Children aged 12-15 who are at increased risk of serious illness from infection with covid will be offered the Pfizer vaccine, the UK’s Joint Committee on Vaccination and Immunisation has announced.

This will include children with severe neurodisabilities and those with underlying conditions that result in immunosuppression. The committee also recommended that children aged 12-17 who live with an immunosuppressed person be offered the vaccine. The vaccine is not being recommended to children outside these groups as the committee concluded that the “health benefits in this population are small, and the benefits to the wider population are highly uncertain.”

Extremely rare cases of myocarditis and pericarditis have been reported in millions of younger adults given either the Pfizer jab (the only vaccine authorised in the UK for children aged 12 and over) or Moderna’s. Penelope Toff, co-chair of the BMA’s Public Health Medicine Committee, expressed concern that adolescents living in multigenerational households, particularly in more deprived areas, had been excluded. She said it was “vital” they be considered.

Covid-19 restrictions in England were eased on 19 July despite new cases rising to 50,000 a day and experts warning that around half a million people could develop long covid during this wave of infections. Other countries—including many in the EU, as well as Singapore, Japan, the UAE, the US, Canada, and the Philippines—all offer children aged 12 and over a vaccine.

Penny Ward, visiting professor in pharmaceutical medicine at King’s College London, said she was confused by the conditions considered to put children at risk, as many listed for 16-18 year olds were not in the younger list. She said, “No clear explanation is given, and as a consequence one might imagine lengthy discussions between parents of children with brittle diabetes and renal disease and their GP.”

When asked at a Science Media Centre briefing about long covid in children, JCVI member Adam Finn said the evidence indicated the “likelihood of long lasting symptoms in children having had the infection beyond one to two months is extremely low.” However, a study of 129 children infected with the virus found that, while only six were admitted to hospital, half still reported at least one covid-19 symptom six months after infection.

In Indonesia all children over the age of 12 are able to get a covid vaccine, whereas in the UK only certain clinically vulnerable children will be offered the Pfizer jab.

**LATEST ONLINE**
- Experts condemn UK “freedom day” as dangerous and unethical
- Indonesia becomes Asia’s new pandemic epicentre as delta variant spreads
- Ethnic minority doctors earn 7% less than white colleagues, report finds
Seven Days In

Fiona Godlee to step down as The BMJ’s editor in chief

Fiona Godlee is to resign as editor in chief of The BMJ at the end of the year, after more than 16 years in the role and the first woman to lead the journal since its inception in 1840.

Under her editorship The BMJ has become one of the world’s most influential and most widely read medical journals. Its impact factor, a measure of the importance or rank of a journal, has risen from 7 in 2005 to 39.8 today, and in the past five years worldwide usage on bmj.com has grown from around a million unique users a month to nearly six million.

The BMJ has also become an investigative campaigner highlighting issues such as research fraud and misconduct, harms of excess medical treatment, and climate change. Godlee also championed the involvement of patients in research and healthcare.

Her work during the pandemic was recognised last week when she was named editor of the year by the Association of British Science Writers. The judges said, “There was nothing more that anyone could ask for the title of editor of the year: vision, creativity, leadership, execution, and impact.”

Godlee said, “The BMJ is heading into a new and exciting phase of its development, so it’s the right time for new leadership. Hard though it is to give up something you love, I’ll be leaving the journal in excellent hands. I look forward to exploring new opportunities.”

Zosia Kmietowicz, The BMJ Cite this as: BMJ 2021;374:n1819

Covid-19

Face coverings will continue in healthcare

Anyone accessing or visiting an NHS hospital or any other healthcare setting must continue to wear a face covering and follow social distancing rules, despite national covid restrictions ending on 19 July, said NHS England. Ruth May, chief nursing officer for England, said that continued adherence was vital “so the most vulnerable people can continue safely to attend hospital, their GP surgery, pharmacy, or any other healthcare settings.”

Colleges urge pregnant women to get vaccinated

The Royal Colleges of Obstetricians and Gynaecologists and Midwives have urged the 58% of pregnant women who have not yet been vaccinated to consider getting the vaccine as soon as possible. Pregnant women are at risk of becoming severely ill with covid-19, particularly in their third trimester. More than 100 pregnant women have been admitted to hospital with covid in each of the past two weeks, and one in 10 has needed intensive care. Infection can also increase the risk of premature birth, pre-eclampsia, emergency caesarean, and stillbirth, although the increases remain low.

Vaccine centres at 30% capacity as demand falls

Vaccination centres are working at 30% capacity because many young adults feel “invincible” and believe that they don’t need the vaccine to protect themselves, said Pippa Nightingale, chief nursing officer at Chelsea and Westminster NHS Trust, at a meeting of NHS North West London’s joint health overview and scrutiny committee on 14 July. On 17 July 58% of England’s 18 to 24 year olds had had a first dose and 17% a second dose, but uptake varied across the country. A total of 755 148 first doses were given to people of all ages in the most recent week, down from 1 173 949 a week earlier.

Healthcare staff in France and Greece must get vaccine

France’s president, Emmanuel Macron (below), announced that anyone who comes into contact with vulnerable people, including doctors, nurses, office staff, and volunteers, must be fully vaccinated by 15 September or risk not being paid. In Greece, nursing home staff have been told to get vaccinated immediately, while healthcare workers must be vaccinated from 1 September. Both countries follow Italy, which made vaccination mandatory for healthcare workers in April.

#NotTooMuchToMask campaign is launched

A new UK campaign #NotTooMuchToMask was launched to encourage people to keep protecting themselves and each other from covid, at a time when cases and hospital admissions are rising. Led by the NHS Confederation, the campaign is supported by the BMA, the Academy of Royal Medical Colleges, the Patients Association, cancer charities, Unison, and other membership bodies. It asks people to continue to wear face coverings, keep indoor spaces well ventilated and meet outdoors where possible, clean hands regularly, get tested and isolate as required, and get vaccinated.

