this week

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MARK THOMAS

Medical school places to double by 2031

Thousands more doctors and nurses will be trained every year under proposals in the long term NHS workforce plan, to be backed by £2.4bn of funding over the next five years.

The long awaited plan projects that the current NHS staffing shortfall of 112 000 will increase to 360 000 by 2037 if nothing is done to tackle recruitment and retention.

The plan recommends increasing medical school places from 7500 to 10 000 by 2028—aiming for 15 000 by 2031, with more places in areas with the most shortages.

GP training places will increase by 50% to 6000 by 2031, starting with 500 new places from September 2025. The NHS will also consult on introducing four year medical degrees and internships to get trainees "on wards and in practices sooner."

Nursing and midwifery training places will increase to around 58 000 by 2031-32 with a target of 44 000 by 2028-29, and 20% of registered nurses qualifying through apprenticeships—up from 9% currently.

Overall, 16% of all clinical training places will be offered through apprenticeships by 2028, including more than 850 medical students, with pilot schemes starting next year. By 2031-32 this will rise to 22% to provide access to more people from diverse backgrounds and underserved areas.

By 2036-37 the workforce will include 10 000 physician associates, with around 1300 trained each year from 2023-24. The NHS will reduce reliance on international recruitment and agency staff to around 9-10.5% of the workforce in 15 years' time, down from nearly a quarter now.

By "improving culture, leadership and wellbeing," the NHS will "ensure" as many as 130 000 fewer staff quit over the next 15 years, the plan said. To retain staff, the plan offers flexible retirement opportunities, a modernised pension scheme, and an emeritus doctor scheme for recently retired consultants.

Latifa Patel, the BMA's workforce lead, said the plan was a long overdue recognition of the vast NHS workforce shortages. Doubling medical school places was welcome, "but we need guarantees that the initial expansion will be followed with the infrastructure to support doctors throughout their careers," she said. "There's no point having more students if there are no academics to teach them, no spaces to learn in, and no consultants and GPs to supervise them once they graduate."

Emma Wilkinson, Sheffield

Cite this as: *BMJ* 2023;381:p1510

MEDICAL COLLEGES' REACTION, page 46
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The NHS workforce plan pledges that 16% of all clinical training places will be offered through apprenticeships by 2028

LATEST ONLINE

- Race should not be used as factor in university admissions, US Supreme Court rules
- Government refuses to set target or strategy to end maternal health inequalities
- Covid-19 inquiry: Brexit blamed for diverting focus away from pandemic planning

SEVEN DAYS IN

Hancock tells covid inquiry of "doctrinal failure" over pandemic planning

MARK THOMAS

The UK government's pandemic planning followed a flawed doctrine of dealing with deaths rather than stopping the spread of the virus, the former health secretary Matt Hancock has admitted.

The country's focus on planning for the consequences of a disaster, such as buying enough body bags or deciding where to bury dead people, was completely wrong, Hancock told the UK Covid-19 Inquiry. "Central to planning should be how to stop the pandemic in the first place," he said. A consequence of this failure he said was that large scale testing or contract tracing had to be built from scratch.

Asked why he had not changed the approach to pandemic planning, Hancock said that it was because he had been assured that the UK was among the best in the world in terms of being prepared. With hindsight, he said, he wished that he had changed the mindset within his department.

He said he was told that influenza was "category 1," as it was the most likely cause of a pandemic. But he told the inquiry that the focus on flu was not the central flaw of pandemic planning but rather the lack of focus on stopping the spread of a virus.

Jacqui Wise, Kent Cite this as: *BMJ* 2023;381:p1478

Covid-19

New data shed light on effects on children

Data published by WHO Europe and the Health Behaviour in School-aged Children study show that the covid pandemic has had a disproportionately negative effect on children and adolescents from lower socioeconomic backgrounds, those who faced lengthy school closures, and those lacking essential support structures such as family and teachers. The data also show that, on average and across various indicators, older schoolgirls have experienced the pandemic's effects more than younger boys, with a marked impact on their mental health.

One in 30 Europeans may have had long covid

Some 36 million people in Europe—around one in 30 Europeans—may have developed long covid over the past three years, the World Health Organization estimated. Yet long covid remains "a glaring blind spot in our knowledge, that urgently needs to be filled," said Hans Kluge, WHO's regional director for Europe. He warned, "Unless we develop comprehensive diagnostics and treatment for long covid, we will never truly recover from the pandemic. We are encouraging more research to be undertaken and urging those eligible for covid-19 vaccination to be vaccinated."

Malaria

Two US states report locally acquired cases

The US Centers for Disease Control and Prevention published an alert after five cases of locally transmitted malaria were reported in the past two months—four cases in Florida and one in Texas. This is the first time in 20 years that locally transmitted malaria has been reported in the US. In the alert published on 26 June the CDC said that all the cases were caused by *Plasmodium vivax* malaria and that the patients had received treatment and were improving.

General practice

QOF consultation will launch this summer

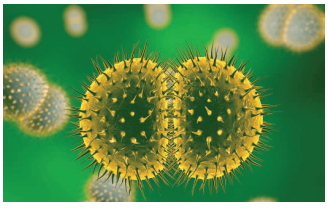
A consultation on the future of the Quality and Outcomes Framework will be launched imminently, a government minister has said.

In response to a written parliamentary question from the Labour MP Chi Onwurah (left), the health minister Neil O'Brien said that after feedback from general practice teams, the BMA's General Practitioners Committee England, the Health and Social Care Committee, GPs, and representative patient groups would be consulted on the future of QOF this summer.

Gonorrhoea

Vaccine is given FDA "fast track" designation

GSK's vaccine candidate to treat gonorrhoea was granted a fast track designation by the US Food and Drug Administration, the British drugmaker said on



27 June. The vaccine candidate is currently in a phase 2 trial and aims to demonstrate efficacy of the *Neisseria gonorrhoeae* vaccine in healthy adults aged 18 to 50 who are considered at risk of gonorrhoea, GSK said. The FDA's fast track designation process aims to facilitate the development and expedite the review of potentially important new drugs and vaccines to treat or prevent serious conditions with unmet medical needs.

Patient safety

Staff must give evidence on mental health deaths

An inquiry into 2000 deaths at a mental health trust in Essex from 2000 to 2020 has been given statutory status, the government announced. The inquiry into Essex Partnership University Foundation Trust was announced in January 2021, but as it has faced "challenges" in engaging former and current staff and the trust itself to give evidence, the governnment has changed its status. Now it "will have legal powers to compel witnesses, including those former and current staff . . . to give evidence," the Department of Health and Social Care said.

NHS has "compassion deficit," says ombudsman

The NHS has an accountability and compassion defecit for patients and their families when things go wrong, England's health ombudsman has warned. In a report published on 26 June, Rob Behrens said the NHS must do more to accept accountability and learn from mistakes, particularly in cases of serious harm or loss of life. He called for better family support, for cultures that embed honesty and learning from mistakes, and for supervision and regulatory structures to prioritise safety.

MEDICINE

A large part of the health service has outdated systems, say MPs

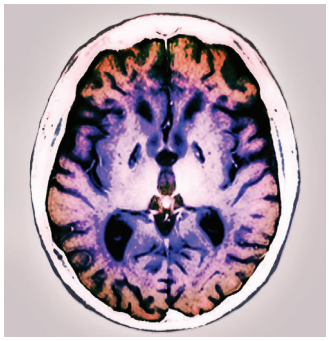
IT

NHS lacks "basic functioning" equipment

A report by the Health and Social Care Committee has said that plans to digitise the NHS in England are being hampered by a "lack of basic functioning IT equipment" in many organisations and a shortage of specialist staff. The MPs' inquiry found that large parts of the NHS had outdated computers running different programmes and operating systems that were "unable to handle the demands of a modern digital health service." While digital innovations could improve choice for patients, the report said, the benefits were not being made clear and many people risked being excluded from care by a dearth of digital skills.

