



JORGE GUERRERO / AFP / GETTY

## Hantavirus passengers isolate in UK

A French woman and a US national who disembarked from the cruise ship MV Hondius have tested positive for hantavirus. Another US national was also reported as showing symptoms of possible infection.

The fresh wave of cases came as passengers were repatriated after the Hondius docked in Tenerife on 10 May.

WHO has confirmed the outbreak is the Andes strain of the virus, which is known to spread between people. As of 8 May eight cases were confirmed or suspected on board, of which three have proved fatal.

The French woman has reportedly been admitted to a specialist infectious diseases hospital in Paris, where her condition was deteriorating. A further 22 contacts of the patient have been traced and are isolating.

US officials said the US national had tested “mildly PCR positive,” although Spanish health authorities said the result was not considered conclusive by their laboratories. The US Department of Health and Human Services said another person was also showing possible symptoms.

Twenty British nationals, a resident German national, and a Japanese passenger who arrived in the UK from Tenerife on a chartered flight were taken to Arrowe Park Hospital in Merseyside to isolate for 72

hours. None have yet reported symptoms.

The Andes strain of hantavirus has a case fatality rate of around 35-40%, with some estimates reaching 50% in older patients or those with underlying conditions. WHO reports that, as the average age of Hondius passengers was 65, their mortality risk was higher than in the general population.

In a statement, WHO said person-to-person transmission of the Andes strain requires prolonged exposure and frequent interpersonal interactions with an infected person. Cruise living conditions present a higher than normal risk of transmission. The agency warned that more cases may occur among people exposed before the containment measures, as seen in the two new cases among French and US nationals. However, it said the current response, with rapid isolation and monitoring of contacts, should limit the risk of further spread.

Twelve hospital staff in the Netherlands are in a six week quarantine after treating an infected patient. The patient's blood test results and urine were not disposed of to the higher standard warranted by potential hantavirus exposure, officials said.

● **BIG PICTURE**, p 178; **COMMENT**, p 198

Katharine Lang, Bristol  
Cite this as: *BMJ* 2026;393:s916

**MV Hondius passengers are transported to Tenerife airport in a military bus to be repatriated**

### LATEST ONLINE

- Most doctors are worried about use of advanced practitioners
- Struck-off doctors finding jobs in other EU countries
- 30 senior US doctors declare Trump as mentally unfit



# MEDICAL NEWS

## Manchester medical school launches investigation into sexual harassment



Manchester University Medical School (left) has launched a formal investigation into several reports of sexual harassment involving students.

In a letter to the school the BMA's Medical Students Committee said it had become aware of reports of "verbal abuse, threats of stalking and intimidation, and sexual violence, with incidents occurring over a number of years." The letter added it was "particularly shocking to hear that other students may be perpetrating these acts."

It continued, "Their actions constitute serious breaches in their expected professional conduct, reflecting behaviours which are not only incompatible with a career as a clinician but are, in many cases, criminal offences."

Ashley Blom, dean of the Faculty of Biology, Medicine and Health, said a "formal investigation into the specific incidents" had now been launched and the school "will undertake a comprehensive review of the cultural and systemic issues raised."

Blom, an orthopaedic surgeon, said, "I am grateful to everyone who has brought these issues to our attention and showed courage and leadership in standing up."

"I strongly encourage anyone who has experienced or witnessed similar behaviour to come forward so that we can take appropriate action."

Elisabeth Mahase, *The BMJ* | Cite this as: *BMJ* 2026;393:s841

## Cancer treatment NHS rolls out "one minute" immunotherapy jab

NHS England announced that it was rolling out a new injectable form of the immunotherapy pembrolizumab (Keytruda) that can be given in just 60 seconds. The new rapid injection can be used to treat 14 cancer types, including lung, breast, head and neck, and cervical, and works by triggering immune cells to recognise and kill cancer cells. Around 14 000 patients start pembrolizumab treatment each year in England, and most will now be eligible for the more convenient treatment, said NHS England.

## Private sector DHSC hires consultancy to support new health centres

The Department of Health and Social Care has awarded Turner & Townsend, a private consultancy, a contract worth £735 000 to advise on the public-private partnerships needed to build 250 neighbourhood health centres. The move sparked fresh concerns about the expansion of the private sector in the NHS, amid a renewed push from ministers to pursue new private

finance initiatives, which proved controversial under previous governments. Sarah Jacques (below), GP co-lead for the Doctors' Association UK, said the new contract "raises significant concern. It goes beyond delivery—it shapes the model itself."

## Martha's rule More than 1000 NHS staff call helplines since launch

More than 1000 NHS staff in England have used "Martha's rule" helplines in the first 18 months of the scheme to help identify rapid patient deterioration. From September 2024 to February 2026 hospital staff made 1781 calls to trigger a rapid review of care. Of these calls, 1080 (61%) helped identify acute deterioration. The programme is named after Martha Mills, who died aged 13 in 2021 from sepsis after her family's concerns about her deterioration were not dealt with.

## Vaccines mRNA jab outperforms standard flu shot

Moderna's new mRNA based seasonal flu vaccine is more effective than traditional flu shots at preventing infection, a late stage international study

showed. Researchers compared rates of influenza diagnosis in more than 40 000 participants who received either Moderna's trivalent mRNA-1010 vaccine or the standard flu jab over several months in the 2024-25 flu season. All participants were over 50. Published in the *New England Journal of Medicine*, the



results showed that 2% (411 of 20 179) of people who had the Moderna vaccine and 2.8% (557 of 20 124) in the standard group developed flu.

## FDA blocks publication of covid and shingles studies

US Food and Drug Administration officials blocked the publication of several studies of covid-19 and shingles vaccines conducted by agency scientists, it emerged. Each blocked study showed the safety of widespread use of the vaccines. A spokesperson for the US Department of Health and Human Services, which oversees the FDA, confirmed the move. They said the studies' conclusions "were not supported

by the underlying data." Critics said the blocks were another example of antivaccine sentiment from the department head, health secretary Robert F Kennedy Jr.

## Nasal decongestants Limit spray use to five days, says regulator

Use of nasal decongestant sprays containing xylometazoline and oxymetazoline to help clear blocked noses should be limited to five days, the MHRA advised. The UK regulator said it had issued updated advice in response to evidence that excessive use of the sprays can cause rebound congestion, a temporary swelling inside the nose that can lead to rhinitis medicamentosa, a chronic condition that causes severe nasal congestion and damage to tissues.

## Welsh elections Two consultants take their seats in the Senedd

Two doctors were among 43 Plaid Cymru members elected to the Welsh parliament on 7 May. Gwyn Williams and Safa Elhassan, both consultant ophthalmologists, stood in Gŵyr Abertawe. Williams told *The BMJ* that having "clinical voices at the top of government will hopefully bode well for the NHS and Wales, although the task is huge and time is short."



# IN BRIEF

## Asthma

### Blue inhaler use falls with new guidelines

More than a million people in England now use a combination inhaler for asthma, surpassing for the first time the number of patients who use solely a blue inhaler. In 2024 the National Institute for Health and Care Excellence published clinical guidelines advising doctors to stop prescribing short acting  $\beta_2$  agonists (Sabas) such as salbutamol on their own for new patients. Experts said the shift signalled a major improvement in treatment and would help reduce hospital admissions and deaths from asthma.

## Malaria

### Vaccine “cuts child deaths by 13%” in Africa



A pioneering malaria vaccine led to significant reductions in child mortality in Ghana, Kenya, and Malawi, a World Health Organization study reported. From 2019 to 2023 an estimated one in eight deaths (13%) were averted among children eligible to receive the vaccine when compared with children in areas where the vaccine was introduced later, the study published in the *Lancet* found. The authors wrote, “These results highlight the urgency to accelerate the deployment of malaria vaccines in areas of Africa where malaria continues to be a leading cause of child mortality.”

## Weight loss drugs

### New tool helps identify who might benefit

Researchers have designed a tool to help identify who is most at risk of developing obesity related



Use of the combination red inhaler has surpassed use of the blue by asthma patients

diseases without relying primarily on high body mass index. Their study found that many people who are predicted to have the highest risk of developing conditions such as type 2 diabetes and heart disease were those categorised as overweight rather than obese. This group of people would not normally get glucagon-like peptide-1 (GLP-1) weight loss drugs prescribed on the NHS. The study, by researchers from Queen Mary University of London and the Berlin Institute of Health, was published in *Nature Medicine*.

## Mental health

### Stabbing “was avoidable” with better care

A stabbing might have been prevented if the perpetrator had received more appropriate mental healthcare, concluded an investigation by England’s parliamentary and health service ombudsman. It found that the 31 year old man, who was later given a diagnosis of schizophrenia, had attacked a member of the public in 2020 after receiving “poor mental healthcare” from an NHS trust, now known as Kent and Medway Mental Health NHS Trust. The investigation highlighted failings in the 12 months before the stabbing, including poor care planning and discharging the patient without reviewing his risk level. The trust apologised and said that it had strengthened services since the incident.

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## WAR ATTACKS

In 1534 days of war in Ukraine the World Health Organization has verified more than 3000 attacks on healthcare

[WHO]



## SIXTY SECONDS ON... BETTING ON PANDEMICS

### A RISKY GAMBLE?

It’s certainly a controversial one. But the practice of staking money on disease outbreaks or future pandemics is a growing trend, with gamblers flocking to online prediction market platforms such as Polymarket.