Flu vaccination

Expanded programme will reach 35 million people

The flu vaccine will be offered to more than 35 million people from September, including all secondary school pupils up to year 11 for the first time. Officials fear higher levels of flu this winter, with more people susceptible because of low levels last season as a result of mask wearing, physical distancing, and restricted international travel. Last year 80.9% of people aged over 65 in England received their flu vaccine, exceeding the World Health Organization’s target of 75%.

International aid

UK cuts could “cause up to 100 000 deaths”

On 12 July the government won a vote to cut £4bn in international aid, dropping from 0.7% to 0.5% of gross national income, despite 25 Tory MPs voting against. The cut, which chancellor Rishi Sunak said would be restored once public finances allowed, could deny nearly three million women and children lifesaving nutrition, block access of 7.6 million women and girls to family planning and contraception, and leave 5.6 million children unvaccinated, which charities warned could cause as many as 100 000 deaths.
Liver disease
Alcohol consumption and deaths rose in lockdown
Data from Public Health England showed that over 12.6 million more litres of alcohol were sold in 2020-21 than the year before, a 24.4% rise, despite pubs being closed. Nearly 60% of respondents said they were drinking more and at riskier levels in March 2021 than in March 2020, and alcohol specific deaths increased by 20% to 6983 in 2020, up from 5819 in 2019. A third of all alcohol specific deaths occurred in the most deprived 20% areas in England, with the biggest rise in the north east.

Norovirus
Public advice issued as vomiting virus cases treble
Public Health England reminded the public of how to reduce the spread of norovirus after 154 outbreaks were reported from 31 May to 5 July 2021, up from an average of 53 outbreaks reported over the same period in the previous five years. It advised that anyone with sudden nausea, projectile vomiting, high temperature, abdominal pain, or aching limbs should stay at home for 48 hours after their symptoms have cleared, wash their hands frequently with soap and water, disinfect contaminated surfaces, avoid cooking for other people, and wash any contaminated clothing or bedding at 60°C.

Intubation
Coroner’s capnography in cardiac arrest warning
The Royal College of Anaesthetists and the Difficult Airway Society reminded doctors to monitor exhaled carbon dioxide (capnography) in patients with cardiac arrest, after the coroner in the case of Glenda Logsdail issued a prevention of future deaths notice. Logsdail died last August at Milton Keynes Hospital after an anaesthetist mistakenly inserted a breathing tube into her stomach instead of her lungs and believed that she was having an allergic reaction. A video to accompany the college’s campaign, “Capnography: No trace = wrong place,” can be seen at bit.ly/3ibblLT.

Workforce
Investment is needed despite new numbers plan
The government has asked Health Education England to produce new plans for the staff numbers needed to run the NHS and social care over the next 15 years. Danny Mortimer, of NHS Employers and the NHS Confederation, said that the announcement should not obscure the urgent need for decisive investment to tackle chronic staffing problems in the NHS and social care. He called for more clarity on the effect on staffing of more medical schools, the target to recruit 38 000 more nurses, and the increased uptake of undergraduate education.

FAKE NEWS
Much covid antivaccine misinformation stems from just 12 people who have a combined following of 59 million social media users
[Center for Countering Digital Hate] Cite this as: BMJ 2021;374:n1821

SIXTY SECONDS ON… THE PINGDEMICC

TOO MUCH PING PONG?
No, this isn’t about a boom in lockdown hobbies. We’re talking about the rise in the number of people who have been “pinged” and told to self-isolate by the NHS Test and Trace app.

IT’S BOUNCED UP?
You could say that. Between 1 and 7 July 520 194 people in England received an alert telling them to self-isolate for 10 days. A further 9932 received the alert in Wales.

PINGING HELL!
Yes, it’s a lot. In fact, it’s the highest number recorded since January. The previous week, 24 to 30 June, 356 677 people in England and 6959 in Wales received an alert.

IN ISOLATION, IS THIS A PROBLEM?
Unfortunately, yes. The sheer number of people isolating is having an effect on a range of industries, including manufacturing and hospitality. Nick Allen, of the British Meat Processors Association, for example, said some companies might have to “start shutting down production lines.”

WHAT ABOUT HEALTH WORKERS?
Until recently, staff could pause the app while at work, but if they were pinged after meeting someone with the virus outside work they still had to self-isolate. Chris Hopson, NHS Providers’ chief executive, said one trust had lost 500 staff to self-isolation.

WHAT’S APPENED NOW?
On 19 July ministers announced that doubly vaccinated frontline staff could avoid self-isolation, with their employer’s agreement, if they had a negative PCR test and daily negative rapid tests for at least seven days.

FREEDOM!
Not quite, staff will still be under a legal duty to self-isolate when not in work and will receive self-isolation reminders. They can work because they are considered to have a “reasonable excuse” under the self-isolation regulations—where their absence from work could result in harm.

CAN’T WE ALL STOP SELF-ISOLATING?
No, that would be ignoring the science. Simon Clarke, associate professor in cellular microbiology at Reading University, warned, “Self-isolation is one of the most effective tools we have to prevent spread.”

Abi Rimmer, The BMJ
Cite this as: BMJ 2021;374:n1822
NHS could be at “breaking point this winter”

Outbreaks of respiratory syncytial virus this autumn and flu in the winter could be around twice the magnitude of a normal year and may overlap with another peak in covid infections, the Academy of Medical Sciences has warned.

Modelling by 29 experts and 57 members of the public brought together at the request of the chief scientific adviser, Patrick Vallance, predicts a peak of covid cases this summer. It shows that although the timing and magnitude of the peak are uncertain and mortality may be less severe than last winter, the rise in infections will put pressure on the health service. Also, more infections increase the possibility of new, more dangerous variants.

The group highlighted that easing of restrictions over recent months had led to a summer surge of infections typically seen in the winter, such as RSV, bronchiolitis, parainfluenza, and rhinovirus.

Respiratory infections can “act synergistically,” with interactions between SARS-CoV-2 and other viruses increasing disease severity, the group’s report said.