Traumatic brain injury

New research platform for UK is announced



The Medical Research Council announced a new £9.5m research platform that it hopes will transform the way traumatic brain injuries are diagnosed and treated in the UK. To tackle a lack of coordinated use of data investigating these injuries the MRC, the National Institute for Health and Care Research, the Ministry of Defence, and Alzheimer's Research UK are jointly funding the initiative to establish a UK-wide research platform, TBI-Reporter. It will be led by the University of Cambridge.

Air pollution

Low emission zones show link to improved health

Policies designed to reduce congestion and air pollution from vehicles in major cities can have a beneficial effect on health outcomes, an evidence review concluded. Researchers from Imperial College London examined the health effects of low emission zones (LEZs) and congestion charging zones (CCZs) in several cities in the UK, Europe, and Asia. Their findings, published in *Lancet Public Health*, showed that multiple cities recorded a decline in measures of cardiovascular disease associated with LEZs and an overall reduction in road traffic injuries associated with CCZs after the measures were introduced.

Alcohol

Minimum unit pricing "has saved lives" in Scotland

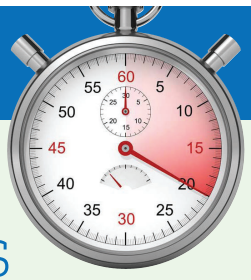
Scotland's introduction of a minimum unit price for alcohol is cutting overall consumption and helping to save lives, results have shown. Public Health Scotland analysed the results of 12 studies it commissioned, together with 40 research papers, and said that the policy had reduced deaths directly caused by alcohol by 13.4% and related hospital admissions by 4.1%. Ian Gilmore, chair of the Alcohol Health Alliance, said that England could not afford to ignore Scotland's experience.

Cite this as: *BMJ* 2023;382:p1521

CONFLICT

Worldwide, **1163** attacks on schools and **647** attacks on hospitals were recorded in 2022—a **112%** year-on-year increase

[United Nations]



SIXTY SECONDS ON . . . **STAFF SICKNESS**

WHAT'S THE DIAGNOSIS?

Sickness absence rates in NHS hospitals and community services have jumped by a huge 29% in the most recent calendar year from the year before the pandemic, an analysis by the Nuffield Trust shows. This equates to an average of 17 000 extra staff off sick each day.

THAT'S A LOT OF ROTA GAPS

Indeed. The analysis of data shows that more staff were off sick in any given month in 2022 than at the worst point in the year before the pandemic. In numerical terms, some 27 million days were lost to sickness absence last year: this is equivalent to 74 500 full time staff not at work, including 20 400 nurses and 2900 doctors.

ARE SOME SERVICES SICKER THAN OTHERS?

Sickness absences rose across all types of NHS trusts, but ambulance services were the worst affected. Three ambulance trusts had one in 10 staff off sick on average every day in 2022.

IS THIS ALL DOWN TO COVID?

No. While there's been an increase in respiratory and infectious conditions, there's also been a substantial rise in staff taking sick days for anxiety, stress, and burnout, which now account for a quarter of sick days overall. In total throughout 2022, six million working days were lost for mental health and wellbeing reasons.

ALL IS NOT WELL

Quite. The Nuffield Trust says the increasing burden of sickness absence is not only pushing up costs and disrupting service provision but is creating extra stress for the remaining staff. This causes more of them to leave, which in turn creates further disruption for patients and services.

HOW CAN THIS SICK CYCLE BE TREATED?

Billy Palmer, a Nuffield senior fellow, says that, although there's been a lot of focus on recruitment, "we need more endeavour to improve the working conditions of existing staff and protect them from illness." He's calling for "concrete support" to enable employers to improve the NHS staff experience and to "break the cycle of staff absences, sickness, and leaving rates."

Gareth Iacobucci, *The BMJ*

Cite this as: BMJ 2023;381:p1494

Nearly half of doctors affected by long covid can no longer work full time, finds survey

Almost one in five doctors (18%) with long covid who responded to a survey said that they were no longer able to work, and fewer than one in three (31%) were working full time, compared with more than half (57%) before the onset of their covid illness.

Of the 603 respondents 49% said that they had lost income as a result of long covid. The survey was conducted by the BMA in partnership with the support group Long Covid Doctors for Action during December 2022 and January 2023.

The report on the findings comes with a series of demands, among them a call for long covid to be considered an occupational disease for healthcare workers and for NHS staff to be given financial support.

Raymond Agius, BMA occupational medicine committee co-chair, said the government had a moral duty to look after healthcare staff who were put at risk during the pandemic. "During the pandemic, doctors were left exposed and unprotected at work . . . This report underlines the devastating consequences of this lack of protection. Doctors still living with symptoms have once again been left at risk with little to no support from the system that they gave so much to," he said.

Kelly Fearnley, a doctor with long covid and chair of Long Covid Doctors for Action, said she and fellow campaigners felt "betrayed and completely abandoned." She said, "NHS employers are legally required to implement only 'reasonable adjustments,' and so things such as extended phased return or adjustments to shift patterns are not always being facilitated. Instead, an increasing number of employers are choosing to terminate contracts."

A Department of Health spokesperson said, "NHS staff can seek support for long covid from their GP or one of the 100 specialist clinics. The NHS has also committed £324m to support people with long covid."

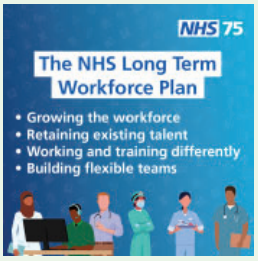
Adele Waters, London Cite this as: *BMJ* 2023;382:p1529

Just over half of respondents (54%) acquired covid-19 during the first wave of the pandemic in 2020, and 77% of these thought they contracted it in the workplace. Only a few had access to respiratory protective equipment, with only 11% having access to an FFP2 respirator and 16% to an FFP3 respirator

Medical colleges broadly welcome workforce plan, but questions remain

The publication of the first ever NHS long term workforce plan is a significant moment, not least because it contains official projections of the shortfall in staff, which it currently sets at 112 000—increasing to 360 000 by 2037 if nothing is done.

Under the proposals, backed by £2.4bn for the first five years, thousands more doctors, nurses, physician associates, and other healthcare staff will be trained. Apprenticeships will be piloted to make up more than one in five of all training places by 2031-32. The NHS will also consult on shortening medical degrees to four years.



There is a lot to unpack in the plan's 151 pages. Medical colleges, which have been rapidly trying to assess what it means for education, training, and recruitment and retention, expressed a certain relief that it was finally here.

"It is an important step forward," said Sarah Clarke, president of the Royal College of Physicians (RCP). The announcement of 15 000 extra medical school places with a focus on areas of greatest need was "particularly welcome," she added.

Projections

More analysis will be needed on the projections and modelling used, said the RCP, but an expansion of specialty training places—which will need funding and a detailed breakdown for each area—was a good start, said Clarke. "It's key that the proposed changes to training are made in close conjunction with experts, including medical schools, training providers, the GMC, and NHS England," she said. "We look forward to seeing more detail on this."

The RCP was among several colleges that had concerns around the number of new doctors coming through the system in terms of "bottlenecks"—with some specialties already hugely oversubscribed—and having experienced staff train them.