### HIGH STAKES?

You bet. In the wake of the hantavirus outbreak, traders are placing wagers on whether it will escalate into a pandemic before the end of 2026. As of 11 May, a whopping \$6m has been staked.

### WHAT ARE PREDICTION MARKETS?

Essentially, they allow people to bet on the outcomes of future events. Online platforms allow users to stake money on all manner of events such as elections, sports results, and major global events.

### DEAD POOL?

Hantavirus is the latest market to emerge. Recently, bets were placed on how many people would be infected with measles in the US. This market is still active, with more than £8m staked. The conflicts in the Middle East and Ukraine have also been the subject of several markets, sparking criticism.

### ARE THERE “DEATH BET RULES?”

US financial rules bar trading on war, terrorism, and assassination, but recent activities have sparked calls for a tougher crackdown. Polymarket is registered in Panama, which complicates things. People in the UK can’t use the site because of rules against “binary” betting.

### ALL BETS ARE OFF?

Polymarket claims it is a public information service. “The collective wisdom of diverse participants leads to highly reliable forecasts,” it says. “This makes prediction markets an excellent tool for gauging real time probabilities of future events.”

### BUT THE HOUSE ALWAYS WINS . . .

In a *Science* discussion paper last month, researchers warned that prediction markets should be viewed as a public health threat. “Scientific framing, gambling-like design, and regulatory gaps create risks of a new behavioral addiction and democratic manipulation,” they argued.

Gareth Iacobucci, *The BMJ*

Cite this as: *BMJ* 2026;393:s914

# Senior doctors balloted for industrial action in England and Northern Ireland

Consultants and SAS (specialist, associate specialist, and specialty) doctors in England and Northern Ireland will soon decide whether they will take industrial action as part of a dispute with their governments.

Both ballots—run by the BMA—opened on 11 May, with Northern Ireland’s vote also including resident doctors. Both disputes focus on pay, but in England the BMA is also calling for wider changes to improve working conditions for consultants and SAS doctors, including more protected time to focus on innovation, teaching, and improving patient services and better recognition for work done out of hours.

## Need for improved career progression

SAS doctors need improved career progression and opportunities, the BMA’s SAS Committee said. It is also pushing for reform of the way SAS doctors are compensated for their time and for improved annual leave entitlement.

The BMA said consultants and SAS doctors in England had seen their pay fall by around a quarter since 2008-09 and is calling for action to reverse this. It said March’s pay award of 3.5% for 2026-27 went “nowhere near doing so.”

BMA Consultants Committee co-chairs Shanu Datta and Helen Neary said, “Industrial action is a last resort, but in the face of a government that seems intent on making the role of a consultant even more demanding with no associated recognition we are left with no choice but to show ministers that we are prepared to stand up for one another, our professionalism, and our patients.”

SAS Committee chair Ujjwala Mohite added, “We hope industrial action won’t be necessary, but SAS doctors must be prepared to stand together to show their value.”

A Department of Health spokesperson said, “Consultants and SAS doctors have seen their starting basic pay go up by around 28.5% over the last four years.

“We urge consultant and SAS doctors to see the BMA’s unreasonable and unnecessary bid for industrial action as the distraction it is from our shared endeavour of rebuilding our NHS and making it fit for the future.”

In Northern Ireland, consultants, SAS doctors, and resident doctors are being collectively balloted after the BMA deemed the 3.5% rise recommended by the pay review body unacceptable. If a yes vote is returned, all doctors working in Northern Irish hospitals could take action at the same time.

David Farren, chair of BMA’s Northern Ireland Consultants Committee, said, “We are balloting because successive, subinflationary, and late pay awards are undermining the morale of doctors and driving them away.”

A spokesperson for the health department in Northern Ireland said it would continue to engage with health unions, but financial constraints meant “there is no room for movement beyond the 3.5% recommended.”

The ballot in Northern Ireland closes on 8 June. England’s ballot closes on 6 July.

Abi Rimmer, *The BMJ* Cite this as: *BMJ* 2026;393:s925



# GPs and hospitals to be forced to share patient data in single record

GPs and hospitals in England will be forced to share patient data with each other under legislation set to be announced in the king’s speech.

The move will, according to a House of Lords speech briefing, “introduce a single patient record (SPR) to bring together all of a patient’s medical records in one place.”

The change comes as a leaked NHS England briefing revealed that

controversial US tech giant Palantir has been allowed “unlimited access” to patient data in a bid to connect data across the health service.

Palantir was given access to the data as part of its work on the NHS’s federated data platform (FDP), a project that aims to improve efficiency across the health service, the *Financial Times* reported.

NHS England’s briefing also acknowledged the “considerable public interest and concern about how

# BMA vindicates Cass findings but questions “overreach”

The BMA’s long awaited critique of the Cass review has largely vindicated its findings into gender identity services for young people.

The union’s report concluded that the evidence base for puberty suppression and gender affirming hormones is limited and uncertain. But it also claims that some government actions taken after the review—particularly the nationwide ban on puberty blockers ordered by health secretary Wes Streeting in 2024—went beyond Hilary Cass’s explicit recommendations.

On puberty blockers the BMA’s review failed to reach a conclusion on whether patients under 18 should have restricted access. It highlighted a “substantive disagreement” within the review’s specially convened group.

Nearly two years after BMA members voted to conduct an

independent evaluation of the review, the report agrees the evidence base for treatment is weak, that the risks of osteoporosis and fertility problems are present in the current evidence, and that there is a need for improved research, better data, and more robust multidisciplinary services.

But the BMA takes issue with Cass, the paediatrician who led the review, on several occasions. It says she simplified “complex findings” or emphasised “potential risks without equivalent contextualisation of potential benefits.”

The review also criticises ministers, stating, “While service design broadly aligns with the review’s recommendations, restrictions on prescribing and the extension into statutory regulation represent policy decisions that go way beyond the original recommendations.”



much access to patient data Palantir [and] Palantir staff have.”

Doctors working with NHS data have said that ministers’ plans to join up patient records while failing to protect their data was “unbelievable.”

The Department for Health and Social Care told *The BMJ* that the legislation in this week’s king’s speech will mean all healthcare providers—including hospitals and GPs—will have to share data so that doctors, nurses, and specialists across England can see a patient’s full medical history.

The department claimed the record would be robust to the threat of data breaches and the public and health professionals will be consulted throughout its design. The SPR will be made available to clinicians as early as 2027 in some specialties, including maternity and frailty care.

“As patients, there’s nothing more frustrating than having to repeat your medical history at every appointment,” health secretary Wes Streeting (left) said in a statement. “When paramedics arrive to heart attack and stroke patients, they can’t see the patients’ medical records, putting them in even greater danger. “It will be a gamechanger that



### Until the security of any data flows can be guaranteed we remain concerned

Katie Bramall

means NHS staff can deliver better care faster and more conveniently, and even saving lives.”

But doctors have not welcomed the move. “I cannot believe they’re going to pass a law that puts the minister in charge of everybody’s health records at a time when the government’s track record of failing to protect patients privacy include UK Biobank,” a senior consultant working on a government funded NHS data project told *The BMJ*.

“They need to put their house in order before launching another data grab. Furthermore, Palantir staff have been given direct access to identifiable patient records, which is specifically what NHS England and ministers said wouldn’t happen.

“So, in the middle of a data leak of these proportions, you change the law to make it even easier to override protections for patients—what on earth are you going to do next year?”

The BMA’s GP Committee for England is also protesting against the decision. The legislation would also transfer elements of data ownership and responsibility away from individual practices.

Minutes from a May 2025 meeting of the data, digital, and technology

committee of NHS England confirmed that it—which will be merged into the health department—will take on the data controller role for the SPR.

“The GP Committee for England has not been part of the discussions on what form the SPR will take, who will be granted access, the purposes for which it will be used, or which company will be contracted to operate it,” said Katie Bramall, committee chair. “There are already mechanisms that allow those in secondary care to view the live GP record, and therefore the government needs to explain why an additional system is needed.

“Until the security of any data flows can be guaranteed, and full patient facing audit trails are made available via the NHS App showing who has accessed confidential medical data and why, we remain concerned.”

NHS England said it had strict policies in place for managing access to patient data and anyone external needing access must have government security clearance and be approved by a member of NHS England staff at director level or above.

Palantir was asked to comment.

Stephen Armstrong, London  
Cite this as: *BMJ* 2026;393:s929

David Strain, chair of the BMA’s board of science, said, “We did find quite a big disconnect with the report’s recommendations and actually what subsequently happened. Cass was saying there are a small number of people who will benefit from the use of these drugs and that that should be held in [specialists’] hands.

“The response to that was an outright banning rather than making recommendations through existing bodies like NICE, which could recommend which drugs should and shouldn’t be used by which people in what setting. That’s where the overreach happened.”

The report also said the government’s reaction to Cass’s report, including the closure of the Gender Identity Development Service (GIDS) at Tavistock and Portman NHS Trust, left patients with reduced access to care and longer waits. Strain said, “At no point did the baroness say all of the children and young people in GIDS should suddenly lose access

to the support that they’re receiving [or that] they should lose access to the psychological support, the family support, and all of those elements.”

### Cass’s response

Responding to the BMA report, Cass said, “The important aspect is that it does validate the conclusions of my review. The BMA were calling for the implementation to be paused pending this report. If it had been paused, it would now be over two years with nothing happening for these young people, so it’s very fortunate that that didn’t happen.