“Early data suggest influenza A leads to an increased susceptibility to SARS-CoV-2 and more severe disease. The wider circulation of other respiratory viruses will apply selection pressures on SARS-CoV-2 and could lead to the emergence of new variants of concern.”

As well as speeding up covid vaccination the report recommends boosting the capacity of staff and beds, increasing testing for covid and flu, and adequately resourcing primary care.

Cite this as: BMJ 2021;374:n1802

General practices criticise being left out of covid booster plan

Doctors’ leaders have criticised a decision not to allow individual general practices to organise and administer covid booster vaccinations this autumn, saying GPs are being ignored.

In a letter about changes to the enhanced service package for the third phase of the vaccination programme, detailing the arrangements for the boosters to be delivered from September, NHS England said that “for a number of reasons” it would not be “operationally feasible” to support the administration of the booster vaccines at individual practices.

The reasons it gave included the supply chain being unable to support deliveries to all practice sites and vaccine characteristics potentially needing “at-scale working.”

The letter concluded, “For these reasons, practices that wish to participate in the booster programme will need to do so as part of a primary care network (PCN) grouping.”

Self-isolation waived for vaccinated NHS staff

NHS and care staff in England who have been told to self-isolate will be permitted to attend work in “exceptional circumstances” if they are fully vaccinated and return a negative PCR test, the government has announced.

The measure is being introduced to alleviate pressure on services after a sharp rise in self-isolating staff. The change in policy covers staff who have been contacted as a close contact of a case of covid by NHS Test and Trace or who have been advised to self-isolate by the NHS covid-19 app.

To qualify, staff must have received two doses of vaccine and a negative PCR test and to have had daily negative lateral flow test results for a minimum of seven and maximum of 10 days, the Department of Health said. Staff should not work with clinically extremely vulnerable patients, as determined by their employer.

The waiver should apply only where a staff absence may lead to a “significant risk of harm,” and careful consideration should be given to the risk of onward transmission versus the risk to the delivery of critical services, the department said.

Case-by-case basis

Decisions should be made “on a case-by-case basis, and only after a risk assessment by the organisation’s management,” it added. Each case must be authorised by the local director of infection prevention and control, the lead professional for health protection, or the local director of public health.

The health secretary, Sajid Javid, said, “The government has backed healthcare services at every turn through this global pandemic, and these new rules will fortify our collective defences, by allowing fully vaccinated frontline NHS and social care staff to continue to work when needed.” Staff who are permitted to work in these circumstances will remain under a legal duty to self-isolate as a close contact when they are not at work.

NHS Providers’ deputy chief executive, Saffron Cordery, said trust leaders welcomed the “pragmatic” measures. “The mitigations outlined will help trusts do everything they can to protect patients and staff from acquiring covid-19 while allowing them to deliver vital NHS services,” she said.

But Danny Mortimer, chief executive of NHS Employers, said, “On the one hand [trusts] are worried about their capacity to support patients, particularly given that many staff will be away for parts of summer as they take overdue annual leave; but on the other hand the last thing they would want to do is expose their patients and colleagues to an increased risk of catching the virus,” he said.

Cite this as: BMJ 2021;374:n1830

24-31 July 2021 | thebmj
patients confidence they can get their booster through their local surgery—especially if this can be done at the same time as flu jabs. Doctors and their teams should be given support and flexibility to take part in a way that works best for their patients.

“It’s frustrating to see NHS England once again disregard the voice of hardworking GPs—specifically by not doing more to enable all practices to give vaccinations from within their own premises if that’s what they wish to do.

“If they were able to do so, it could limit the impact of the booster campaign on other important GP services. It would also mean GPs and their teams could offer opportunistic vaccinations to patients attending with other illnesses.”

NHS England has emphasised that GPs can be involved and that practices have until 28 July to notify their clinical commissioning group of their willingness to participate in phase three of the campaign. The letter also explained that under the new arrangements the lead practice for a PCN grouping would receive £12.58 a dose given, with a £10 supplement for jabs given in other settings such as care homes or to housebound patients.

Vautrey told The BMJ, “The flu vaccine campaign is part of our business as usual. It’s what we do every year, and practices factor in their staffing and working arrangements around all the other commitments.” There was likely to be a better uptake of flu and covid booster vaccinations if they were both provided at practices, he argued.

Despite the fact that it had not yet been confirmed that it was safe to administer a flu and a covid vaccination at the same time, Vautrey said, “I hope and expect that the outcome of ongoing trials will be that co-administration will be possible.”

THE LETTER also explained that the lead practice for a PCN grouping would receive £12.58 a dose given, with a £10 supplement for other settings such as care homes, or to housebound patients.

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**Burnout is damaging our health and patient care, GPs warn**

High levels of stress are severely harming the health of GPs and their ability to provide care for their patients, doctors have told MPs.

In a parliamentary briefing on 15 July representatives from the Doctors’ Association UK and the campaigning group GP Survival said a crisis of “unprecedented scale” in primary care needed urgent attention.

John Hughes, a retired GP who now chairs GP Survival, said the pressure on practices had intensified because GP numbers had not increased in line with surging demand, and ministers’ pledges to boost GP numbers had not been delivered. Constrained funding relative to the hospital sector, negative media coverage, and high levels of bureaucracy necessitated by the NHS and regulators had also contributed to GPs feeling burnt out, he added.

“GPs are leaving at a rate of three per day. There’s a major exodus from the profession,” Hughes said. “Over 20% more GPs are reporting burnout than a year ago, and GP suicide rates are up to four times the national average.”

“We really do have a profession in crisis,” he concluded.

Louise Hyde, a GP in Powys in Wales, told the briefing how she had stepped down as a GP partner at the end of 2019 because of the “pressurised, very intense” workload, which had seriously affected her health. “I was irritable, I couldn’t stop thinking about work, I was miserable with the children . . . and I started to feel quite guilty. Eventually I started to have suicidal thoughts and nasty mental images of harm happening to me, and I sought help from my GP,” she said.

