve their running costs, before they were stripped of 18 functions, including workforce planning and primary care. And in June it was announced that the 42 ICBs would, by April 2027, be merged into around 27 "clusters."

All this happened before Labour unveiled its 10 year plan that focuses on "three shifts"—from treatment to prevention, analogue to digital, and hospital to community—and which set out an ambition to "build ICB capability."

"We were in this slightly perverse situation where ICBs were reorganising without knowing what they were meant to be doing," says Morgan.

Ministers are not using time on things that matter to patients
Bill Morgan

Progress in general practice

Labour hoped to reset staff relations last July by announcing a 22% pay rise over two years for resident doctors. The offer was accepted in September, but continuing discontent has resulted in another vote for strike action.

Anandaciva sees a risk of industrial unrest for years to come, quoting a senior NHS trust manager who warned, "We're preparing for more rolling waves of strikes by different professional groups. It's becoming a more normal feature of healthcare."

In June 2023 the Tory government unveiled its *NHS Long-Term Workforce Plan*. Its recommendations included doubling the number of medical school places, increasing GP training places by 50%, and almost doubling the number of adult nursing training places. An updated version is now expected, to reflect the 10 year plan—which rejected those numbers, saying that by 2035 "there will be fewer staff than projected" in the 2023 plan.

The professionally qualified health workforce grew by about 32 000 in the year to March 2025, slightly less than the previous year. Qualified permanent GPs rose by 1124, roughly three times the previous year's rise.

The additional roles reimbursement scheme was introduced under the Conservatives in 2019 to enable primary care networks to claim back salary costs for new recruits to 17 roles, such as pharmacists, physician associates, and occupational therapists. In August 2024, under Labour, the scheme was expanded, with £82m, to include recently qualified GPs. From October 2024 to April 2025 a total of 1738 GPs who had qualified within the previous two years were supported this way.

"The most notable thing you can attribute to the government is around general practice—the broadening of the scheme to introduce a wider, larger workforce with the ARRS," says Billy Palmer, senior fellow at the Nuffield Trust.

HEALTH HITS AND MISSES

On track

- More appointments
- Increasing the GP workforce

Slow progress

- Reduced waiting times for treatment
- More scanners
- New hospital building

Struggling

- Mental health staffing
- Social care reform
- Access to dentistry
- Workforce relations
- Workforce planning

Modest progress on waits

Labour has made some progress on access to care and waiting times for treatment. But Rob Findlay, director of strategic solutions at the healthcare data management company Insource, points out that from mid-2021 the Tory government began to slow the rate of increase in waits for treatment, "and to Labour's enormous luck it starts to head into shrinking territory just as it gets elected."

Progress then stalled at a decline of around 150 000 waits a year. To achieve its aim of hitting the 92% referral-to-treatment target within 18 weeks by the end of the parliament "it needs to get down to the minus one million line by the end of this financial year and stay there for the full four years," Findlay says.

Labour claims that it has delivered 40 000 more appointments a week. The fact analysis website Full Fact says the goal "appears on track." But other claims are less defensible, the Health Foundation has found. "They said crack teams of clinicians working in 20 trusts had reduced the waiting list by 130% more than other trusts," says the Health Foundation's Dixon. "We did a massive analysis and found there was no significant difference."

Public's perception "bleak"

Labour promised to create a National Care Service, but social care reform has been postponed yet again. In January Streeting commissioned the crossbench peer Louise Casey to lead an independent commission on how to reform the sector, but it is not scheduled to complete its work until 2028, the year before the next general election.

In response to the commission's announcement, Martin Green, chief executive of the social care representative organisation Care England, said the plan "risks becoming yet another report that gathers dust while the sector crumbles . . . How many more reports must we endure before action is taken?"

Public perceptions of NHS performance are "bleak, but we are starting to see a bit of optimism," says Anna Quigley, head of health and social care at Ipsos.

At the end of last year 41% of people thought care standards had worsened over the past year, which was at least better than the 66% who thought care was worsening in early 2023. "Similarly, if you ask people whether things are going to get better, it's now 21%, up from 11% six months before," Quigley says. "More people say the government has the right policies, but it's still only 17%."

Judgment time

In December the Treasury outlawed raiding trusts' capital budgets to fund revenue spending, raising the prospect of more investment in equipment such as scanners. Only 16 projects under the new hospital programme will begin construction by 2030, raising doubts the remaining 18 will happen.

The NHS received a relatively generous 3% real terms spending rise a year in June's spending review, but the Nuffield Trust points out that, when compared with Labour's pledges, the settlement "soon melts away."

In any case, more money is no guarantee of progress. Labour's plan may be intended for a decade, but it will be judged in four years.