The report does, said Cass, “refer to some statements that I made that [it says] were not fully substantiated.” But she added, “I didn’t base any statement just on one reference—but also from listening to clinicians and academics to get their views on those particular aspects. It is based on a broad view of the evidence and clinical opinion.

“I think that’s probably

### The BMA were called for the implementation to be paused. If it had been, it would now be over two years with nothing happening for these young people

Hilary Cass



about as strong as one can be on many of the complexities in the field.”

The BMA review has caused internal division and resignations at the organisation. Strain said, “The BMA is here to look at the science. We can now go back to those members who were very critical of the baroness and say, ‘She did the best with the information that we had at hand.’”

A spokesperson for the health department said, “The Cass review was robust, backed by clinicians, firmly grounded in evidence, and provides a guide on how to improve gender services.

“The secretary of state has consistently been clear that the safety of children and young people must come first. That is why, following a recommendation from the Commission on Human Medicines, a ban on the sale and supply of puberty suppressing hormones was introduced.”

Rebecca Coombes, *The BMJ*  
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# UK Biobank data leak risks undermining trust and harming future research, experts warn

- Experts warn that recent leaks from large UK database may be “tip of the iceberg”
- Data breaches prompt concerns that volunteers may withdraw from flagship scheme
- Academics say action is needed to maintain public confidence and protect the project



**Biobank has been following people now for 15 years, so it's got loads of useful stuff about ageing**  
Felix Ritchie

Last month it emerged that medical details from 500 000 participants in the UK Biobank project were for sale on the Chinese e-commerce site Alibaba.

The leak, which came just a month after UK Biobank datasets were discovered on the code sharing platform GitHub, has sparked concern that people may withdraw from the flagship research database amid fears over the security of their health data.

After the latest data incident Patrick Vallance, UK minister of state for science, research, and innovation, warned that further leaks were likely. “New listings will emerge, and we continue to work with the Chinese government to remove them quickly,” he told the House of Lords.

In response to the Alibaba leak, UK Biobank suspended all access to its research platform while it limited the size of files that could be taken off the platform. This measure, it said, “will allow researchers to export the results of their research, while severely limiting their ability to take any de-identified participant data.”

UK Biobank was founded as a charity in 2003 by the Department of Health and medical research charities. It holds genome sequences, scans, blood samples, and lifestyle information of 500 000 volunteers. More than 18 000 peer reviewed scientific papers have been published using UK Biobank data.

But the leaks have prompted

concerns that volunteers may withdraw their data. As of 1 May, UK Biobank said that 100 people had inquired about withdrawing, but after its chief executive, Rory Collins, had spoken to them personally only 50 actually did so.

Academics have raised concerns, however, that the damage has only just begun.

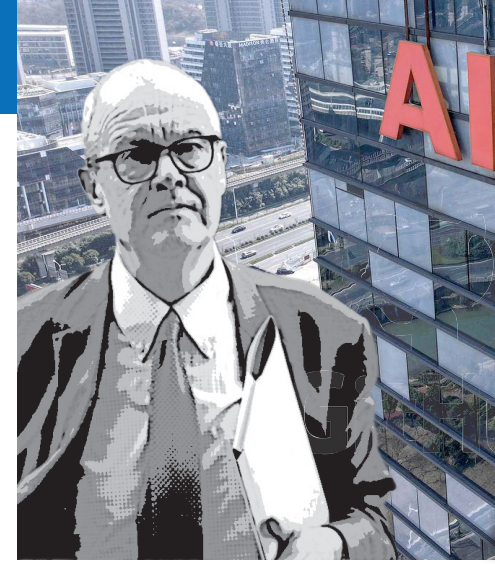
## ? Has trust been damaged?

Felix Ritchie, professor at the University of West England, created one of the UK's first trusted research environments (TREs) when working at the Office for National Statistics (ONS). TREs are secure platforms that allow authorised researchers remote access to sensitive, de-identified patient data.

Reflecting on the fallout from the UK Biobank leak, Ritchie told *The BMJ*, “I've had a number of discussions with non-medical groups that allow data to be downloaded, and they are panicking over this because they're getting calls from their longitudinal study respondents trying to withdraw their data.

“We don't want Biobank to stop, because it's a fantastic resource for researchers. Maybe a new Biobank would start again from scratch, but Biobank has been following people now for 15 years, so it's got loads of useful stuff about ageing. This is why the leaks are so annoying.”

Though UK Biobank doesn't yet have access to its volunteers' primary care data, that access has been granted. In



February the government published a data provision notice paving the way for coded GP patient data in England to be shared with consented cohorts such as UK Biobank.

But the BMA has now withdrawn its consent from that agreement as part of its collective action against the government over new contractual terms. In its announcement the union highlighted the UK Biobank security breaches as it called on general practices to “cease signing up to any new voluntary data sharing agreements that extract patient data for secondary uses,” such as charities, commercial third parties, or universities.

Mark Coley, IT lead for the BMA's General Practitioners Committee for England, said, “The Biobank breach shows the dangers of allowing researchers access to raw event level data such as detailed health records, sensor readings, and genetic data. That's why we support OpenSAFELY [an alternative platform], as such a level of access is impossible by design. There is no ‘download’ button.”

Coley hopes that no GP data will be shared by general practices until UK Biobank's secure data environment is completed in 2027 and built-in output checks can occur to prevent data extraction by any researchers.

“The problem is,” said Coley, “with Biobank being in the news, these events damage trust.”

## ? Have there been any other UK Biobank data leaks?

Some researchers are warning that the leaks that have been made public may be the tip of the iceberg. Luc Rocher, a data privacy researcher at the Oxford Internet Institute who has been monitoring takedown notices issued by UK Biobank, said the charity had



UK Biobank holds genome sequences, scans, blood samples, and lifestyle information of **500 000** volunteers. More than **18 000** peer reviewed scientific papers have been published that used UK Biobank data



**Patrick Vallance (far left) warned of further UK Biobank leaks similar to those found on Alibaba and GitHub, while Mark Coley said patients' trust was damaged**

taken action on at least 30 other data breaches in the past month, including denying access to Yale University.

Researchers at the University of Surrey suspect that a large section of the UK Biobank dataset—not including genomic or imaging data but including information such as health assessments, hospital records, family history, and questionnaires—has already been leaked and is being used by researchers around the world.

In a paper published last December the Surrey team counted the number of research papers in journals that used UK Biobank data without stating the researcher's application number. Failing to do this would breach a condition of using the data.

In the years up to and including 2023 the Surrey team found two papers a year didn't carry the number. In 2024 that jumped to nine (10% of all papers citing Biobank data), and it remained high at over 7% in 2025, with papers from researchers in China, India, and Saudi Arabia among those failing to cite their application number.

Possible reasons for not stating the number "would include laziness—or sometimes academics, being academics, will forget they need to do that part of it," said Nophar Geifman, professor of health and biomedical informatics at Surrey University and one of the research team. She said, "We have no concrete evidence of foul play, but we think the data are out there and have been for a while."

UK Biobank issued a statement to *The BMJ* saying the missing numbers were an academic oversight. A spokesperson said, "As part of their contract with us, all researchers are required to list their UK Biobank project number



**Once data has left its original environment, you have effectively lost control of it**  
Jessica Morley

**Participants deserve clear answers about what happened, why it happened, and what will change to prevent it**  
Nicola Byrne



on any relevant publications. A small proportion of researchers forget.

"We have teams of people who track publications that use our data and match them to projects held with us, and when we find someone hasn't attributed their project number on a paper, we get in touch and confirm the project match and ensure that they don't forget to do this next time."

**Is vulnerability avoidable?**

But Jessica Morley, an associate research scientist at the Yale Digital Ethics Center, highlighted that in datasets such as UK Biobank's that contain common demographic and health attributes individual records were "inherently" vulnerable.

"We have known for ages that [when] relying on the 'de-identify and disseminate' method of data, once it's left its original environment, you have effectively lost control of it," she said. "And so, the idea that there are copies of it lying around that people have used for purposes that it was not originally approved for is entirely believable, because that's inherent with the Biobank model of data use."

UK Biobank's chief communications officer, Edward Sykes, told *The BMJ*, "This is partly a result of us being the first to set up a dataset like this. In 2012 when we launched, the standard way of making data available was by download. In 2024 we shifted to platform-by-default, where all new projects take place.

"Researchers still need to be able to download their findings and their analyses, some of which can be very large files. Most similar datasets only support tens of projects, or maybe a few hundred researchers, so they can use a manual 'airlock'—but we're on a completely different scale so need an automated one. We're in the process of having that built. Until then, we have been partly reliant on the contracts that research institutions sign."

But Ritchie says that when he established the Virtual Microdata Laboratory at the ONS to provide researchers access to sensitive data he was able to set up a secure system where downloads

were controllable, long before UK Biobank's launch. The Danish government did something similar in 2003 when it set up its patient data system.

"Biobank is right in the sense that in the health area, this was very unusual," Ritchie told *The BMJ*. "But to say that no one else was doing it . . . no, we already knew how to do it, and we'd already done it."

**Is there a risk to research?**

The leaks pose a huge risk to medical research, Morley warns. She said schemes such as care.data and general practice data for planning and research saw "massive spikes in the opt-out rate over privacy concerns."

"We know that there's almost a direct relation between trust and people's willingness to participate in research," she said. "We also know that the people who are more likely to opt out or to not volunteer are not random. It's people within the population who are more likely to be less trusting. You are going to struggle to maintain Biobank's level of diversity and representativeness, and that's going to harm science."