Hyde said her practice was able to draw on the work of an experienced locum GP, which allowed her to take a step back. “I had two months off, I came back on a phased return, and I realised that the workload was so intense that I was going to struggle to manage to achieve work-life balance as a partner.”

Shan Hussain, a GP in Nottingham, said that investing in prevention, developing a positive vision for general practice, and tackling the bureaucracy in general practice were all factors that could help to reduce pressure on GPs.

**Seeking help**

Clare Gerada, a GP and medical director of the NHS Practitioner Health service, said the programme had seen a “staggering increase” in doctors seeking help over the past 12 months, with GPs still the largest in number, at 1995.

“We have to address the workload,” Gerada told The BMJ. “We can’t have 12-15 hour days. We need an equivalent to SAGE to look at what we do about the GP workforce and demand crisis. It should be chaired by a primary care physician [and] involve patient groups and perhaps the NHS Assembly.”

Gareth Iacobucci, The BMJ

Cite this as: BMJ 2021;374:n1823
BRIEFING

What changes do health leaders want to see to the health and care bill?

With the bill passing its second reading in the House of Commons, and the BMA saying it won’t support it, Gareth Iacobucci looks at the proposals and the reactions of critics and supporters.

What is the purpose of the bill?
The legislation has two major aims. The first is to remove legal barriers to integrating healthcare in England by ending the internal market and reversing most of former health secretary Andrew Lansley’s controversial Health and Social Care Act 2012.

The second is to shift substantial powers away from the NHS and back to the secretary of state for health and social care, giving Sajid Javid, and future health secretaries, more power to intervene in the running of the NHS and in local decisions.

What does the bill say on competition?
Legal requirements introduced in the 2012 act to promote competition and competitively tender some clinical services will be revoked. The rationale is that this approach led to a fragmented and at times wasteful delivery of services, with organisations finding it difficult to cooperate and join up services across the system and spending a lot of money on bidding for contracts.

This change was requested by the leadership of NHS England and has now been backed by the government.

How will the structure of the NHS change?
The 106 GP led clinical commissioning groups that were established (originally as 211 bodies) under Lansley’s act to coordinate local services will be abolished next April. In their place will be larger integrated care systems, which already exist in non-statutory form in 42 geographical areas. ICSs will be tasked with coordinating and planning care across a local area, with the aim of improving population health. Each ICS will comprise two new bodies: an integrated care board, responsible for controlling most NHS resources; and an integrated care partnership, less formal collaborations between the NHS, local authorities, and other agencies that will develop plans to guide local decision making. The ICSs have been heavily backed by NHS England’s departing chief executive, Simon Stevens.

What new powers does the bill give to the secretary of state?
It reverses much of the operational independence of NHS England that was enshrined in Lansley’s act. It gives the health secretary substantial new powers to direct the operational running of NHS England, to intervene early in local decisions on service reconfiguration, and to direct decisions in areas such as service procurement, funding of new drugs, and senior leadership appointments.

The bill would also allow the health secretary to abolish professional regulators and NHS arm’s length bodies without needing additional parliamentary legislation. This huge shift of power towards Whitehall was not requested by NHS England and is a source of concern among health and care leaders.

What are their concerns?
Giving politicians more control over the detail of how the health service runs may lead to worse decisions

Nigel Edwards

Richard Murray of the King’s Fund says the bill risks distracting from important reforms concerning integration, while Jennifer Dixon of the Health Foundation argues that there is “no clear rationale” for the move.

In a joint statement the NHS Confederation, NHS Providers, and the Local Government Association warned that handing more power to Whitehall could “undermine the ability of ICSs to meet their statutory responsibilities to ensure services are safe and financial targets are met.”

What else have critics said about the bill?
The lack of action on workforce issues is also a big concern. The BMA passed a resolution last week formally calling for the bill to be rejected, arguing that it carries “significant risks” and fails to tackle the major problems the NHS is currently facing, most notably the covid-19 pandemic, workforce shortages, and the extensive backlog of care.

In a joint letter to the Times the leaders of several medical royal colleges, the BMA, the NHS Confederation, charities, and think tanks said that absence of provision for long term workforce planning was a “glaring omission” from the bill.

The Royal College of Physicians supports integration but said the bill’s inclusion of a new duty for the health secretary to publish a report “describing the system in place for assessing and meeting the workforce needs of the health service in England” once every five years fell short of what was needed in terms of workforce planning.

Longstanding lack of a transparent, costed, and funded long term workforce plan must be tackled

Saffron Cordery

Saffron Cordery
Drug companies fined more than £260m for overcharging NHS

The Competition and Markets Authority has fined drug companies more than £260m for inflating the price of hydrocortisone tablets by more than 10,000%.

The price the NHS paid for a single pack of 10 mg hydrocortisone tablets rose from 70p in April 2008 to £88 by March 2016, the CMA said. The 20 mg version rose from £1.07 to £102.74 a pack over the same period.

The CMA also found that potential rivals had been paid not to enter the market and preserve the companies’ ability to increase prices. The firm Auden Mckenzie paid off—would-be competitors AMCo (now known as Advanz Pharma) and Waymade. Actavis UK continued paying off AMCo after taking over sales of the pills in 2015.

From 2008 to 2015 hydrocortisone tablets were sold by Auden Mckenzie. Actavis UK (now known as Accord-UK) took over the business in 2015 and is held liable for Auden Mckenzie’s conduct before that date.

The CMA has fined Accord-UK—and, for their ownership periods, its parent companies Intas and Accord Healthcare and former parent firm Allergan—£155m for charging the NHS excessive and unfair prices for almost 10 years, from 2008 to 2018. Accord-UK and Allergan were also fined a further £66m for paying two would-be competitors to stay out of the market. Those two companies, Advanz Pharma and Waymade, were fined £43m and £2.5m, respectively.

As well as imposing substantial fines, the CMA said its decision meant that the NHS would be able to seek damages for the firms’ ‘behaviour, should it choose to do so. The authority’s chief executive, Andrea Coscelli, said the abuses were some of the most serious it had uncovered in recent years.