Richard Vize, public policy journalist and analyst, London richard.vize@publicpolicymedia.com

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ROLE MODEL

Ling Wong

The consultant colorectal surgeon talks to **Kathy Oxtoby** about the complex surgery he performs—and how it's important to find hope in every situation

"I'm the type of person who doesn't give up on people," says Ling Wong, a consultant colorectal surgeon specialising in intestinal failure surgery at University Hospitals Coventry and Warwickshire NHS Trust.

His patients need a surgeon with this quality—many have had numerous failed surgeries and are "often feeling hopeless" by the time they come to see him for their first consultation. Such are the complexities of their conditions that it can take three to six months before surgery can take place, during which time Wong is not only involved in the preparations for treatment, including scans and parenteral nutrition, but also in getting to know them, listening to their fears, and building trust.

"I always say to patients that we will go through this journey together, and that together we can succeed," he says.

The surgery he performs is complex and can often take at least eight hours. When the outcomes are successful it can transform lives. "It is hugely rewarding," he says.

My guiding principle in training doctors is: 'I will not crush the weakest reed or put out a flickering candle'

"Patients say, 'You've changed my life completely. I thought there was no hope—now I can enjoy life again.' Every patient gives me a reason why I do this difficult surgery."

Growing up in Brunei during the 1960s, Wong would hear from his mother about the lives of patients she came across during her work as a domestic in the local hospital. Listening to these stories, he "thought how useful it would be if I could pursue a career as a doctor."

In 1984, he began his studies at the University of Glasgow's medical school. One of his teachers was the renowned physician Abraham Goldberg. "He took a personal interest in our education, showed us how to examine patients, and was one of the reasons I became interested in teaching," Wong says.

He spent two years at Glasgow Royal Infirmary. He was advised by his supervisor to consider a career in surgery as he was so good with his hands.

In the early 1990s, he moved to Leicester to do basic surgical training. "I fell in love with surgery and never looked back," he says. "With surgery you get results. You change people's lives so quickly—from having a condition to being almost fully cured in a few weeks."

Wong then went on to do two years of research in immunology in colorectal cancer with general surgeon Ian Fraser, and in 1997 received the best paper award from the *British Journal of Surgery*.

During the latter part of his higher surgical training in the West Midlands he specialised in colorectal surgery, having become fascinated by the specialty while based at Queen Elizabeth Hospital Birmingham, which has a centre for the treatment of inflammatory bowel disease.

He qualified as a consultant surgeon in 2001 and worked in general surgery at University Hospitals Coventry and Warwickshire NHS Trust. Five years ago he took on his current role, when the trust was selected as a regional intestinal failure centre.

Wong looks to inspire and support others through his teaching and has a degree in medical education. "My guiding principle in training doctors is: 'I will not crush the weakest reed or put out a flickering candle.'

"Trainees say I have lots of patience. You've got to give them that chance," he says. "I also find teaching consolidates my own learning."

As an honorary associate clinical professor at Warwick Medical School he was awarded the accolade for outstanding contribution to the education of medical students at the trust's outstanding service and care awards in both 2014 and 2018.

Now he is aiming to train up a junior consultant so they can "pick up the baton" of intestinal failure surgery. "I'm not going to be here forever. I need to train up a surgeon willing and capable of doing this work," he says.

Outside work, Wong enjoys spending time with his family, playing sports, and tending to his plants. "I'll go to the garden centre and select the most broken plants and nurture them. I like the challenge. And in a few months, you can see the difference." As with his patients and students, "I don't give up on my plants."

He believes there is "usually hope in every situation. And as doctors we need to instil that hope in patients—however small it is."

Kathy Oxtoby, London

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NOMINATED BY KHALID HUREIBI

"At a critical juncture in my career, Ling Wong's guidance, mentorship, and unwavering support played a pivotal role in shaping me into the surgeon I am today.

"He exemplifies what it means to be a conscientious surgeon—meticulous in his clinical practice, dedicated to patient care, and always striving for excellence.

"Beyond his technical skill, he is an outstanding educator and surgical trainer. His mentorship has profoundly impacted my career, shaping my approach to surgery, education, and professional development."

Khalid Hureibi is a consultant general and colorectal surgeon at Kettering General Hospital.