As the Department of Health and Social Care (DHSC) tries to get a grip on UK Biobank data, Sam Smith of the patient privacy pressure group MedConfidential warns, "It's essential that all stakeholders are included in the discussion. Because when you lock stakeholders out of this conversation, what you get is this mess."

The DHSC will decide whether further action is needed after a rapid review by UK Biobank's board.

Nicola Byrne, national data guardian for England, said it was reassuring UK Biobank had taken "immediate steps" to secure data but added, "This must now be matched by full transparency and accountability. Participants deserve clear answers about what happened, why it happened, and what will change to prevent this happening again. Decisive action is now essential to maintain public confidence in responsibly governed health data research."

Stephen Armstrong, London  
Cite this as: *BMJ* 2026;393:s889

# What the UK can learn from Australia's crackdown on tobacco and vapes

- Vaping prevalence has fallen since the Canberra government banned e-cigarette sales in 2024
- But a growing black market has seen a spike in criminal activity since the new law
- UK still offers vaping to help smokers quit but the aim is to reduce appeal to young people



The UK's landmark Tobacco and Vapes Act, which became law last month, creates a “smoke-free generation” by making it illegal to sell tobacco products to anyone in the UK born after 2008.

It also aims to reduce young people's use of other products containing nicotine, such as vapes, while keeping them available to help adults quit smoking.

To help make vaping less appealing to young people, UK ministers are being handed new powers to regulate the design and advertising of products containing nicotine, create a licensing scheme for selling them, and introduce further restrictions on where they can be used in public.

The UK's approach differs from that of Australia, which in July 2024 imposed a strict national ban on the sale and importation of e-cigarettes (nicotine containing or otherwise) to anyone of any age.

Now, vapes are available in Australia only if sold by a pharmacist on prescription as a smoking cessation aid for people aged 18 or over. Vaping devices approved for sale in pharmacies are restricted to three flavours, and the advertising of vapes is also banned by law.

At a press conference shortly before the ban became law, Australia's federal health minister, Mark Butler, described vaping as a “public health menace”

and vowed to stamp it out. “It is nothing more than a cynical device to recruit a new generation to nicotine addiction,” he said.

Nearly two years on from that ban the effects of the crackdown have been mixed.

Data from Australia's Generation Vape research project indicate that the prevalence of vaping among young people has decreased. The latest survey of around 700 14-17 year olds found the proportion who said they had never vaped had increased significantly from 71.4% in April 2024 (just before the ban) to 79.9% in March this year.

There was also a downward trend in the proportion who had tried a few puffs, those who had vaped more often (10 to 100 times), and those who had vaped more than 100 times.

Becky Freeman, associate professor in public health at the University of Sydney, who is involved with the Generation Vape study, said the data indicated that the ban was having a positive effect not just on prevalence but also on young people's attitudes to vaping.

“We didn't hear at all, when we first started the Gen Vape project, that vapes were ‘cringe’ or embarrassing, and we're increasingly hearing that from participants now,” Freeman said.

She emphasised the importance not just of banning vapes but also

of public health campaigns, advertising bans, and media coverage that challenge the idea that vapes are safe.

“All those things together made a difference,” she said.

## Growing black market

But these gains are being overshadowed by a growing and dangerous black market in illicit tobacco and vapes, which has led to murders, kidnappings, and fire bombings as organised crime muscles into the lucrative trade.

In Australia around half of all tobacco sales and more than 95% of vape sales are now illicit, in a market valued at around \$A7.2bn (£3.8bn).

Michelle Jongenelis, professor of psychology with expertise in health promotion at the University of Melbourne, said Australia's experience with banning vapes highlights the importance of enforcement.

“One of the biggest learnings, I think, for the UK in all of this is the importance of creating the right conditions for the law that you have implemented to succeed,” she said.

In Australia's federated system the vape ban law was enacted at the national level, but enforcement of that law—including penalties and other punitive measures—was left up to the individual states and territories.

Some have been more diligent than others, Jongenelis says. “Queensland has over 200

**When we first started we didn't hear at all that vapes were ‘cringe’—we increasingly hear that from participants now** Becky Freeman

enforcement officers who are going around and making sure that stores are doing the right thing, and if they're not they're shutting those stores down.”

The Queensland state government now has some of the strictest laws in Australia on illicit tobacco and vape sales, including the right to quickly shut down illegal tobacco and vape businesses for up to three months and seize all smoking products, lawful and illicit, found at stores engaged in illicit sales.

In contrast, Western Australia has been criticised for having fewer inspections of tobacco selling premises now than before the ban was introduced.

At the same time, Australia has one of the highest tobacco taxation rates in the world. The average price of a mainstream brand of cigarettes was nearly \$A55 (£29) per pack of 20 in 2025, and tobacco taxes made up around 60% to 80% of that price.

#### Demand for nicotine continues

But James Martin, associate professor in criminology at Deakin University in Victoria, said bans and high prices haven't removed the underlying demand for nicotine, which has proved remarkably resilient.

“When you have strong, persistent demand for any good or service, and you restrict legal supply, then you create the risk of a black market forming,” he said.

Once a large scale illicit market has formed, it can be difficult to rein it in just through enforcement.

Martin said, “A lot of the tobacco control establishment are under the impression that we can just enforce our way out of this problem, which is very, very problematic from a criminology perspective.”

With illicit tobacco so readily available and much cheaper than the legal versions, there is now concern that the total ban on vapes might have the perverse effect of steering people from vapes back to smoking.

“I'm very worried that we will see increases in smoking among 18-24 year olds,” Freeman said.

This is partly because illicit tobacco is so much cheaper and more accessible but also because of the high rates of vaping in this age group.

Freeman added, “They were the first generation of Australians to take up vaping in a really big way, and we know that you are five times more likely to go on to smoke if you vaped as a teenager.”



In Australia around half of all **TOBACCO** sales and more than **95%** of vape sales are now illicit, in a market valued at around \$A7.2bn (£3.8bn)

#### Doctors “don't know where to refer”

Another problem that has emerged with Australia's ban on vape sales to under-18s is how to help people already addicted to nicotine to quit, said Aziz Rahman, professor of public health at Federation University in Melbourne.

“When you talk to GPs and paediatricians, they don't know what to do, they don't know where to refer, they don't know whether the same policies for smoking cessation should be applied for vaping cessation,” he said.

Rahman and colleagues have been surveying Australian clinicians who work with adolescents about the effects of the vaping ban, and the responses so far point to a lack of preparedness for the ban.

“They are not ready to provide the support to the adolescents who want to quit,” Rahman said. “I think the health system was not ready when they implemented this ban.”

This may be one advantage of the UK approach of a ban on buying tobacco products based on year of birth, he said, “because it is really changing the norms: that smoking is not acceptable, any form of tobacco is not acceptable.”

#### How UK's approach differs

The UK approach is also different in that it represents a gradual phasing in of a ban rather than an abrupt stop and still allows for the use of vapes as an alternative to tobacco, said Hazel Cheeseman, chief executive

of the charity Action on Smoking and Health.

“Australia's approach is around controlling nicotine altogether and not perhaps using that commercial nicotine as a way of reducing the prevalence of tobacco, particularly combusted tobacco,” she said.

In contrast, in the UK “people who currently cannot be sold tobacco legally will never be able to buy tobacco legally, so it doesn't remove anything from people who can currently make those purchases,” she said. “It will not eliminate smoking completely, particularly among the first cohort, but it will substantially reduce smoking because of that dual effect: it will make it harder to access, and it will reduce demand.”

However the tobacco and vape crackdown plays out in the UK, Freeman warned that the tobacco industry was fighting harder than ever as the population smoking prevalence drops below 10%.

“This idea that you can get to a certain point where the tobacco industry won't care about your market because it's too small—no,” Freeman said.

As Australia tightens controls on both tobacco and vapes, she said, “I have seen them actually really turning up the heat in terms of putting their political pressure on governments and speaking publicly.”

Bianca Nogrady, Sydney  
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## THE BIG PICTURE

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# HANTAVIRUS SUPPORT: Army drops in with medic and supplies to remote British island

A UK army medic and nurse were among a team that parachuted onto the south Atlantic territory of Tristan da Cunha, where one of the 221 residents has a suspected case of hantavirus.

The patient, a British national, had left MV *Hondius*, the cruise ship hit by a deadly outbreak of the virus, in mid-April to return home to Britain's most remote inhabited overseas territory.

He first reported symptoms, including diarrhoea and fever, on 28 April, two weeks after



BRITISH MINISTRY OF DEFENCE/AP

leaving the cruise ship. He is said to be in a stable condition while isolating.

An intensive care doctor and nurse parachuted in tandem with two of six paratroopers onto Tristan da Cunha, with support from RAF aircraft that had flown from Brize Norton in Oxfordshire.

Two of the paratroopers jumped in tandem with the health workers, who stayed on the island to support the permanent two person medical team. The paratroopers' return to base on a ship

was carefully planned “in light of the medical situation,” a spokesperson said.

Oxygen and 3300 kg of medical necessities for the island's hospital were also air dropped, as supplies were at a “critical level,” the Ministry of Defence told the BBC. The spokesperson added that it was the first time that UK military medical personnel had been parachuted in to an area to provide humanitarian support.