“Auden Mckenzie’s decision to raise prices for debranded drugs meant the NHS had no choice but to pay huge sums of taxpayers’ money for lifesaving medicines,” she said. “In practice, the NHS was at one point being charged over £80 for a pack of tablets that had previously cost less than £1.

“These were egregious breaches of the law that artificially inflated the costs faced by the NHS, reducing the money available for patient care. Our fine serves as a warning to any other drug firm planning to exploit the NHS.”

An Accord Healthcare spokesperson said it was disappointed by the CMA’s decision and would appeal. “Having only inherited the product in January 2017, we have done nothing but continuously reduce the price in the face of significant competition,” they said, adding that the company does not and has never owned Auden Mckenzie.

Abi Rimmer, The BMJ

Cite this as: BMJ 2021;374:n1809

IN 2018-19

7.3% of the health budget was spent on private providers, up from 5.5% in 2012-13

What about the role of the private sector?

The BMA supports the removal of enforced competition but said the bill would permit the awarding of contracts “without scrutiny” to private providers, as has been seen with the procurement of personal protective equipment for the pandemic and the £37bn spent on the test and trace system. It also warned the legislation leaves open the possibility of private health providers having a seat on ICS boards and being able to influence commissioning decisions, which it said “must be ruled out.”

The shadow health secretary, Jonathan Ashworth, also raised concern about a “new wave of lucrative crony contracts handed to the private sector.” The campaigning group Keep our NHS Public is opposed to the bill on similar grounds.

Wasn’t privatisation a big fear with the Lansley reorganisation?

It was. In 2014 The BMJ found evidence of a big increase in the number of contracts being awarded to private firms after the 2012 act, although this didn’t translate into significantly increased spending, as many contracts were of small value. In 2018-19 7.3% of the health budget was spent on private providers, up from 5.5% in 2012-13.

But isn’t the new bill un picking the 2012 act?

It is, but that hasn’t stopped similar accusations of privatisation being made. Whether they have credence is likely to come down to your ideological viewpoint and the intent you ascribe to the bill’s wording.

Critics believe the government is paving the way for the continuing advancement of commercial interests into the NHS and that the bill will allow private companies not only to secure new contracts but also to hold onto existing ones regardless of past performance. But others say the legislation does not suggest this and that privatisation is a long way down the list of concerns about the bill.

What amendments are healthcare leaders calling for?

The BMA said the bill would require “significant amendment” to gain its support. Specifically, it is calling for “genuine and transparent protections” against increased involvement of the private sector in the NHS, embedding clinical leadership throughout ICSs, dealing with the “power grab” by the secretary of state, and ensuring political responsibility for staffing levels.

In their Times letter the coalition of national leaders urged the government to amend the bill so that England has “robust, independent projections of the health and social care staff the country will need, to help make shortages a thing of the past.” Saffron Cordery, deputy chief executive of NHS Providers, said the bill “will create a situation which is counterproductive to our workforce plan” must be tackled.

In addition to backing the call for workforce projections, the Royal College of Physicians has also called for the bill to make it mandatory for ICSs to ensure that NHS organisations for which they are responsible conduct and resource clinical research.

Gareth Iacobucci, The BMJ

Cite this as: BMJ 2021;374:n1800

EDITORIAL, p 136

What amendments are healthcare leaders calling for?

The BMA highlighted the threat to patient care and NHS stability posed by the Lansley bill

Abi Rimmer, The BMJ

Cite this as: BMJ 2021;374:n1809

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As well as imposing substantial fines, the CMA said its decision meant that the NHS would be able to seek damages for the firms’ ‘behaviour, should it choose to do so. The authority’s chief executive, Andrea Coscelli, said the abuses were some of the most serious it had uncovered in recent years.

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Abi Rimmer, The BMJ

Cite this as: BMJ 2021;374:n1809
THE BIG PICTURE

Danse macabre on “freedom day”

Clubbers at London’s Piano Works mark the lifting of most remaining covid restrictions in England on 19 July. The nightclub was one of many venues across the country that opened for the first time since March 2020.

The UK is forecast to soon have more new SARS-CoV-2 infections a day than it did at the height of the second wave. As clubs opened on Sunday night 48 161 new cases were recorded. Because 68% of UK adults are fully vaccinated the case rates have not led to the numbers of deaths seen in January, but less than 25% of under-30s have had both doses of vaccine.

The devolved governments in Scotland, Wales, and Northern Ireland have taken a more cautious approach. All have retained mandatory public mask wearing and distancing rules, and Wales and Northern Ireland still restrict how many people can meet indoors and out.

Alison Shepherd, The BMJ
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England’s new health and care bill
The health secretary’s gains sweeping new powers, with unclear consequences for patients

The NHS in England is about to be reorganised (again). On 6 July, the UK government published the Health and Care Bill 2021-22,1 which details plans for changes to NHS rules and structures in England. The bill spans 224 pages and, broadly speaking, it is a story of two halves.

The first half is a set of changes to promote collaboration in the health system. Under these plans, every part of England will be covered by an integrated care system. These currently exist informally in 42 areas, serving populations of around one to three million. Each system will be made up of two new bodies: an integrated care board (area based NHS agencies responsible for controlling most NHS resources to improve health and care for their local population) and an integrated care partnership (looser collaborations between NHS, local government, and other agencies, responsible for developing an integrated care plan to guide local decisions). Clinical commissioning groups will be abolished and replaced by the new integrated care boards. Existing requirements to competitively tender some clinical services will be scrapped.2

Encouraging collaboration to improve services makes sense—and goes with the grain of recent NHS policy.3 But the potential benefits of greater collaboration—both in the NHS and between health care and wider services—are often overstated.4 5 And reorganising NHS agencies can distract and disrupt.6 11 This is particularly concerning given the enormous pressures currently facing NHS services.2 13

The pandemic response is hardly an advert for closer political involvement in the health system

The new structure also risks being complex and vague. The relationship between NHS providers and integrated care boards is unclear. Integrated care partnerships seem to play a bit part role and risk being sidelined by more powerful NHS agencies. This would undermine the bill’s aims for better integration of services beyond the NHS and limit the ability of local systems to tackle social and economic factors that shape health.