The Royal College of General Practitioners (RCGP) said that this

BMA ANNUAL REPRESENTATIVE MEETING

Doctors will strike for "as long as it takes," vows BMA chief

The BMA's chair of council has vowed that doctors will strike for "as long as it takes" if the government refuses to negotiate with them in their quest for fair pay.

In a keynote address to the BMA's annual representative meeting in Liverpool on 3 July, Philip Banfield (right) praised BMA members for their "collective strength and collective will to say enough is enough."

Hailing the "vigour and spirit" of England's junior doctors, he said, "I'm inspired by the stand they have taken. For their courage and the unwavering support that specialists, associate specialists, and specialty doctors, consultants, and GPs have given in uniting behind them."

England's junior doctors recently announced they would be striking for five days from this Thursday, in what is believed to be the longest walkout in NHS history. Consultants in England will also strike for two days the following week, after more than 20 000 voted for industrial action.

Banfield said he had written again to the prime minister, Rishi Sunak, asking

would require "sustained investment" in training capacity and infrastructure.

Fiona Donald, Royal College of Anaesthetists' president, said the "ambitious targets" and the £2.4bn were to be celebrated. "We now need to see more detail on numbers and a commitment to the expansion of anaesthetic training places to cope with demand, immediately and in the future," she added.

Retention

The Royal College of Radiologists also commented on the lack of specialty specific projections but said the immediate priority should be "ensuring experienced doctors are not leaving the workforce early due to poor working conditions." It was important to understand "how devastated and burnt out doctors are feeling, especially as these are the very doctors who will need to give even more of their time to train recruits," it added.

The inclusion of flexible job plans and additional support for doctors nearing retirement was of note, the college said. But the plan needed to consider all factors contributing to early retirement, "to ensure that senior doctors feel valued."

By "improving culture, leadership and wellbeing," the NHS would "ensure" that as many as 130 000 fewer staff left the NHS over the next decade and a half, the plan stated. But NHS England needed to consider how it would ensure trusts were taking the recommended actions, the Royal College of Radiologists added.

Camilla Kingdon, president of the Royal College of Paediatrics and Child Health, said, "Morale is declining, and high rates of burnout across all areas of the workforce must be urgently addressed in order for these plans to succeed. We know that this current workforce crisis will not be fixed overnight, and we do feel some relief that we now have a way forward."

Implementation

GP training places are set to rise by 50% to 6000 over the next 15 years, but "in the meantime we are losing doctors faster than we are training them," the RCGP said. A national single entry portal to all retention schemes was needed, as well as funding for local tailored support, it said.

Shortened medical degrees is an area needing a strong evidence base, a number of colleges warned. Apprenticeships "will need careful thinking through," with more detail on how they would work in practice.

The RCGP said, "We've been told the medical profession will be in the driving seat on implementation, but we need to see how this is going to happen and how the government and NHS England will collaborate with the profession to ensure that the right workforce is trained in the right way, and at the right time, for the NHS to survive."

Emma Wilkinson, Sheffield

Cite this as: *BMJ* 2023;382:p1535

It's key the proposed changes to training are made in close conjunction with experts, including medical schools, training providers, the GMC, and NHS England Sarah Clarke

We now need to see more detail on numbers and a commitment to the expansion of anaesthetic training places to cope with demand Fiona Donald

him to agree to talks with junior doctors facilitated by the Advisory, Conciliation, and Arbitration Service to try to "break the deadlock and reach a settlement."

"I want to repeat our message. Throughout the junior doctors dispute we have always said we will meet without preconditions anytime, anywhere, to resolve problems. This offer still holds," he said.

But he warned, "A meaningful negotiation needs a credible offer. To disregard the Review Body on Doctors' and Dentists' Remuneration last year showed contempt for junior doctors in England. To pitch an offer below the recommendation this year would be obscene."

CONSULTANTS will also strike this month on 20 and 21 July, after more than **20000** voted for industrial action

On the consultants' vote to strike in response to their take home pay falling by 35% since 2008-09, Banfield said, "They are joining the fight to ensure we do not lose our most senior and expert doctors—those who will train the next generation."

He also highlighted that SAS doctors in England are "considering their next steps" after seeing pay fall by over a quarter in15 years, while GPs in England are preparing for an indicative ballot if the government fails to negotiate a new contract that is "fit for purpose."

Banfield added that pay was a glaring omission from the workforce plan. "Who will train the workforce? Who will teach medicine when there are no medics and academics left? Investing in medical school places while refusing to reverse years of pay erosion is illogical."

In a bullish closing message to assembled representatives, Banfield said, "The patients we save and care for know what we're worth. This country knows what we are worth. Let's send a clear message to those in government who cannot ignore us any longer. We will not stay silent about what needs to change."

Gareth Iacobucci, *The BMJ* Cite this as: *BMJ* 2023;382:p1523

NEWS ANALYSIS

Could the consultants' strike be the straw that breaks the government's back?

As the NHS faces an eighth consecutive month of industrial action, **Elisabeth Mahase** examines whether the consultant strike could finally push the government to negotiate

The double whammy of junior doctors and consultants striking will be a huge risk for the NHS to manage
Julian Hartley

Last week more than 20 000 consultants in England voted for industrial action over pay, with a huge 71% turnout and 86% voting in favour. During a two day strike planned for 20 and 21 July consultants will offer "Christmas Day cover," with most routine and elective services cancelled and only emergency cover in place.

The huge mandate for action marks a significant moment, as consultants have taken industrial action only twice in English history.

The BMA estimates that consultants in England have seen their take home pay cut by 35% since 2008-09. The basic salary for consultants in England is £88 364 to £119 133 a year.

The BMA's Consultants Committee chair, Vishal Sharma, said, "All consultants are asking for is fairness. Newly qualified consultants are paid £42 an hour basic pay, and this goes up to £57 an hour after 19 years. This is for our most expert and experienced doctors. They are working harder than ever, managing excessive workloads covering rota gaps and vacancies."

He added that, with a global shortage of doctors, consultants could be attracted away with offers of higher salaries and better conditions. "When the NHS waiting list is at a record high, it's therefore not a question of whether the government can afford to restore their pay, it's whether they can afford not to," he said.

The BMA is calling on the government to end pay erosion—beginning with an agreement on the 2023-24 pay award—and to commit to a mechanism to reverse the long term pay reduction. "If the government comes forward with a credible offer to fix pay now and in the future that we can put to members, a strike can be averted," said Sharma.

Ready to reopen talks?

Pay talks took place over four weeks in April and May. They broke down with the BMA saying that the government had refused to provide a pay rise in line with inflation and had failed to commit to ensuring that the Review Body on Doctors' and Dentists' Remuneration was fully independent. The union then balloted its members on taking action.

A spokesperson for the Department of Health called the ballot results "disappointing." They said, "Consultants received a 4.5% pay uplift last financial year, increasing average earnings to around £128 000, and they will benefit from generous changes to pension taxation announced at budget."

The spokesperson added, "Strikes are hugely disruptive for patients and put pressure on other NHS staff. We stand ready to open talks again."

Power of the BMA

The lack of ministerial movement has been felt elsewhere. The government initially stood by as the Royal College of Nursing (RCN) took strike action without any negotiations taking place, and then unions representing NHS staff on Agenda for Change contracts struggled to get ministers to move from a 5% offer—with most ultimately accepting it. While consultants have turned out in large numbers to vote for strikes, the RCN lost its vote to renew the strike mandate.