Alison Shepherd, *The BMJ* [Cite this as: \*BMJ\* 2026;393:s927](#)

# MHRA-NICE pathway: industry over patients

Approval mechanisms must be grounded in patient need and population health

In April 2026, the UK government announced a new pathway to expedite the availability of new medicines in the NHS.<sup>1</sup> The joint regulatory and health technology assessment (HTA) approval pathway is designed to make products available three to six months sooner by aligning National Institute for Health and Care Excellence (NICE) decisions with those of the Medicines and Healthcare Products Regulatory Agency (MHRA), such that regulatory and HTA decisions are issued simultaneously.<sup>2</sup>

The MHRA evaluates the clinical efficacy and safety of new medicines before market authorisation, while NICE assesses their clinical effectiveness and cost effectiveness against existing alternatives in the NHS. These processes have different evidence requirements. Ideally, both sets of decisions are underpinned by randomised controlled trials that compare new drugs against the standard of care and evaluate patient relevant outcomes such as mortality. In recent years, however, regulators have increasingly relied on small non-randomised studies without control arms, measuring surrogate endpoints that do not reliably predict clinical benefit for patients.<sup>3</sup>

These shifts in the evidence base supporting new drug approvals have complicated HTA, as comparative effectiveness and long term cost effectiveness are difficult to establish without comparators or clinical endpoints. Meaningful alignment of regulatory and HTA evidence requirements would strengthen both processes and reduce the risk of ineffective, harmful, or low value products reaching the market.

However, this is not what the new pathway offers. Rather than aligning evidentiary standards, it runs two independent processes in parallel with the aim of synchronising their conclusions. This will be achieved by



**Fixed evaluation deadlines are associated with higher rates of adverse events**

NICE bringing its technology appraisal process forward to run concurrently with MHRA's regulatory review.

The new pathway brings clear advantages for industry. Products reaching the market sooner begin accruing revenue earlier and benefit from a longer period before sales become eligible for rebates under the voluntary agreement between the UK government and the pharmaceutical industry.<sup>5</sup>

Benefits to patients and the NHS are considerably less clear. Earlier access to effective new drugs can matter for patients with substantial unmet needs, and months of delay can carry clinical consequences. But the pathway does not target this population; it will expedite NHS availability of new medicines irrespective of evidence of added therapeutic benefit.

## Risks

The new pathway will impose timelines to ensure that MHRA and NICE decisions are reached simultaneously. Fixed deadlines on drug evaluation have historically been associated with higher rates of adverse events,<sup>10</sup> and medicines approved through expedited regulatory pathways have a greater frequency of post-marketing safety events than those approved through standard routes.<sup>11-13</sup> This is particularly concerning given that the MHRA has already compressed its procedures through international recognition pathways, whereby regulatory decisions made in other

jurisdictions, including the US, receive near automatic UK approval.<sup>14</sup> As a growing share of new drug approvals in the US benefit from expedited regulatory programmes,<sup>15</sup> the UK is increasingly exposed to greater uncertainty about the safety and efficacy of drugs approved in other settings.

Furthermore, companies will in some cases be required to submit evidence to NICE before the MHRA review has begun. NICE committees will therefore be asked to deliberate on a product whose pharmacokinetic efficacy and safety profile have not been vetted by the regulatory authority.

Evidence suggests that the population health effect of new medicines recommended by NICE between 2000 and 2020 was negative, meaning that the resources spent on those drugs could have generated more health if directed towards more cost effective interventions.<sup>17</sup> The new pathway will bring expensive medicines into NHS commissioning earlier, extending the period over which they divert resources from other services. These health opportunity costs will be felt more acutely because of the 2025 US-UK trade agreement, which commits NICE to raising its cost effectiveness threshold by 25%.<sup>18</sup> This means that the NHS will pay more per unit of health benefit from new drugs than it derives from equivalent spending elsewhere.

A renewed commitment to grounding medicines access policy in patient need and population health is needed. At a minimum, government should set out the assumptions underpinning this pathway and assess its expected benefits and harms across all affected stakeholders—not only industry, but patients and the wider NHS.

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Huseyin Naci,  
director,  
Pharmaceutical  
Policy Lab, London  
School of Economics  
and Political Science  
[h.naci@lse.ac.uk](mailto:h.naci@lse.ac.uk)

# Covid inquiry reveals critical system gaps

Module 3 shows that future pandemic readiness depends on better resourcing and restored trust

**M**odule 3 of the UK Covid-19 inquiry, detailing the effect of the pandemic on the UK's healthcare systems, was published on 19 March 2026. The conclusions are clear: the NHS coped, but only just, and at a substantial cost to the staff, patients, and health and social care services. The collapse of the healthcare system was avoided only through the extraordinary efforts of those who laboured to deliver care while facing overwhelming pressure.<sup>1</sup>

In the face of a complex, and in this case, fast moving threat, the resources a service has when it initially meets the threat are important in shaping the overall outcome. The UK's healthcare systems entered the pandemic with workforce shortages, an ageing hospital estate, a lack of equipment, low numbers of hospital beds, and high bed occupancy.<sup>1,2</sup> The fragility of the healthcare system reflected longstanding policy decisions that tolerated chronic understaffing, delayed capital investment, and long waiting times. Those decisions intersected with deep, pre-existing health inequalities,<sup>3</sup> which the module 3 report documents starkly in excess mortality among people with disabilities, those with long term conditions, and those in deprived and ethnic minority communities.<sup>1</sup>

Healthcare systems, already operating at close to maximum capacity, had no headroom to absorb a shock of the magnitude of covid-19.<sup>4</sup> This lack of resilience left the UK's health services ill equipped when covid-19 hit, pushing them to the brink of collapse more than once.<sup>1</sup> As a result, the UK had to resort to extreme measures—wholesale cancellation of elective care, emergency discharge policies, and repeated lockdowns.

The report also records that poor pre-pandemic planning left the UK



**Learn from our experiences and recognise that heroism is not a substitute for sound policy decisions**

with limited testing capacity and that early 111 and triage services were overwhelmed. Once the virus had seeded widely and surveillance lagged, ministers were left with a binary choice between extreme social restrictions and catastrophic overwhelming of hospitals and critical care.

The report also describes the moral injury and complex grief created by visiting restrictions: people dying alone, relatives saying goodbye by phone or text, and poorly communicated do not resuscitate decisions. These experiences will affect public trust in healthcare and policymakers for years. Advance care planning and visiting policies are not technical details; they are central to how a society chooses to treat its sick and dying during a crisis.

## Improving systems for the future

Sadly, the pandemic is not over; rather, it has changed shape. The backlog created by the suspension of elective care has left millions of people waiting for treatment. Some have deteriorated beyond the point where surgery remains possible.<sup>1</sup> Pauses in screening programmes have resulted in loss of life and increased mortality rates for conditions such as colorectal cancer.<sup>1</sup> However, substantial and rising waiting lists existed before the pandemic, so responsibility for the backlog cannot solely be laid at the pandemic's door.<sup>5</sup>

Against this bleak backdrop, there were also notable successes. The

UK's research response was world leading, with large, randomised trials including Recovery<sup>6</sup> and Remap-CAP<sup>7</sup> transforming global standards of care, and observational platforms like ISARIC4C<sup>8</sup> and GenoMICC<sup>9</sup> enabling rapid understanding of disease mechanisms and risk, saving lives in the UK and beyond,<sup>10</sup> all largely delivered by clinicians who made time to recruit patients into these studies on top of their already overwhelming workloads.

The inquiry is an effort in the service of the future, in the hope that the hard won lessons from the public, NHS patients, and staff do not go to waste. The evidence gleaned from module 3 perhaps offers the most important lesson of all: "What happened in the UK was not inevitable; alternative outcomes were possible."<sup>1</sup> If you are reading this while facing the onset of another pandemic, you must seize the opportunity to learn from our experiences and recognise that heroism is not a substitute for sound policy decisions.

The covid-19 pandemic revealed aspects of our healthcare systems that ordinarily remain hidden or ignored. It cast societal inequalities in sharp relief,<sup>3</sup> showed the importance of monitoring, protecting, and promoting staff wellbeing,<sup>1-12</sup> and the need to create a resilient healthcare system with greater capacity to surge to meet unheralded demand.

Beyond these preparatory and preventive actions, if the UK is to survive another such threat without replaying the same cycle of lockdowns, overwhelmed services, human attrition, and loss, it must start from a different place: a more equitable society, with a properly resourced, genuinely resilient health and social care system, where trust between policymakers, healthcare workers, and the public has been restored.