Centralising control
The second half of the story is a set of changes to strengthen the health secretary’s control over the daily running of the NHS in England. These changes lack rationale and warrant scrutiny. The bill gives wide ranging new powers to the health secretary. These include powers to direct NHS England (the national agency responsible for overseeing NHS planning and budgets) in relation to almost all its functions. They also include powers to intervene at any stage in service reconfigurations, such as decisions about merging or closing hospitals. NHS leaders must notify the health secretary about proposals to reconfigure services.

And the health secretary will be able to “retake” decisions already made by NHS leaders, as well as direct them to consider new service changes.

How these changes will benefit patients is unclear—and they might make things worse. Decisions about service changes are complex, and evidence to inform them is often limited and disputed.16 17 Government should be careful what it wishes for; in the words of Rudolf Klein, “centralising power means centralising blame.”18 Accountability will always rise upwards to politicians in a tax funded health system. But these changes seem to be more about control. And the pandemic response is hardly an advert for closer political involvement in the health system.

Greater central intervention might also undermine the bill’s focus on giving power to local leaders to improve population health.

Who is the author of this legislation anyway? The first half of the story is the legacy of Simon Stevens, the outgoing boss of NHS England. The second half belongs to Matt Hancock, the previous health secretary. But come the end of July 2021, neither will be in post. Reports suggest that Sajid Javid, the new health secretary, wanted to delay introducing the bill to parliament because of “significant areas of contention”—only to be over-ruled by the prime minister.20

Javid has a long list of priorities as the country “learns to live” with covid-19, including tackling the backlog of unmet health needs, dealing with staff shortages, reducing vast health inequalities, and reforming England’s broken social care system.19 The bill will do little to tackle these fundamental challenges and risks distracting the NHS as it tries to recover from the biggest shock in its history.

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EDITORIAL

Ethnic disadvantage in training and regulation

The GMC must move faster to fix this serious and longstanding problem

The wheels of regulatory reform turn very slowly. On 18 May 2021 the UK’s General Medical Council (GMC) set targets for eliminating disproportionate complaints from employers about ethnic minority doctors and eradicating disadvantage and discrimination in medical education and training. The targets specify that the GMC will achieve the first by 2026 and the second by 2031.

Ethnic minority doctors are twice as likely as white doctors to be referred to the GMC by their employer for fitness to practise concerns and that the referral rate for doctors qualifying outside the UK is three times higher than that for UK doctors. In education and training, pass rates for postgraduate exams reflect a 12% difference between white and ethnic minority doctors who trained in the UK, rising to more than 30% for overseas graduates.

Concerns about fairness in referrals to the GMC were first raised in 1994. After initially denying the problem, the GMC published a series of reports over a period of 23 years that identified where the problems occurred—an excess of complaints initiated by employers. Problems relating to differential attainment in education and training have also been evident for years.

The stress and anxiety caused by referral to the GMC cannot be underestimated, as evidenced by the case of Sridharan Suresh, who took his life in 2018 after being referred. It took a further 23 years of research for it to identify that the problem was in fact disparities in referrals by employers—not patients.

Discrimination perpetuated

Extraordinary tolerance of inequalities in attainment is an indictment not only of the GMC but of the many royal colleges, which perpetuate a system of examinations that systematically disadvantages doctors because of their ethnicity. In the presence of such discrimination, many ethnic minority doctors can be forgiven for concluding that they are disadvantaged because of the colour of their skin or their accent. Relying on the courts to resolve these issues simply encourages an adaptive submission to continuing exploitation while affected doctors wait for some form of judicial remedy.

The creation of an independent Medical Practitioners Tribunal Service to adjudicate on whether doctors are fit to practise is modest progress. The GMC still retains the power to investigate complaints against doctors and should be working with the NHS to ensure that local processes and resolution are used whenever possible to reduce referrals. One solution could be an independent body that investigates complaints against doctors fairly and ensures that local processes and resolution are used before resorting to a GMC referral.

Finally, repeated workplace assessments are increasingly used to assess doctors’ performance. As a longitudinal form of assessment these should be more transparent and open to scrutiny than isolated off-site clinical exams done behind closed doors. Although more work needs to be done on workplace assessments, they may be a fairer way of assessing postgraduate doctors seeking specialist accreditation.

While the GMC could be congratulated for admitting discrimination and setting elimination targets, a commitment to resolving this longstanding problem within 10 years will strike many as unacceptably slow. If a regulator with parliamentary authority to maintain professional standards systematically disadvantages a group of doctors simply because they are not white, it is not fit for purpose.

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Eating disorders during the covid-19 pandemic

Spikes among children and adults seeking treatment may indicate rising global prevalence. New models of virtual care could help, finds Jane Feinmann

The story often starts in a positive way. “At a consultation, kids tell us that when the pandemic started, they decided to eat healthier and begin exercising more,” said Ellen Rome, head of adolescent medicine at Cleveland Clinic, Ohio.

That positive start is the prelude to a tragic turn, however. “Then an adult will pick up the story and say, ‘The next thing we knew, she’d lost 10 kg’,” said Rome. “Other kids tell us that without a schedule they started eating when they were stressed or bored and ‘suddenly the weight balloons.’”

Rome was speaking at the International Conference on Eating Disorders in June. There were first-hand accounts of the problems faced by severely ill patients during the pandemic, with the closure or restriction of in-patient services being a major factor.

Carolyn, the Canadian mother of an adult with anorexia who relapsed in late 2019, described how she drove her daughter to the local emergency department more than 10 times during the pandemic. “Each time, they discharged her as soon as she was stabilised,” Carolyn told the conference, explaining that her daughter’s relapse was continuing.

And while much media coverage has come from Europe and North America, the pandemic has shown that in fact disordered eating is a global epidemic.