WHY WE'RE TAKING ACTION: **consultants speak out**

Elisabeth Mahase and **Rebecca Coombes** asked some senior doctors what brought them to this point

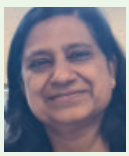
ROB GALLOWAY

Emergency medicine consultant, University Hospitals Sussex NHS Trust

"I don't know any consultants struggling to feed their family, but this doesn't change what the basic wage is or the real terms pay cuts. The NHS is nothing without its staff. I know so many consultants and junior doctors who are burnt out, who don't think that working in the NHS is worth it anymore.

"The long term damage to patient care from this is enormous. The NHS is a brilliant concept that's being utterly mismanaged by our politicians. Those of us who work in the NHS are being let down by our political leaders. We need new ideas, policies, workforce plans, and funding to save the NHS before it's too late."

SUNILA JAIN



Consultant ophthalmic surgeon and LNC chair, Lancashire Teaching Hospitals

"Generally, I love my work, my patients, my surgery, my clinics. I don't want to cancel my patients, but striking [is for] the future generation of doctors, because I don't want people to be well trained here in the UK and then disappear."

ELEANOR CHECKLEY

Intensive care consultant and BMA Consultants Committee member

"It feels like we're finally putting a line in the sand and saying enough is enough. So much has been done to us as a group. We've had our voice in senior management reduced over the years. We now do a lot of the admin work that we used to have

Talks with junior doctors in England also collapsed in May, with the BMA saying the government was refusing to budge from its 5% offer. Junior doctors are being re-balloted on possibly continuing action after the strike mandate expires at the end of August. They have so far taken 10 days of strike action since March, and a five day walkout—the longest in NHS history—is planned for 13-18 July.

Alex Bryson, labour economist and professor of quantitative social science at University College London's Social Research Institute, told *The BMJ*, "In the case of the nurses, maybe the government will be thinking things have shifted a little bit back in their favour." But because most junior doctors and consultants are part of the same large union, collective action was easier to organise, he said.

With the consultants' mandate lasting until early winter and junior doctors potentially extending theirs for another six months, Bryson said the strike potentially extending into winter made the stakes "very high," ahead of a general election in 2024.

How much political capital will the government want to spend in allowing this dispute to be protracted?
Alex Bryson

"Cutting NHS waiting lists is in the government's top five priorities," he said. "So it's not going to be good for them when they get hit by the additional demands of the winter months in the NHS.

"It's hard to know how much political capital the government will want to spend in allowing this dispute to be protracted because it is in their gift ultimately to settle. As well as the direct financial cost there is a potential downside, especially if they're being seen to have conceded.

"The upside is that they might get political kudos from saying they're investing in the NHS and they've listened to important staff members. So, they could go either way."

Bryson added that the government might be worried about acceding to these payoffs because of the signal it could send to other public sector workers about the "going rate" for pay.

Julian Hartley, chief executive of NHS Providers, said the "double whammy" of junior doctors and consultants striking will be a "huge risk for the NHS to manage." July will be the eighth consecutive month of industrial action across the NHS, which has led to more than 651 000 routine operations and appointments being postponed to date, he said.

"We understand how strongly doctors feel and why they are striking," said Hartley. "Trust leaders will continue to do everything they can to limit disruption and keep patients safe, but that's getting harder and more expensive with every strike."

THE BMA estimates that consultants in England have seen their take home pay cut by 35% since 2008-09

Softening tone?

On 2 July, the eve of the BMA's annual representative meeting (ARM), the government appeared to be softening its tone. The *Times* reported England's health secretary, Steve Barclay, would be willing to give doctors a bigger rise if there was movement on both sides and he was leaning towards adopting the review body's recommendations, which are expected to suggest an annual rise of 6%.

In his keynote address to the ARM in Liverpool on 3 July the BMA's chair of council, Philip Banfield, said, "Throughout the junior doctors' dispute we have always said we will meet without preconditions anytime, anywhere, to resolve problems. This offer still holds."

But he warned, "A meaningful negotiation needs a credible offer. To disregard the review body last year showed contempt. To pitch an offer below the recommendation this year would be obscene."

Elisabeth Mahase, *The BMJ*
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administrative staff do. And yet, we're still expected to do more and more in the clinical time that we have, without the support services.

"I've been through burnout, and I can see in so many of my colleagues that even just having the strike ballot itself has created a different atmosphere. It makes us feel that we've got some control over our work lives."

TOM DOLPHIN

Consultant anaesthetist, London

"Everybody is pretty tired. We've all been working very hard for a long time, and it feels like we're not being recognised by the government for that. And that's trickling down into workplace relations with our senior managers. However, the striking ballots and the campaign that's going ahead have actually re-energised some people because it feels like we can actually do something about it.

"I think a lot of people have said that they aren't keen to go on strike, but they don't see an alternative because we've tried all the usual ways—DDRB [the Review Body on Doctors' and Dentists' Remuneration] and so on—and that hasn't worked. So, we've got to do something."

JAN WISE

Consultant psychiatrist, London, and BMA Consultants Committee member

"Morale is appalling. People are looking for any way they can do something else. They've stopped going the extra mile. The IT infrastructure is broken. In the past year I've spent more time being unable to access patients' records than being able to access them. And patients are fed up with me saying, guess what, you have to tell me your condition again.

"The awareness of pay erosion doesn't help. People understand that they're not worth a third less than they were 15 years ago. Not only is this insulting to an intelligent group but they see the plumber getting paid more than they do for coming out at the weekend.

"If it were lawful, I would walk away full stop until you paid me what I'm worth."

Elisabeth Mahase, Rebecca Coombes, *The BMJ*
Cite this as: *BMJ* 2023;382:p1532


STEFAN ROUSSEAU/PA/ALAMY

NEWS ANALYSIS

How Palantir is strengthening its hold on NHS patient data

As the latest deal with the US data analytics company is signed, **Stephen Armstrong** examines its scale

On 20 June NHS England awarded a new £25m contract to the US data analytics company Palantir to move its existing NHS covid-19 and elective recovery data projects to a new platform. This will form the basis of the NHS federated data platform (FDP), a planned nationwide data system.

The platform follows a series of failed attempts to create a more integrated data system, including £12bn spent on the NHS national programme for IT, which closed in 2011, and £8m spent on care.data, which was cancelled in 2016.

What is Palantir?
Palantir—named after some magical telepathic crystal balls in the *Lord of the Rings*—was created in 2004 by the PayPal founder and conservative activist Peter Thiel along with Alexander Karp, Palantir's chief executive, using seed funding from the US Central Intelligence Agency's venture capital fund In-Q-Tel.

Its early customers were the National Security Agency, the Federal Bureau of Investigation, the CIA, and the US Marines, who used it in Afghanistan.

What does Palantir software do?
Palantir offers four software systems: Gotham for military and law enforcement, Foundry for healthcare and business, Metropolis for the finance industry, and Apollo for supply chain and logistics. They all mine and collect different kinds of data—financial records, spreadsheets, DNA samples, video clips—into one place.

The software then creates maps, charts, and histograms to make reading the data simple. In the US, police forces and homeland security use Gotham for "predictive policing": spying on and profiling citizens to guess who may be a criminal in the future, as well as hunting undocumented migrants.

Peter Thiel (above) and Alexander Karp cofounded Palantir in 2004 using seed funding from the CIA. The company signed its first NHS contract in 2020, for a covid data store

How did a privately funded US military company end up controlling NHS patient data?
The company started courting ministers and senior NHS England officials in 2019 and secured its first contract in March 2020, to supply Foundry to create the NHS emergency covid-19 data store.