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Charlotte Summers, professor, University of Cambridge

Tim Cook, professor, University of Bristol

Ganesh Suntharalingam, consultant in intensive care medicine, London North West University Healthcare Trust

Kevin Fong, professor, University College London Hospitals NHS Trust  
kevin.fong@nhs.net

# NHS Online: In-depth look at the radical plan that could revolutionise care in the UK

A new “online hospital” for specialist care has become a cornerstone of the government’s plan to modernise the health service. But what exactly is it, and will it deliver? **Chris Stokel-Walker** reports



**Patients will benefit from us industrialising the latest technology**  
Jim Mackey



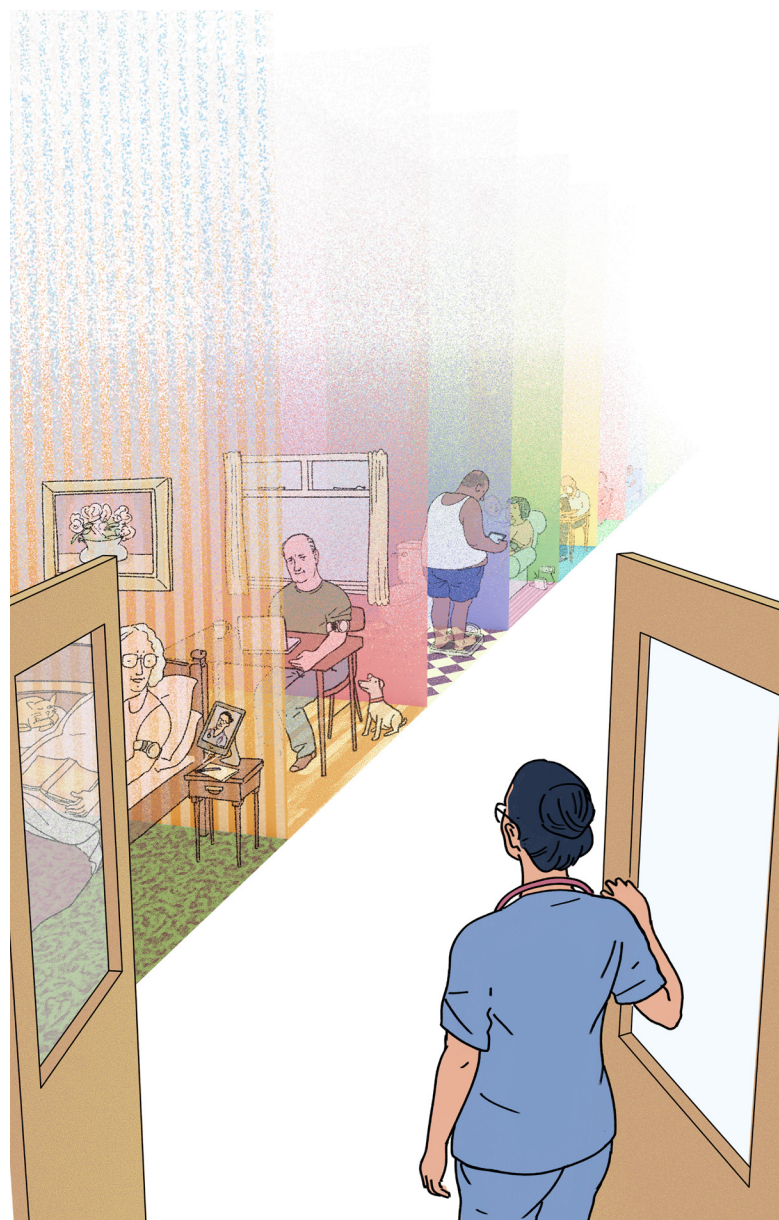
**It’s an opportunity to bring down waiting lists**  
Sara Shaw

**F**ixing the NHS and its long care backlog has been one of the key pledges of the Labour government and the Department of Health and Social Care, and they think they have hit on a solution: NHS Online.

NHS England’s website describes it as “a new online service for specialist care.” Brokered through the NHS app—which has become a cornerstone of the health department’s plan to modernise the NHS—the initiative would allow patients to be connected with clinicians specialising in a handful of areas across the country digitally.

The initiative was heralded as a “huge step forward for the NHS” by Jim Mackey, NHS chief executive, when it was first mooted last September. “Patients who choose to receive their treatment through the online hospital will benefit from us industrialising the latest technology and innovations, while the increased capacity will help to cut demand and slash waiting times,” Mackey said at the time.

But many unanswered questions remain about how it will work. The amount of information in the public domain about how it works is so small that it’s difficult to tell



MALCOLM WILLET

what impact it’ll have, says Sara Shaw, professor of health policy and practice at the University of Oxford.

Trish Greenhalgh, a medical doctor and professor of primary care health at the University of Oxford, adds that “the scope of this NHS Online hospital isn’t clear,” so it is difficult to understand whether it’ll succeed in its goals.

Yet both agree that there is promise in the idea.

## What is NHS Online?

Claudia Pagliari, a senior researcher at the Usher Institute at the University of Edinburgh, says the initiative seems to be, at this stage,

“mainly hospital specialists and consultants doing planned care appointments and various specialist activities.”

Patients would have the option—but would not be required—to use the system to have online appointments with specialists in a number of areas that the health service says already have strong evidence that digital care works. That includes various areas of ophthalmology, including glaucoma and cataracts, inflammatory bowel disease, iron deficiency anaemia, prostate conditions, and menopausal and menstrual issues.

Those specialisms are areas where the NHS currently struggles with long waiting times. In

ophthalmology, for instance, only two thirds of patients were seen within the 18 week target set by the government, according to an analysis in March 2025 by the patient lobby body Healthwatch. The actual target was 92% of patients.

“It makes sense as an opportunity to bring down waiting lists and address some of the backlog and use tech and innovation in a productive and positive way,” says Shaw.

“My understanding is that it would be totally separate from current systems,” says Hilary Williams, clinical vice president at the Royal College of Physicians, who says she has attended “a few” meetings about it. That chimes with the understanding of other experts, who see it as a bolt-on to existing systems, delivered through the NHS app, and much more protocolised than the existing NHS process of appointments.

GPs are likely to be referring patients into the system, says Pagliari, which means they’re not entirely divorced from the process but wouldn’t be doing more activity.

NHS Online’s distance from the rest of the health service could be both a blessing and a curse, says Williams. “You’re almost setting something up from scratch.” That’s potentially a problem, she says, because the NHS’s history with large IT projects is mixed, to say the least.

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### When is it likely to begin?

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More details are expected on a new NHS Online website that will go live this summer, said NHS England, which will include some of those questions that aren’t fully answerable. And “from 2027” patients can choose to receive care through the initiative.

NHS England has set lofty goals for the programme: it hopes some 8.5 million appointments could be arranged and take place within the first three years of the system launching. That’s a tiny but meaningful fraction of the NHS’s total: more than 380 million GP appointments and more than 600 million “contacts” are made with the health service each year.



**The scope of this NHS Online hospital isn’t clear**  
Trish Greenhalgh

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### What have professional bodies said about it?

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NHS England points to a survey of 300 consultants released in March 2026 that claims 60% of them would be interested in working for NHS Online alongside their present roles.

Interest in such significant numbers—if the proportion of consultants who expressed an interest was spread across the whole NHS, and those who showed interest actually then signed up—means the service would be more than fully staffed, which is an indication of support for the service, the NHS claims. Whether that would take working hours away from the existing service or come on top of currently worked NHS hours is unclear.

However, not everyone is so unvarnished with their praise. When the initiative was announced last year, the Royal College of Physicians of Edinburgh was muted in its appraisal of the project, saying it was worried the project could exacerbate inequalities. That was also the concern of Healthwatch, which said it was “essential” that people were offered support to use the NHS app to gain access to care and not left to fend for themselves.

“I think the flexibility for staff and patients has got to be good,” says Williams. “What you wouldn’t want to do is see people do this as their whole job.” The NHS is already struggling with staffing, she points out.

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### What benefits could it offer?

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“There are genuinely interesting opportunities for the staff, never mind the patients,” says Greenhalgh.

For patients, there is the ability to see specialists from the comfort of their own home, and potentially faster than they would on traditional



**The flexibility for staff and patients has got to be good**  
Hilary Williams

waiting lists. For staff, there are also benefits—such as being able to earn extra money, to tackle the overwhelming pressure on waiting lists, and to be able to take advantage of the flexibility it offers to pick up additional work when you want outside working hours.

Taken as a whole, there’s real opportunity from the plans to tackle the longstanding problems that have blighted the NHS and to help patients be seen more quickly in those areas. “The potential is there to work quite well, and we’ve seen examples where it can work,” says Shaw.

It could also mean NHS staff end up with more cash in their pockets through extra work, as well as having the ability to work a little more flexibly, albeit in addition to, rather than instead of, their in-person day jobs. Still, Greenhalgh thinks it is unlikely any specialists will be solely working for NHS Online without also doing in-person clinics.

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### What are the drawbacks?

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Continuity of care is a common worry among the experts *The BMJ* spoke to. But there are also teething problems with introducing such a new system.

Workload and backlog issues on waiting lists might initially go backwards rather than forwards, says Pagliari. “Typically, to start with, when you introduce these new systems, you add duplication and you add extra work,” she says.

The fear of “bolting on another separate system” is a worry for Williams. “It’s unclear what the connectivity is at the minute.”

Shaw worries that it could become “another big tech project that hasn’t been particularly well thought through or articulated.”

Chris Stokel-Walker, freelance journalist, Newcastle upon Tyne  
stokel@gmail.com

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**Typically when you introduce systems, you add duplication and you add extra work**  
Claudia Pagliari



## BMJ INVESTIGATION

# Medical warnings fail as industry wins fight for wood burners in new homes

Freedom of information requests show that Scottish ministers abandoned tighter restrictions on new stoves after industry lobbying despite warnings about PM<sub>2.5</sub> air pollution—and England will allow stoves in new developments. **Sophie Borland** investigates

**U**K ministers have abandoned legislation designed to ban wood burners from new homes after warnings from the industry that it would harm the economy, lead to redundancies, and worsen fuel poverty, *The BMJ* can reveal.

The Scottish government had earlier dropped similar proposals after pressure and meetings with the Stove Industry Association (SIA), which claimed that using a stove to heat your home was a “basic human right.”