“The belief that eating disorders are confined to high income countries is a dangerous myth that perpetuates health disparities,” says Cynthia Bulik, professor of eating disorders at the University of North Carolina. The picture is skewed, with the available literature originating from only a few affected countries, Ravi Rajkumar of the Jawaharlal Institute of Postgraduate Medical Education and Research in Pondicherry, India, told the conference.

In fact, children in many countries have developed eating disorders during the pandemic. “Uncontrolled food intake has characterised the lockdown,” said Huda Al Hourani, assistant professor at the Faculty of Applied Health at the Hashemite University in Jordan.

**Negative emotions**

New research presented at the conference—attended by researchers, clinicians, and experts with experience from 56 countries—showed why previously healthy adolescents succumbed during the pandemic.

In normal times, more than half of eating disorders begin during a particular time window in adolescence when peer-to-peer social comparison is an essential part of development of body image, self-esteem, and social cognition, said Angela Favaro, head of the Department of Neuroscience at the Padova Neuroscience Centre in Italy. “Social avoidance” as well as inflexible thinking and negative emotions are key predictors in early onset eating disorders, she told the conference.

Lockdowns and school closures have enforced social avoidance, leaving children “exposed to an absence of peer-to-peer social comparison at a crucial time in their development.”

Stefan Ehrlich, professor of psychological and social medicine at the Technical University of Dresden, said research has shown food restriction can lead to resistance to ghrelin, the “hungry hormone” produced by the gut that prompts people to seek food—a process
“reinforced when adolescents are isolated from their peers.”

In India, where one in four adolescent girls and one in five boys are estimated to have “disturbed eating habits and behaviours,” many of these suffered “increased anxiety as they came under constant supervision when families return to their villages, living in cramped conditions,” paediatrician Kritika Malhotra of Jawaharlal Nehru Medical College told the conference.

Teens, adults, and doctors, too

Adults have also presented with eating disorders in record numbers during the pandemic—the conference heard reports of binge eating and purgative behaviour from Argentina and Lebanon.

A contributing factor, according to Jennifer Couturier of McMaster Children's Hospital in Ontario, Canada, was “the bombardment of social media posts and messages about ‘inevitable’ weight gain related to staying at home.”

“It seems likely that exposure to the stress of the pandemic has pushed over the line those with an average genetic risk for an eating disorder that they might otherwise never have expressed,” Bulik told The BMJ.

Healthcare professionals are also vulnerable to maladaptive eating behaviours, Mohsen Khosravi, from the University of Medical Sciences, Zahedan, Iran, said. “We know that negative emotions including anxiety, stress, depression, and anger trigger disordered eating behaviours,” Khosravi told The BMJ.

“For healthcare professionals, the lack of medical equipment in the current crisis is accompanied by the intensification of negative emotions, triggering disordered eating.”

Paulo Machado, head of the Eating Disorders Research Group at the University of Minho University in Portugal, told the conference that many with an existing diagnosis experienced a “worsening of their condition, especially if associated with difficulties in emotion regulation.”

“Worsening of their condition, especially if associated with a ‘worsening of their condition, existing diagnosis experienced the conference that many with an eating disorder.”

Embracing technology

Online consultations, widely introduced during the pandemic, have proved an unexpected hit, however.

While more than half of surveyed patients with an eating disorder in the Netherlands and the US complained that their treatment had deteriorated when interviewed at the beginning of the pandemic, a follow-up study, to be published soon, showed that fewer than one in four felt the same in May 2021. “Presumably, in that time, practitioners and patients have become more familiar with the technology,” lead researcher Christine Peat, assistant professor of psychiatry at the University of North Carolina, told the conference.

Portuguese patients regarded online services as “a lesser form of treatment when our clinic first stopped in-person consultations,” said Machado. But now the clinic is open and many prefer to stay online, he said. In Israel, ultra-orthodox families, who mostly avoid technology, including the internet, “are allowing their daughters to participate in online clinics they wouldn’t want them to attend in person.”

The rise in technology based consultations led to the first guidelines on virtual care of eating disorders in children, adolescents, and emerging adults, published in April and produced by a Canadian consensus panel as part of a project funded by the Canadian Institutes of Health Research. Couturier, lead author of the guidelines, acknowledged they were based on the small amount of available evidence, but said the need for guidance was acute given that “the eating disorder population is particularly vulnerable and at significant risk of death should they not receive appropriate care.”

Treatment questions

Couturier’s team also identified noticeable gaps in knowledge, notably around the role of virtual care in more intensive services such as virtual day hospitals. It echoes a demand for more research and funding from leading global specialists, made in Lancet Psychiatry in February.

Stephen Touyz, professor of clinical psychology at the University of Sydney, told the conference that new treatments should incorporate the “wonderfully innovative technologies that are currently transforming healthcare.”

“The virtual reality sector has made spectacular advances and could now assist with body shape over-evaluation. Smartwatches that allow live electrocardiogram data to be recorded could be developed to enable live streaming feedback at meal times, one of the greatest challenges for patients with eating disorders,” he told The BMJ. These could lead to better treatments that also take account of new findings in brain dynamics and genetics in eating disorders.

The need is urgent, says Khosravi. There is concern—based on evidence from previous global health disasters—that this pandemic will worsen the severity of symptoms of eating disorders. Recognising the global nature of these disorders and the impact of the pandemic is a start.

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ESSAY

Covid makes it harder for GPs to offer the quiet listening that made all the difference to me

An anonymous patient explains how her doctor used shared decision making to help her manage her distress, but, she says, this is being threatened by the impact of the pandemic, including more triage, remote care, and burnout among primary care physicians.

How are the kids doing? Did they go to school today? These were among the first things she asked me. This was the beginning of sustained, personalised care from a general practitioner whose talents were asking the right questions and quiet listening.

My husband was in an operating theatre, my head was spinning, and I hadn’t slept in days. He needed a biopsy of lymph nodes close to his aorta. We knew that he was really sick. We didn’t know what kind of cancer he had. I was terrified that he was dying (he was) and that there would be no cure (there wasn’t).