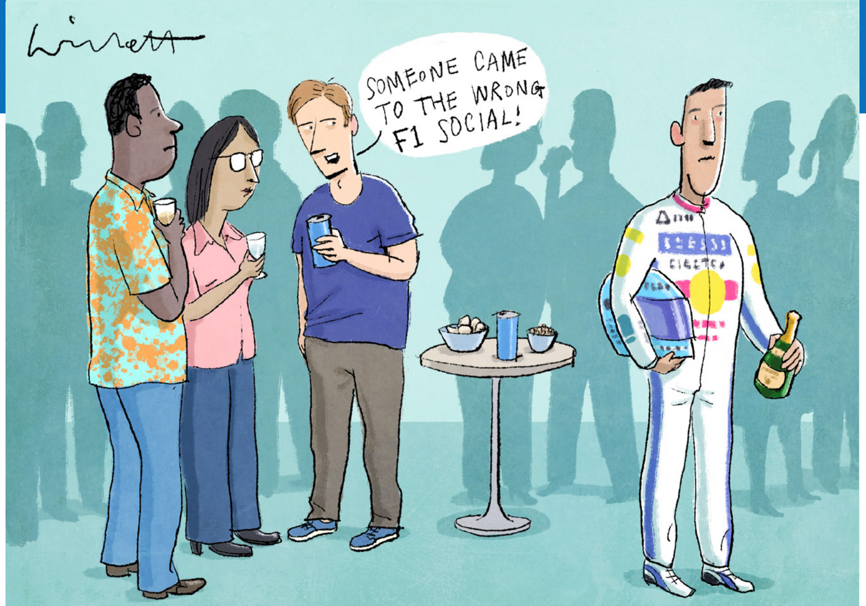
NOMINATE A ROLE MODEL

To nominate someone who has been a role model during your medical career, send their name, job title, and the reason for your nomination to emahase@bmj.com

CAREERS CLINIC

How should I prepare for my first day of FY1?

Knowing who to approach and taking initiative can set new foundation year 1 (FY1) doctors up for success, **Elisabeth Mahase** hears



Get organised early

Natasha Binnie, foundation year 2 doctor

"Firstly, congratulations on finishing medical school. That is a huge achievement and something to be proud of. As you approach your first day as an FY1 doctor, it's completely normal to feel a combination of excitement and nerves. Despite working towards this day for over five years, it can still feel overwhelming.

"Don't worry too much about the clinical side. You've already done the hard work by getting through medical school. There are very few expectations of new FY1s. What matters is being organised, approachable, and willing to learn. Always ask for help when you need it. SBAR—situation, background, assessment, and recommendation—will be your best friend for many situations including escalating to seniors. Remember, no question is too small or too silly to ask.

"Make time for life outside of work. When you start working, it can be easy to let medicine take over your entire life. But having something outside of work that you enjoy is important for your wellbeing. This could be a new hobby or something you already love doing. For me, that was running. It gave me time to switch off my thoughts and cope with the emotional challenges of being a doctor.

"Get organised early. Using a calendar to plan your shifts and time off can help you plan time to see friends and family. It is so important to maintain friendships, and plan fun things to do outside of work that you can look forward to when you're working long shifts."

Know where to go

Catherine Dominic, academic foundation year 2 doctor

"My first day as an FY1 felt like being dropped in at the deep end, so I'd like to share some advice that helped me.

"Start with the logistics: know where to go, who to report to, and what time to be there. Pay attention to induction, learn who the key contacts are, and access your Horus ePortfolio. Being late or lost is an avoidable stress.

"If you aren't already, try to get familiar with the hospital systems during shadowing—ordering bloods or chasing scans, which is a huge daily part of FY1, is much easier when you're not figuring out the software under pressure. Trial a jobs list that works for you during shadowing—people like to do it in different ways.

"Pack ahead—a couple of pens, your ID badge, stethoscope, water, snacks. Try to eat, drink, and take a break if you can.

"You don't need to make a huge impression on your first day, but make sure you are polite, ask questions, and introduce yourself to the team that you'll be working with, especially the ward nurses. They will be invaluable, especially early on, as they know how everything works.

"Try to remember that it's normal to feel out of your depth and that nobody expects you to know everything. If you're unsure, ask, and if you're stuck, escalate. It's far better to check than to make assumptions. Always prioritise patient safety when you are finding your feet.

"From here on, it will get easier. The aim isn't to be perfect, but to be safe, to learn, and to do the best you can for your patients."

Attend social events

Callum Allison, neurosurgery registrar

"Stethoscope? Check. ID badge? Check. Butterflies? Definitely. There has never been a doctor who has entered the front door of the hospital on their first day without any anxiety whatsoever—it is normal. To begin with, a bit of reassurance—you've studied hard for five years (or more) and wouldn't have reached this stage unless you were ready. It may seem hard to believe right now, but everything you will eventually need—efficiency, prioritisation skills, and clinical acumen—will come with time.

"My top tip? Know who to approach if support is required. The most appropriate points of contact will be given to you early on. Your clinical supervisor, educational supervisor, and training programme director are the core contacts—familiarise yourself with these people.

"Many foundation doctors find themselves a long way from home, so socialising is key. Join the doctors' mess in the first few days and attend social events—it's here that friends and memories are made for life. Remember to take leave to visit friends and family often.

"It's easy among the discharge paperwork and prescriptions to lose sight of the educational opportunities out there, even if at times they do feel out of reach. If you think you want to be a surgeon, seek out theatre time. A physician? Get to a clinic where possible. If you find opportunities hard to come by, discuss this with your clinical supervisor—a taster week is a good option."

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