Freedom of information requests sent to key Whitehall departments also show that ministers in England have avoided a similar ban after the SIA argued that modern stoves offered “significant benefits” that aligned with government goals to reduce carbon emissions and improve air quality.

This is despite concerns raised

by medical royal colleges and the chief medical officer for England, Chris Whitty, that stoves are a major source of air pollution, particularly in cities.

Campaigners tell *The BMJ* that the government is “giving in to polluting business” and ignoring the “pathological health impacts” of wood burning stoves in its pursuit of economic growth.

But the SIA says that a core part of its role is “to engage responsibly and transparently with policymakers to ensure that decisions are informed by technical evidence, industry expertise and data, and an understanding of the potential real world impacts of policy decisions on households and businesses.”



**SIA says a core part of its role is “to engage responsibly and transparently with policymakers”**

*The BMJ*'s revelations come as ministers in England are considering imposing cigarette-style health warnings on new stoves, a measure that campaigners say falls well short of tackling the problem. Domestic burning is a major source of fine particle air pollution, known as PM<sub>2.5</sub>, which is small enough to penetrate deep into the lungs and potentially enter the bloodstream.

Recent figures from the Department for Environment, Food and Rural Affairs (Defra) show that the UK's annual PM<sub>2.5</sub> emissions from wood used as fuel have increased by 50% in 20 years, from 4100 tonnes in 2004 to 6400 tonnes in 2024.

Whitty is particularly concerned about the rising popularity of wood burners in urban areas and has told *The BMJ* that these are contributing “a significant and growing proportion of air pollution” and “in some places reversing many decades

of progress.” A *BMJ* investigation in March found that local authorities had been threatened with legal action by the SIA for running public health campaigns that warned of the health risks of stoves.

### Meetings between industry body and Scottish government

To examine whether the SIA was lobbying ministers against tougher regulation, *The BMJ* sent freedom of information requests to government departments in England and the devolved UK nations.

The Scottish government said it had met with the SIA three times in June and July 2024, just before temporarily dropping a policy banning stoves from new homes that September and then abandoning it altogether in November that year.

Notes taken at one of those meetings show that a director from the trade group spoke of “tales of real woe” resulting from the new legislation, including “redundancy,” a “withdrawal of investment,” and a “knock-on effect on other associated tradesmen.”

The meetings followed a series of press releases from the SIA warning against the ban in April, May, and June 2024, one of which disclosed how it had “lobbied hard on behalf of its members.” It claimed the proposed legislation “further marginalised” Scottish residents in fuel poverty and was causing “severe financial impacts,” and it directly petitioned the Scottish government. The association also argued that modern stoves offered mental health and wellbeing benefits and that “being able to provide heat for your family is a basic human right.”

The SIA told *The BMJ* that it had highlighted “legitimate” concerns with the Scottish government, including how a ban would affect “households who rely on solid fuel stoves as a secondary source of affordable, reliable heat.” It added, “This was a particular consideration for the many homes in Scotland in rural, off-grid settings.”

The quality of the SIA’s work was recognised with a prestigious Trade

## Last winter, particle pollution in Brighton & Hove was 91% higher compared with the summer



A public health campaign from Brighton and Hove City Council

Association award in February 2025, sponsored by the Department for Business and Trade, for “sector representation of the year.” The SIA said applicants had to demonstrate “representative action” on issues of “importance to the future prosperity and growth of its members.”

In England, the SIA coordinated a joint letter to the Department for Business and Trade, the Department for Energy Security and Net Zero, Defra, and the Ministry of Housing, Communities and Local Government in February 2025 to “advocate for the inclusion of modern wood burning stoves in the UK’s energy and environmental policies.”

It claimed the stoves “offer significant benefits that align with the government’s objectives,” including improving air quality and reducing carbon emissions. The letter was cosigned by six other groups in the sector, including the British Flue and Chimney Manufacturers Association and the Small Woods Association.



**The government’s relentless pursuit of economic growth at all costs is seriously threatening the health of millions of people around the country**

Chloe Owen



**Government policy when it comes to the stove industry is completely incoherent and unacceptable**

Jemima Hartshorn

### Government inaction “threatens health of millions” in UK

Jemima Hartshorn, founder of the campaign group Mums for Lungs, which campaigns to end the use of wood burners, told *The BMJ*, “It’s simply shocking that government is giving in to polluting business again. All the health and climate evidence is clear: we need to keep our homes warm without burning. Government policy when it comes to the stove industry is completely incoherent and unacceptable.

“Wood burning is one of the major contributors to particle pollution, and yet the industry has been given an award from the Department for Business while it is promoting stoves that need to be outlawed.”

Chloe Owen, clean air policy manager at the charity Asthma + Lung UK, told *The BMJ*, “With the government’s relentless pursuit of economic growth at all costs, the way that they’re responding to these tactics is seriously threatening the health of millions of people around the country.

“They’re completely ignoring all the pathological health impacts that are underneath all of that. They’re manipulating and playing into the fact that the public has quite a low level of awareness of the harms of wood burning and are not aware of the real impacts that it’s having on their organs and their bodies. It’s just manipulation tactics.”

Although Defra is considering imposing cigarette-style health warnings on new stoves as part of a consultation that closed on 19 March, campaigners say that the measures “fall well short” of protecting the public against the harms from older stoves already installed.

### “Disaster” of wood burners in new homes

On 22 April the Royal College of Physicians’ special adviser on air quality, Stephen Holgate, told MPs that stoves should be banned from new homes. Giving evidence to the Environmental Audit Committee’s inquiry into air pollution, he said,

## We've got this huge building programme in the UK but we don't want every house to have a wood burning stove—that would be a disaster

Stephen Holgate



“There’s no question about the toxicology of wood smoke pollution. It’s a major issue. Very high levels of exposure, over a relatively short period of time, are having major health impacts. The wood stove industry has been a very powerful lobbying group in this whole area.”

Asked whether stoves should be

banned from new homes or stripped out of existing homes, Holgate said, “Let’s start by not putting in new wood burners. That would be a pretty good start. We’ve got this huge building programme which is apparently taking place across the United Kingdom... but we don’t want every house to have a wood burning stove—that would be a disaster.”

The SIA told *The BMJ*, “We believe a blanket ban on wood burning stoves in new homes would risk overlooking the advancements in technology and the long term downward trend in particulate emissions from domestic combustion.” In March, meanwhile, the Ministry of Housing, Communities and Local Government published the long awaited future homes standard that had been due in 2024, and a spokesperson confirmed wood

burning stoves would be permitted in new homes.

This is despite calls from the Royal College of Paediatrics and Child Health for wood burning stoves to be phased out in urban areas, while the Royal College of Physicians of Edinburgh, the Royal College of General Practitioners Scotland, and the Royal College of Paediatrics and Child Health Scotland have urged the Scottish government to reinstate the ban on stoves in new homes.

Sophie Borland, freelance journalist, Hertfordshire [sophie.borland@gmail.com](mailto:sophie.borland@gmail.com)

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Wood burning stoves should be phased out in UK cities, warns leading air pollution expert  
Read the full interview with Stephen Holgate online at [bmj.com](https://www.bmj.com)

## Air pollution: a major killer but a blind spot in medical training

Despite mounting evidence that air pollution affects every organ system, it remains largely absent from training for UK doctors.

An analysis by *The BMJ* has found that a key syllabus used in training almost 14 000 resident doctors a year contains just three mentions of “air quality” and “air pollution” across 2074 pages. All three references are contained in a single chapter on respiratory medicine.

For doctors on the front line of care, the omission from the Federation of the Royal Colleges of Physicians of the UK’s curriculum is striking. Thomas Daniels, a consultant respiratory physician at the University Hospital Southampton, calls this a “failure of the medical profession.”

He says, “Doctors, and healthcare professionals in general, almost never talk about air quality with their patients. And yet we know it’s one of the most important environmental factors affecting health, across a wide spectrum of diseases. That to me feels like a gaping hole in medical practice.”



Daniels warns that the problem is self-perpetuating: “We’re in a vicious cycle whereby the people doing the teaching don’t know what they don’t know, so they don’t teach the new generation coming through.”

Stephen Holgate, the Royal College of Physicians’ (RCP) special adviser on air quality, agrees that the knowledge gap extends across generations. He says that medical students “are not taught about the wider impacts of breathing toxic air,” but older and experienced doctors “are also unaware of its health harms.” He is calling for curriculum reform, as well as a catch-up programme for practising doctors.

## A coroner warned of the dangers of the adverse effects of air pollution after the death of 9 year old Ella Adoo-Kissi-Debrah

After the death of Ella Adoo-Kissi-Debrah—the first person in the UK to have air pollution exposure recognised as a cause of death—the coroner warned that doctors and nurses weren’t doing enough to communicate the “adverse effects of air pollution on health” to patients and carers.

The government has pledged to work with professional bodies, including the RCP, to ensure that doctors have “adequate knowledge” of the health risks of pollution. But the updated curriculum barely touches the issue.

For Nicholas Hopkinson, professor of respiratory medicine at Imperial College London, a change is long overdue. “Healthcare professionals should be advocating about [air pollution], and to do that confidently you need to have a basic, sound understanding of what’s going on.”

A Federation spokesperson said the next round of curricula revisions in 2027 would address air quality as an area of ‘omission,’ and that it was holding a working group later this month.

An RCP report warns that as many as 30 000 deaths a year in the UK can be attributed to air pollution—yet it receives far less attention than other harms.