This included data from sources as varied as Apple mobility trends, Public Health England's monthly cancer activity data, prescription data, GPs, ambulances, emergency departments, intensive care units, 999 and NHS 111 data, and the master patient index of UK healthcare records. The contract was awarded when ordinary procurement policies were suspended, and Palantir was paid a nominal £1.

Why did Palantir charge just £1?
Last October the *Washington Post* published an email from Louis Moseley, Palantir's executive vice president for the UK and Europe, with the subject line, "Buying our way in...!"

Sent in September 2021, the email outlined a plan to deepen relations with the NHS without public scrutiny. In December 2020 the contract was extended for two years in a £23m deal, and this January it was extended for another six months for £11.5m. Last week's £25m transition deal brought the total to £59.5m.

What about the FDP?
Officially, the latest contract is known as the Palantir Foundry Transition and Exit Contract. It provides "the smooth transition and exit service of critical products that were developed to respond to the pandemic, to alternative provisions including the transition of products to the new [FDP] supplier following completion of the procurement process and award to the [FDP] supplier."

So, is this the exit for Palantir?
Many people—including the BMA, the Doctors' Association, the legal firm Foxglove, and the health data privacy campaigner medConfidential—think not. "A 2021 sales pitch was the basis for the notion of the federated data platform, and in 2023, NHS England copied Palantir language into the tender documents," said medConfidential's Sam Smith at an event hosted by Westminster Health Forum on 8 June. The latest contract puts Palantir in a strong position to win the £480m FDP contract.

What are the objections?
The FDP aims to create a single point of access to patient data for hospitals, GPs, and social care—all to be accessible to central government on a single software platform. But Palantir has failed to design for patient consent, said a report sent to MPs on 19 June by Foxglove and the Doctors' Association UK. "GPs have long raised concerns about the appropriate use of patient data," said David Wrigley,

THE PLATFORM follows a series of failed attempts to create a more integrated data system for the NHS, including £12bn spent on the NHS national programme for IT, which was shut down in 2011, and £8m spent on care.data, which was cancelled in 2016

digital lead of the BMA's General Practitioners Committee. "The crux of the doctor-patient relationship is trust, and while GPs are supportive of safe and consensual uses of patient data, we want to see it done in a way that won't damage the confidence that patients have in the profession."

Is Foundry useful?

NHS data specialists surveyed by the *Financial Times* said that Foundry was not "user friendly," came at an exorbitant cost, and had a design that made it difficult for the NHS to switch providers in the future. "Senior leadership love it because it produces nice, shiny dashboards, but as an analyst it doesn't allow you to do the kind of data manipulation that is the building blocks of your analytical skills," one NHS analyst told the *FT*.

Another said the idea of Palantir running the FDP had "almost an element of ridiculousness to it." Its software doesn't work well with other industry standard systems such as Jupyter, a data science tool used by most NHS data scientists.

What if Palantir wins the FDP contract?

"When NHS England staff say, 'We need Palantir or the NHS will die,' that's the equivalent of what their predecessors said about care.data in 2013, GPDPR [General Practice Data for Planning and Research] in 2021—and they all believed it equally," Smith told the Westminster forum.

Care.data and GPDPR failed when millions of patients opted out because they didn't trust that their data would be safe. Currently, 3.3 million adults have opt-outs through the NHS's National Data Opt-Out scheme. And research from YouGov has found that 48% of adults in England who have not yet opted out are likely to do so if the FDP is introduced and run by a private company. The BMA has asked for urgent discussions with NHS England and the Department of Health over "how they plan to use confidential patient data within this data platform and what role Palantir will play," said Wrigley.

Stephen Armstrong, freelance journalist, London

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COMMENT

Patients have a right to know how their confidential data will be used

The UK government's recent decision to award Palantir, a US based multinational company, a contract to work on a large NHS patient data project risks harming the NHS's reputation and may, unintentionally, cause patients to opt out of data sharing and thereby lead to harm.

It's important to remember that patient data are invaluable. They are used to decide where to locate new services, to set standards for quality of care across the country, and in important research, which helps to develop new treatments.

Safeguard patients

Currently patient data—including GP records and details of hospital care—are stored in separate software systems spread across GP surgeries and hospital trusts. These systems have robust governance processes in place to safeguard patient data.

NHS England wants to bring these data together into a single place—the NHS federated data platform (FDP). The aim of the FDP is noble—if done correctly it could be used to improve decision making and patient care and experience by facilitating better planning and management in five key areas: population health; care coordination; elective recovery; immunisations, vaccines, and supply chains. However, how this is done, and by whom, is just as important as the why.

Since the announcement of the FDP, it has been widely expected that Palantir was being kept in mind for this contract because of the company's involvement in other healthcare contracts. Last week NHS England decided to award Palantir a transitioning contract.

TAIDGH BARRON/ZUMA/ALAMY

CONCERNS HAVE BEEN RAISED ABOUT THE COMPANY'S INFORMATION GOVERNANCE PROCESSES

Essentially, the transitioning contract means Palantir will start the process of moving patient data onto the FDP before the procurement processes which will give other companies the opportunity to bid for the full data transfer contract.

Why has Palantir been given the contract? This is a company founded with the help of $2m from CIA funding and concerns have previously been raised about its information governance processes.

The entire process for developing the FDP and putting it out to "tender" has not been sufficiently transparent and does not appear to have been competitive, given that Palantir already provides a similar service via the covid-19 data store and has now been given an interim contract ahead of the "full tender" decision.

Well respected and safe alternatives for sharing patient data exist and it seems that these options have not been adequately considered. The BMA is calling for NHS England and the Department of Health to have an open discussion clearly outlining the scope of data they plan to collect, how exactly they plan to use it, what role Palantir will play, and how it meets the NHS's core values.

We want to ensure that when the contract does finally go out to tender, the successful bidder actually meets the high information governance and ethical standards expected of any organisation contracted to process patient data. Doctors and patients must know sensitive and confidential data will not be used for commercial gain and are subject to rigorous and transparent information governance processes.

Risk of losing evidence base

If the FDP causes patients to opt out of data sharing, then we risk losing an indispensable evidence base. Also, doctors cannot afford to have a patient's trust in the healthcare system compromised in this process.

If trust is compromised the very formation of the FDP risks damaging the patient experience, which evidence tells us will lead to poorer health outcomes as patients become less likely to adhere to medical advice and this, in some cases, can lead to increased death rates.

David Wrigley, deputy chair and digital lead, BMA GP Committee (England)

Cite this as: *BMJ* 2023;381:p1482

If patients' trust is compromised then the formation of the data platform risks damaging the patient experience
David Wrigley

1 "Dedication," a portrait of "Mother Obe," a nurse for 47 years, taken by nurse Emmanuel Espiritu