Asking if the kids had gone to school was the right question. In the context of a late diagnosis of incurable cancer, it’s a litmus test of how bad things are at home. In the following months, I became what can only be described as a walking waterfall. I was frightened of losing my husband. I was also frightened of losing the roof over our heads: the financial impact of cancer is something that too few people talk about.

The stress became unbearable. My husband exhausted NHS treatment and was negotiating access to clinical trials. He was in hospital for months at a time. My life was at an all time low. Navigating this patch of my life was like walking on quicksand.

Conversations were about tailoring care to the individual: finding the right solution for me.

Hanging on to my mental health

I didn’t have flattened affect: I could still see joy and laugh. But I cried at night, as my husband groaned, sweating, startling, and waking with the pain that followed him everywhere. For months, I was hanging on to my mental health by a thread.

Discussing this with my GP was difficult. Her quiet listening was crucial. What followed was not a prescription for antidepressant drugs or an inpatient admission to a psychiatric ward, though both were very possible outcomes.

Instead, with my GP, I made a plan. You could call it a care plan, but it was instigated by the patient, not the health professional. A key feature was the joint decision to demedicalise my experience of distress. Together we agreed that I wouldn’t start taking antidepressants: I chose to live with the distress and to find resilience. These discussions were very personal and practical and included where to get advice on managing financial pressures, balancing the demands of work and being a carer, and psychological support.

If things got really bad, I’d avoid going to the emergency department: she suggested other options for an acute mental health crisis that in her experience tended to work out better for patients, such as attending the charity Mind’s sanctuary service. Avoiding unnecessary treatment saved the NHS money. My GP probably also helped me to avoid a psychiatric admission to hospital. None of this would have been possible without a GP who knew, and practised, the art of quiet listening.

No algorithmically programmed chatbot could do what she did in conveying humanity and allowing me to lead a clinical conversation. Entering “thoughts of suicide and self-harm” into an online triage tool or virtual symptom checker could not have produced the same outcome as I experienced through face-to-face care, or the same efficiency and value for the NHS.

Our conversation was about tailoring care to the individual: finding the right solution for me. This was personalised care in action. It speaks to the sharp end of conversations about the limits of the biomedical and clinical sciences to medical practice.

The BMJ’s Too Much Medicine campaign has focused on changing clinicians’ behaviour.
by identifying diagnostic practice and treatments that are unlikely to benefit most patients (bmj.com/too-much-medicine). What may be missing is a concurrent emphasis on empowering patients. How can clinical practice develop to enable patients jointly with clinicians to hold risk and manage uncertainty? How can practice develop to allow patients to lead conversations in which they can demedicalise their experiences of living with poor health or of dying?

I saw my GP a couple of times each month. The care I received was a masterclass in the highly skilled work of managing uncertainty and holding clinical risk in the community rather than referring to others. This helps create positive patient outcomes that avoid the harms of over-investigation and over-treatment, and it manages demand for health services. This is primary care’s hugely valuable but often under-recognised contribution to the efficiency of the whole system.

The care I received was a masterclass in the highly skilled work of managing uncertainty

My GP’s willingness to play a supporting role was key. She elected that we jointly manage risk. By listening, rather than leading the conversation, she allowed me to make choices that were empowering while enabling me to demedicalise my experience of distress. She took her lead from me. I opened the conversation about whether I was depressed. I gave her my view of the evidence; I asked for her view. After a careful pause, she said, “I think you are not depressed.” We took it together from there. We talked about treatment options. Cognitive behavioural therapy works best when reframing can help adjust a patient’s perspective on a problem. My GP and I agreed that this was not the right approach for my situation, where the problem itself was causing distress. Instead, we brainstormed together about who might locally offer psychological support based around acceptance and commitment therapy. The cancer charity Maggie’s, as it turns out.

My GP’s approach fits with newer thinking, exemplified in the SHERPA (sharing evidence routine for a person-centred plan for action) framework, for example, which values practical conversations that start by co-constructing with patients the nature of the problem. The focus is on simpler, more natural conversations about care that are appropriate for, and agreed with, individual patients.

How might quiet listening fit with active listening, often taught to students in medical school? Instead of an emphasis on listening with fascination, quiet listening is more about empathy in practice, about quiet spaces in conversations.

I am both a carer and a patient. Often my GP and I discussed both in the same consultation. Moving between the two conversations can be jarring for me—“How is your husband?” “Ah, it’s been an interesting few weeks. He’s broken his arm, his leg, and been hospitalised for two major internal bleeds.” “Shall I examine that lump under your arm now?” This
was a single conversation, but my GP paused after discussing my husband and watched me. My head was down, my eyes on the floor. When my body language told her I was ready—when I lifted my head, and looked at her—she smiled and asked if I was ready to be examined. It’s subtle, but important, this ability to create quiet spaces within a consultation.

With an emphasis on patient activation, which focuses on what you can do, it can be hard to find space for conversations about what you can’t do. Quiet listening makes space to speak about worrying you can’t feed your children properly, not being able to buy their shoes, not having money to pay for a funeral. These are some of the things that distressed me the most. The Dutch anthropologist Annemarie Mol points out that care “makes space for what is not possible.” Quiet listening is an important part of this.

A doctor whom I trust and who knows me well is crucial in enabling quiet listening and to leading conversations about my own care. Seeing the same doctor over time also means that I don’t have to repeat my story to many doctors. Once is enough: some things are not fun to talk about. Seeing the same GP over time has a survival advantage similar to many drugs and complex interventions, evidence shows. High relational continuity is associated with lower mortality, better self-management of long term conditions, and fewer admissions to hospital.

The same GP can notice changes that would not be obvious to a doctor who doesn’t know me. I’m prone to ironic humour and making inappropriate jokes, for example, even about what was happening to me then. If I stop doing this, I’m in trouble. Losing my sense of humour indicates seriously deteriorating mental health. A GP who didn’t know me well couldn’t read that.