### Weight of factors

*The BMJ*’s analysis of the federation’s syllabus showed that air pollution was given far less weight than other factors. Air pollution or air quality is mentioned three times in one chapter, whereas “obesity” is mentioned 36 times in eight different sections, “alcohol” appears 35 times in eight sections, and “smoking” is referenced six times in four sections.

## ROLE MODEL

# Cooking for the homeless and dressing up as Santa—the GP putting community at the heart of his work

Phillip Bennett-Richards tells **Halimah Nisa** that those in power have forgotten the importance of the GP-patient relationship

**F**or Phillip Bennett-Richards, a longstanding GP in Tower Hamlets and a GP training programme director, “community is vitally important.”

In recent years he’s spent time cooking for a local homeless shelter and dressing up as Father Christmas for local elderly residents. Bennett-Richards strongly believes that being involved in the local area as a GP is a key part of care continuity.

“Continuity of care is the cornerstone of general practice and the powers that be would do well to remember that. The trust that’s built up over years from continuity of care is really important for patients, practitioners, and the whole community,” Bennett-Richards says. He is well aware of the push towards an instant access model but says that not finding a balance between them “is going to harm overall care.”

Bennett-Richards began working on Tower Hamlets’ Aberfeldy Estate in 2000 with colleague Sarah Pitkanen. They started in a lock-up shop with no heating and poor lighting.

“It was the sort of premises that you wouldn’t have expected in Victorian London, let alone the first year of the 21st century,” he recalls.

Despite the area remaining one of “profound differences between wealth and poverty,” the quality of primary care has substantially improved in the past 25 years, along with education and housing.

Bennett-Richards first moved to Tower Hamlets while training at University College Hospital from 1989 to 1994.

“It’s one of those places where you never think of going to, but when you’ve gone to it, it’s very difficult to leave. For all its faults, it’s a lovely community. It found me. Then, once I decided to be a GP, which came a little later, there was no other place that I would want to work.”

Becoming a GP was not a straightforward process for Bennett-Richards. He joined Middlesex Hospital Medical School in 1981 before leaving in his second year, opting for a degree in toxicology and pharmacology at the School of Pharmacy instead. “I was very idealistic, and it was a tough time.”

“Those times in the early 1980s, with the political and social upheaval, saw a lot of de-industrialisation, which affected my homeland in Wales quite significantly in terms of steel and coal. It just seemed that there was so much going on in the world, I just didn’t think I could carry on with that.”

But he soon regretted his decision. “Almost as soon as I left, I realised that I’d made a bit of a mistake—more than a bit of a mistake—and decided, if I could, I should try and get back into medicine.”

Bennett-Richards returned to study medicine at Middlesex Hospital Medical School, which later merged with University College Hospital, in 1989 and qualified in 1994. “I’m very open in sharing that with student colleagues who are struggling. People need support during that time, and I guess I’m living proof that you can do it.”

“I’ve been incredibly fortunate to have role models along the way that have guided me. I’ve been able to take



**No matter how many professions allied to medicine and AI tools come in, there will still be a need for doctors**

a little bit from each of them when it comes to delivering training,” he says.

But he acknowledges that today’s GP trainees face a tough job market. “It is an increasing stress for those who have been in training for 10 or 12 years to then be worried at the end of the day that they may not have a job.”

“I feel an acute responsibility in being part of that training process and trying to ensure that the opportunities are there for employment at the end. General practice is in a parlous state at the moment, in terms of funding and organisation.”

He says that when it comes down to it, “no matter how many professions allied to medicine and AI tools come in, there will still be a need for doctors to make decisions—for well qualified, well trained doctors to be a part of that process.”

“I think that sense will out in the end.”

Halimah Nisa, freelance journalist, London  
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### NOMINATED BY FARRAH JARRAL



Farrah Jarral, GP, London

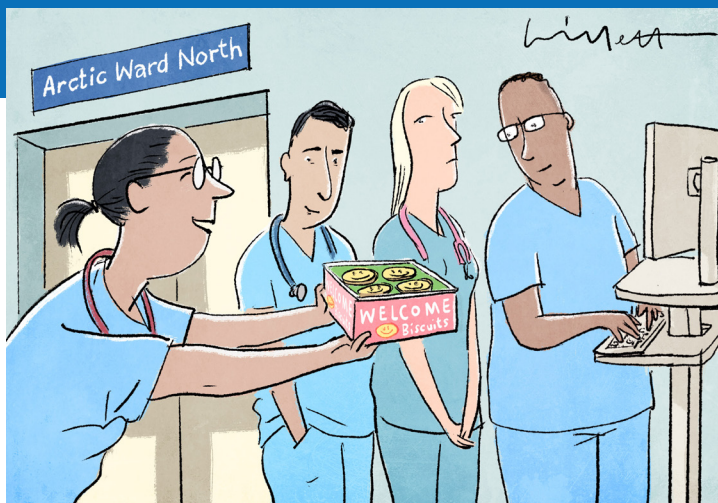
Phil is a longstanding Tower Hamlets GP training programme director and his kindness, competence, and good humour are unparalleled. He was my educational supervisor back in 2008-11, and recently when I was out of clinical practice for more than two years for various reasons I turned to him to help me get back on track. He really is a wonderful human and doctor, and I’ve never met anyone like him.

### 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 [arimmer@bmj.com](mailto:arimmer@bmj.com)

# I feel unwelcome on a new ward—what can I do?

Showing genuine curiosity can help thaw cold first impressions, **Elisabeth Mahase** hears



**Don't jump to conclusions**  
Sara Mirza, GP trainee

“Feeling unwelcome is more common than people admit, but it rarely reflects your ability.

“Firstly, give it a fortnight before drawing conclusions. Cold first impressions often thaw with time and familiarity. That said, it’s worth remembering that the responsibility for a welcoming environment doesn’t lie solely with you. Teams have a duty to include new members, and if a consultant is distant, remember that says more about the culture than your worth.

“Handovers are where invisibility tends to hurt most. If you’re being talked over or sidelined, arriving early and knowing your patients thoroughly helps—a confident, structured presentation signals that you belong in the room. If you’re interrupted, a calm ‘can I just finish the summary?’ is completely reasonable.

“With cold or distant seniors, I’ve found it more effective to engage clinically rather than socially. Ask their view on a tricky management decision or flag an interesting finding. Most people warm up when they see genuine curiosity and a willingness to think out loud about uncertainty.

“What you’re really navigating is psychological safety: the degree to which a team feels safe enough for honest, open contribution. Finding one ally early, such as a fellow doctor, a senior nurse, anyone who can informally introduce you to how the ward works, can change things quickly. Social belonging often spreads through one person first.

“If things don’t improve, try to distinguish between a team that’s simply slow to warm versus one where you’re being actively excluded. The latter warrants a conversation with your educational supervisor.”



**Offer a brew and biscuit**  
Marilena Giannoudi, Royal College of Physicians of Edinburgh (RCPE) trainees and members’ committee co-chair

“Here are some tried and tested steps that I, and my colleague Yu Cheng (Edward) Foo, RCPE foundation observer, can recommend if you’re struggling on a new ward.

“Get to know the team. Start any new rotation with a walkabout of the ward, approaching all colleagues and introducing yourself and your role. Mention that you’re new to the department. Try your best to remember them when you next see them. This goes a long way towards making a positive first impression and might smooth over any hiccups in collaborative working, especially while you’re easing into your role.

“Ask questions. Different wards often have slightly different ways of doing things and it takes time to get to know the nuances of a new work environment. Don’t be shy—ask how the senior members of the team expect the jobs to be completed.

“Manage your own wellbeing and don’t take things personally. In a stressful ward environment, it’s easy to get caught up in politics. Ensure that you continue to undertake your hobbies outside of work.

“Talk to your line manager or your educational or clinical supervisor about what you’re experiencing. Medicine is challenging enough as a profession without lacklustre team dynamics imposing an additional mental toll. Supervisors may be able to let you know about tricky dynamics, suggest adjustments to your work schedule to help mitigate these, or even, where appropriate, facilitate a transfer to a different working environment if the situation becomes untenable.

“Finally, if in doubt, offer cups of tea—it’s amazing what a brew and a biscuit can do to improve team morale.”



**Reflect on what’s driving this feeling**  
Bethan Griffith, consultant acute physician

“What feels like exclusion is often a reflection of system pressures, rather than how you are perceived. Even so, it can affect your confidence and how effectively you work. It’s worth taking a moment to reflect on what’s driving this feeling. Is it, for example, a lack of introductions, uncertainty about expectations, or difficulty accessing seniors? Being specific helps. Not every team will feel like a natural fit, but this doesn’t mean you’re unwelcome.

“Small practical steps can help. If you’re unsure about where to start, introduce yourself; be clear about your role; be approachable and accessible; and ask how the team usually works. Simple questions such as, ‘How would you like me to help today?’ can reset the dynamic.

“Joining board rounds and contributing briefly can make you more visible and help colleagues learn your name. Conversely, learning names or small details about colleagues can also help. These interactions often shift a team from transactional to supportive. Focusing on shared goals, particularly patient care, can create common ground.

“If things don’t improve, speak to someone sooner rather than later. That might be a consultant, your supervisor, the nurse in charge, or an experienced trainee. Framing it around wanting to work well within the team is more effective than focusing on what’s gone wrong.

“If you continue to feel excluded despite reasonable efforts, it’s appropriate to escalate.”

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