2 An ambulance in the "Beast from the East", by paramedic Joe Cartwright

3 Flo, a freelance hairdresser, at the Royal Free, London, taken by Jenny Brodie

4 Ewa Gasior, a senior research nurse, captured the many hands that contribute to delivering patient care

THE BIG PICTURE

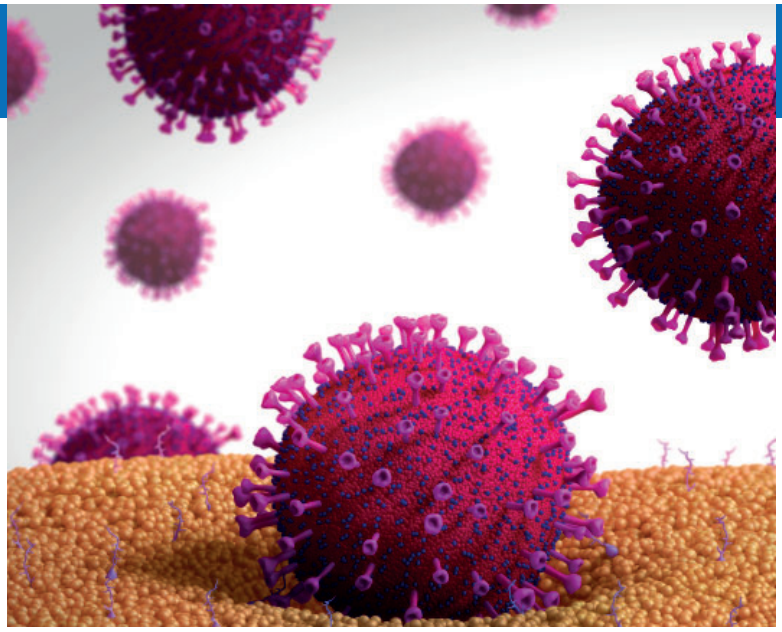
Care, captured by NHS workers

Winners of a photography competition for staff and volunteers to mark 75 years of the NHS have been unveiled. Run by NHS England in partnership with Fujifilm, the competition received hundreds of entries all telling unique stories of what the NHS means to the photographer. The images will be on display at the NHS 75th anniversary service at Westminster Abbey on 5 July. All 75 shortlisted photographs will also be in the "Our NHS at 75" exhibition, at the FujiFilm House of Photography in Covent Garden, London, from the same day.

Alison Shepherd, *The BMJ* Cite this *BMJ* 2023;382:p1522

Where do viruses hide in the human body?

SARS-CoV-2 has refocused scientists on the general question of where viruses persist in people. **Andy Extance** summarises a complex situation



Where do known viruses linger in the body?

Virus particles often hide in "immunoprivileged sites" around the human body, also sometimes called sanctuary sites, that our immune systems don't monitor or protect as closely as the rest of our bodies. These include the brain, spinal cord, pregnant uterus, testes, and eyes, for which damage by immune cells would be highly problematic. The testes can harbour Zika and Ebola viruses, for example.

Viruses such as influenza and SARS-CoV-2 primarily infect the respiratory tract but can move elsewhere. Influenza viruses can persist after infection in people's intestinal tract and stool, through swallowed secretions from the nose and throat or viruses in the blood. HIV is a latent virus that inserts its genome into the DNA of a person's immune cells, specifically their T cells and macrophages. Latent hepatitis C virus resides in the liver.

Over the past 20 to 30 years laboratory measurements have become sensitive enough to pick up on viral RNA outside the known sanctuary locations.

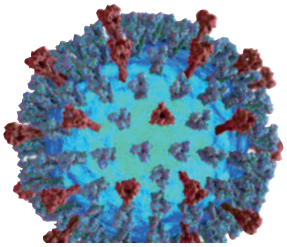
"We were surprised to find that this was common in measles—its main site of persistence is lymphoid tissue," says Diane Griffin, a microbiologist and immunologist at Johns Hopkins Bloomberg School of Public Health in Baltimore, Maryland. "Anybody who looks will now find RNA persistent, probably, after acute virus infection." Such signs have been found in blood, joints, the respiratory tract, gastrointestinal tissues, and kidneys.

Some viruses can remove external signs that a cell is infected, allowing them to escape the attention of the immune system in places outside conventional sanctuary sites.

What do they do there?

Whole viruses, also called virions, comprise either RNA or DNA surrounded by a protein coat. Those that persist in sanctuary sites can continue gradually infecting the cells around them. There they hijack the host cell(s) to make copies of themselves.

RNA viruses such as hepatitis C virus and HIV can evade immune control and can continuously produce infectious virions throughout a patient's life.



MEASLES

We know people where, six months after recovery, you get transmission of Zika or Ebola, or reactivation of problems
Diane Griffin

How long can viruses hide for?

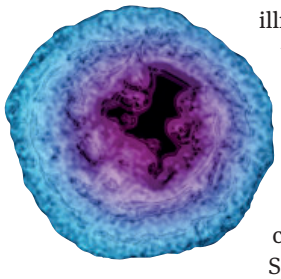
It varies. Griffin's team has also found measles RNA months later than it was previously recognised, after the infectious virus has been cleared.

A low level of immune activity in sanctuary sites usually keeps the viruses under control without killing the cells. And sometimes—especially outside sanctuary sites—the immune system can clear the virus but leave its genetic material behind to reproduce later, known as a "latent" virus. For example, antibodies in the brain may suppress viral RNA production without harming infected neurons.

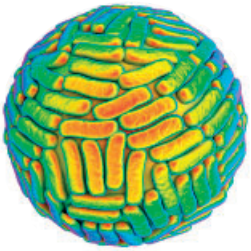
There are more than a dozen viruses that can become latent, of which Epstein-Barr virus is one of the most common, infecting as much as 90% of the human population. After an initial Epstein-Barr infection, the remaining viral RNA can lead to later disease and asymptomatic viral shedding.

Other latent viruses include DNA herpesviruses, varicella (chickenpox), and herpes simplex viruses. Chickenpox is well known for reactivating to cause shingles, and herpes simplex can give rise to mucosal ulcers and cold sores, which help the viruses to infect a new group of susceptible people.

Transmission can take place months or even years after recovery from acute disease, potentially enabling spread to new geographical regions. For instance, in 2021 in Guinea, an Ebola survivor had a recurrence of acute illness one year after their initial infection. This led to community infection and triggered a "new" outbreak. This, says Griffin, is an example of evolving understanding about what persistence means in Ebola and the potential public health and long term consequences.

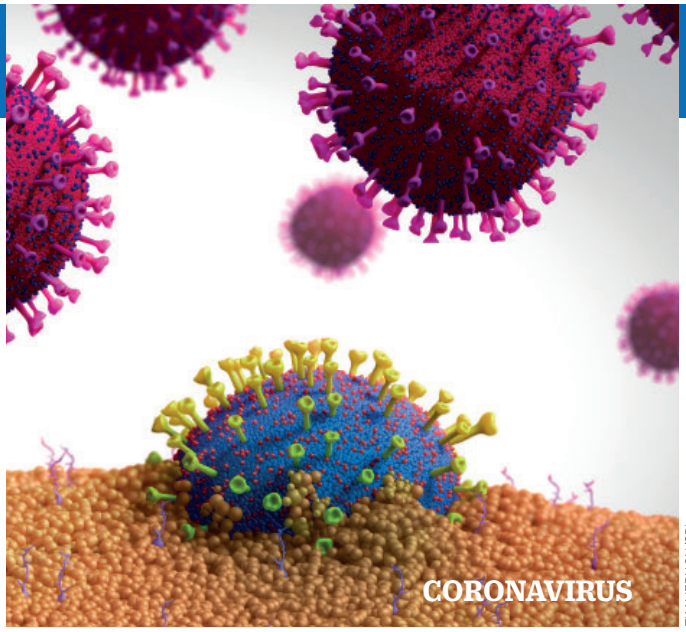


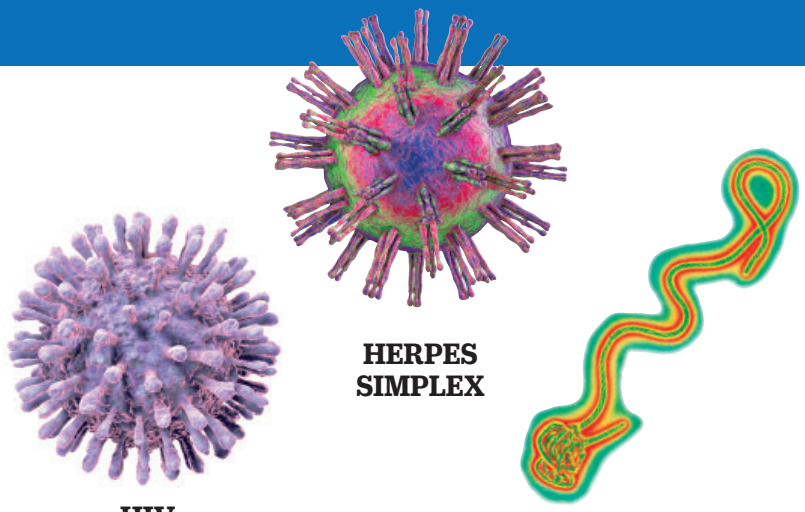
CHICKENPOX



ZIKA VIRUS

She also points out that some viruses such as Ebola and Zika don't have a known latent phase, yet "we know people where, six months after recovery, you get transmission of Zika, or Ebola, or reactivation of problems . . . That means that full length RNA is there and can resume production."





TIM VERNON/SPL

Can different variants hide for longer?

Sometimes. Viruses often evolve so that they avoid inducing innate immune responses, helping them replicate and survive longer inside cells. These are variants that are less likely to burst cells open, or that can limit or prevent the expression of proteins that make them recognisable by antibodies, or both.

Griffin notes that such variants may not be so readily transmitted. She highlights the fatal brain infection subacute sclerosing panencephalitis, which occurs seven to 10 years after a measles infection. "That virus is highly mutated by that time," she says. "There is a good immune response, but the immune response does no good. It's not capable of getting rid of those cells."

With SARS-CoV-2, Daniel Chertow, a critical care and infectious disease specialist at the US National Institutes of Health Clinical Center in Bethesda, Maryland, has found differences depending on where the virus is found. From autopsy samples, his team sequenced the genetic code for the SARS-CoV-2 spike protein that helps the virus enter cells. Usually, explains Chertow, what you find in the lungs is more or less what you find elsewhere, but this wasn't always the case. "There was a variant in the brain that was distinct from what we found in the respiratory tract," he says. "That is suggestive that this virus has the potential to 'evolve' in different anatomic compartments."

Where does SARS-CoV-2 hide?

This is still being investigated. One study describes autopsies that found traces of SARS-CoV-2 RNA in the lymph nodes, small intestine, adrenal gland, heart, and brain, persisting for 230 days after symptom onset in one case. For comparison, in another paper, an immunocompromised 4 year old boy secreted influenza virus in his stool for over two months after infection but for over 18 months in his respiratory secretions.

"Previously the paradigm was that this was predominantly a respiratory virus," says Chertow, who led the study. "At least in a subset, this has the potential to be a widely systemic virus that can infect cells and tissues throughout the body, including in the brain. It also has the potential to replicate in those different sites."

Does viral persistence cause long covid?

Some studies have associated persistent SARS-CoV-2 RNA with long covid, known technically as post-acute sequelae of covid-19 (PASC), although others have not. Studies have also found viral RNA in the blood of people with more severe covid-19, suggesting that infection has spread systemically, and this is one of a number of factors that might help predict PASC. However, it's not yet clear how important this viral RNA is when compared with inflammation, autoimmunity, or the possibility that SARS-CoV-2 has reactivated latent infections with other viruses such as Epstein-Barr.

Griffin says it's likely that long covid is actually more than one disease, with multiple contributing factors. You can almost always find viral RNA in acute covid-19, she says, but only a few people have any long term consequence of that—which is "one of the puzzling features." Yet she believes that the link between viral RNA and long covid is "likely to be very important."

Chertow adds, "Among the different hypotheses about what underlying drivers of the clinical manifestations of long covid might be, [viral] persistence is high on that list."

What about other postviral syndromes?

Various viruses, including parvovirus B19 and Epstein-Barr, have been linked to triggering myalgic encephalomyelitis (chronic fatigue syndrome or ME/CFS). However, as with long covid, Griffin says that "there may likely be more than one different kind of infection that can lead to that particular syndrome."

It's hard to disentangle connections with persistent viruses. "We have a big advantage with long covid in that we have a much better understanding of the virus and we have a lot of people to study," she says. "We can hope that all that attention will result in a better understanding that can be applied to these other syndromes."

Another positive development is the spotlight now being shone on virus reservoirs because of the pandemic. "This has not been an area that has received much attention until now," says Griffin. In her opinion, research into SARS-CoV-2 is likely to teach humanity about older viruses, particularly the role of persistent RNA.

Do you have a "Covid Unanswered Question"? Email mlooi@bmj.com, and we'll try to cover it in a future instalment.

There was a SARS-CoV-2 variant in the brain that was distinct from that in the respiratory tract
Daniel Chertow

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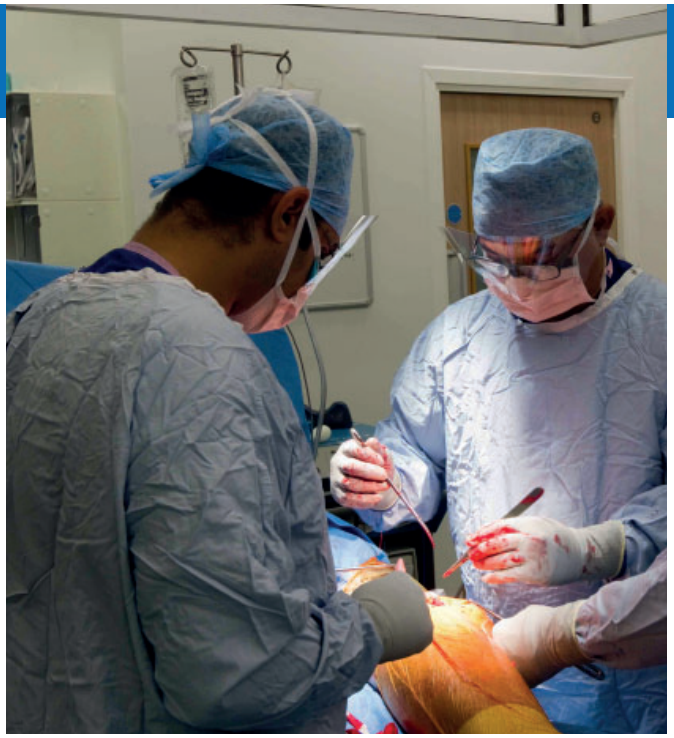
HEALTH INEQUALITIES

How data are changing the way clinicians prioritise patients and tackle waiting lists

NHS trusts are starting to use many factors beyond just waiting times and clinical priority to allocate care. This is important to avoid the elective care backlog exacerbating health inequalities, writes **Riddhi Shenoy**



Consider two patients with back pain waiting for a therapeutic lumbar injection, says Daniel Hayes, director of performance and informatics at Coventry and Warwick NHS Trust.

The first has been waiting 36 weeks for treatment and would traditionally be booked in for the procedure before the second, who has been waiting 27 weeks. Consider now that the first patient is in their 30s and is normally fit and well, whereas the second is in their 60s, lives in a deprived area, and has had three emergency attendances related to pain management in the past year. With this additional information, priority might change, enabling the second patient to be booked in first because they would benefit more from having the procedure earlier—and this would avoid exacerbating existing health inequalities.

There are many factors other than waiting time and clinical priority that affect health and should be used to prioritise care, says Hayes. These include medical, ethnicity, social, lifestyle, and other factors. Without considering these other factors, patients with the same condition, waiting for the same treatment, for the same length of time can end up with very different outcomes, increasing existing inequity.

A recovery plan for the elective care backlog must be inclusive, says Kiran Patel, chief medical officer at University Hospitals Coventry and Warwickshire NHS Trust. "Elective care scheduling needs to be driven according to outcomes, not waiting time alone."

Medical, ethnicity, social, and lifestyle factors should be used to prioritise care

Elective care scheduling needs to be driven according to outcomes, not waiting time alone
Kiran Patel

Prioritising patients

Data from NHS England show that 362 498 people had been waiting more than 52 weeks for elective treatment in February 2023. On average, the number of people on waiting lists had increased by more than half (52%) in the most deprived areas of England from April 2020 to July 2021, compared with a third (36%) in the least deprived areas.

NHS England has created the Health Inequalities Improvement Dashboard, which presents trends in a range of indicators of inequality, including ethnicity and deprivation. This is available to regions, integrated care systems, primary care networks, NHS providers, and local authorities to see their own local data. It can be used to analyse waiting lists by indicators of inequality and, alongside local data, can be used to identify where health inequalities exist and what is driving them and to inspire improvement.

Data driven strategies are key to reducing health inequalities in tackling the elective backlog,

MARK THOMAS

CASE STUDY: REDUCING DNAs

Outpatient appointments after referral can provide an opportunity for reducing health inequalities.

Of the 103 million NHS outpatient appointments booked in 2021-22, just under 8 million ended in a "did not attend" (DNA), and patients living in deprived areas might be more likely to miss their appointments.

Since May 2022, University Hospitals of Leicester NHS Trust has run a pilot to improve non-attendance at planned care for patients living in the most deprived areas. The pilot was started in the respiratory medicine department and has since been scaled to all specialties at the trust.

Patients living in the most deprived areas were contacted two weeks before their planned appointment to remind them and offer support with factors such as costs, parking, or longer appointments. The non-attendance rate of those contacted was approximately 10%, which is similar to the overall trust non-attendance rate, compared with 16% among patients who were not contacted.

"We have moved towards embedding this practice as business as usual," says Ruw Abeyratne, director of health equality and inclusion and consultant geriatrician at the trust.

She stresses the need to engage with communities to understand barriers to accessing services, before co-creating solutions. "To improve how we deliver our services, we can and must listen and adapt to what communities tell us."

said Bola Owolabi, director of national healthcare inequalities improvement at NHS England, at a panel hosted by NHS England and the Social Care Institute for Excellence last December. NHS guidance emphasises the need for accurate, timely, and complete datasets to inform interventions to reduce inequalities. In line with this national guidance, healthcare providers across the UK are already using data to analyse waiting lists by deprivation and ethnicity.

Data driven strategies are key to reducing health inequalities in tackling the elective backlog
Bola Owolabi

Machine learning, real time information

Patel's trust has developed a machine learning tool to use clinical, social, and demographic information alongside waiting times to prioritise patients on elective care waiting lists. The tool has been in use since September 2021 and is due to expand to Leeds Hospital NHS Trust this year, with an additional 70 trusts across the UK waiting to be involved.

The tool uses real time data to update waiting lists daily. This allows booking staff to identify the next patient for treatment, even if there's a last minute cancellation. Priority is determined using a range of factors including comorbidities, number of emergency admissions, and deprivation scores.

It can be tailored to healthcare specialties with customisable criteria. Machine learning can then identify criteria that have a greater effect on health outcomes and assign heavier weighting. Pain scores might be given a greater weighting than ethnicity for orthopaedic waiting lists, for example, to ensure that patients in the most pain are treated first.

Patel calls for careful consideration of the factors being used to prioritise care. "Individual risk factors that drive health inequality, such as disability and lifestyle factors, need to be considered alongside population level factors such as ethnicity and deprivation," he wrote last September.

Patients have yet to be convinced on some factors, however. Last year, between March and April, Ipsos ran a series of qualitative workshops asking 50 participants from the trust's catchment area what they thought of the change to prioritisation. Participants agreed that disease factors, including severity, effect on quality of life, and comorbidities, should contribute to prioritisation. But they didn't see ethnicity and deprivation as relevant.

The workshops also found that some factors are divisive. Should the ability to attend school or work or carry out care responsibilities be considered, for example? Not everyone agreed, but Patel is sympathetic—if a child is missing school while waiting for care, the negative effect on the child's development should contribute towards prioritisation decisions. "When we focus on outcomes, we start to embrace clinical and social determinants and the socioeconomic impact of the healthcare we deliver," he says.

CASE STUDY: FLAGGING LEARNING DISABILITIES

In addition to analysing waiting lists by deprivation and ethnicity, Calderdale and Huddersfield NHS Foundation Trust has created a dedicated team, led by nurse consultant Amanda McKie, to improve outcomes in patients with learning disabilities.

McKie attributes the success of the team to "a clear message." A Public Health England report in 2020 showed that people with learning disabilities nationally were two to three times as likely to die with covid-19 as the general population. This message has formed the basis of the trust's wider efforts to prioritise people with learning disabilities.

McKie's team found that children and young people with learning disabilities were not always accurately flagged on their electronic patient record. In response, the team expanded the learning disability flag to include those with recorded genetic conditions often associated with learning disabilities and reviewed over 500 children and young people on the waiting list for elective surgery to identify those with a learning disability. This enables earlier planning of reasonable adjustments needed, such as extra time or support required at their appointment or procedure.

The team prioritised patients with learning disabilities for elective surgery; they were displayed on a dashboard, which was updated monthly, to reduce the backlog. Every patient with a learning disability on the waiting list during the pandemic has now received care.

The dashboard is now used to help achieve an 18 week target from referral to treatment. It includes primary and secondary care data with information on attendance at outpatient appointments, emergency admissions, length of inpatient stay, and readmissions. "It's more than collecting data. We've used it to change the way we work," McKie told *The BMJ*.

We've used data to change the way we work
Amanda McKie

Patient level data, customised clinical plans

East London Foundation Trust has introduced analytics for equity to its existing real time dashboards for all services, using interactive software. One feature is that all staff can sort their waiting lists according to age, ethnicity, gender, and deprivation.

Amar Shah, consultant forensic psychiatrist and the trust's chief quality officer, says: "It's enabled us to look at patient level at those who have been waiting longer, and to ensure we pay particular attention to ensuring they are prioritised, and their needs are accommodated."

We need to get to local communities and patient level to build theories around where the inequities exist
Amar Shah

Data from Tower Hamlets, east London, showed that people with Asian or Asian British ethnicity were more likely to wait longer for assessment and to live in the most deprived areas than people with a white ethnic background. Further analysis identified variations in waiting time at patient level, with difficulties finding interpreters contributing to longer waiting times for people with Asian or Asian British ethnicity. This informs and enables administration staff to ensure that interpreters are provided for these patients' appointments.

"For others, there may well have been different reasons for the long wait," Shah tells *The BMJ*. "The principle, though, is that by looking at the data in this way, we can identify particular groups and individuals who are waiting longer than usual, try to build a theory about what may be contributing to the long wait, and the clinical team can then customise the plan to ensure we are paying attention to individual need."

He adds that, although national, regional, and system data can be interesting, "we really need to get to local communities and patient level to build theories around where the inequities exist and what might lie behind this."

Clinicians need easy access to data in a visually clear format to "ignite curiosity" into disparities in local services, he adds.

Data from Tower Hamlets, east London, showed that people with Asian or Asian British ethnicity were more likely to wait longer for assessment

BIANKA KADIC/ALAMY

Riddhi Shenoy, editorial registrar, *The BMJ*

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