this week

PIG KIDNEYS page 465 • **RSV VACCINE** page 467 • **DEROGATIONS** page 468

RCP's Clarke urged to quit over PA vote

Members and fellows of the Royal College of Physicians (RCP) have voted overwhelmingly to limit the pace and scale of the rollout of physician associates (PAs)—a result that has exposed a rift between grassroot doctors and the college and led to calls for the resignation of its president.

On 13 March members and fellows expressed concern at a fractious extraordinary general meeting (EGM) that the RCP had presented data from a survey about PAs in a biased way.

RCP hosts the Faculty of Physician Associates and receives membership and examination fees from PAs.

Four of five EGM motions covering PAs' scope of practice, accountability, evaluation, and impact on training opportunities were passed with 95.6% to 96.9% of the vote, showed results released on 21 March.

The controversy centred on the fifth motion, which called on the RCP "to limit the pace and scale of the rollout until the medicolegal matters of regulation, standards, and scope of practice are tackled." The motion was passed with 78.7% of the vote.

The turnout for the ballot was 31%, with 4398 votes cast.

RCP president Sarah Clarke said, "RCP will now work closely with its council, board of trustees, and key stakeholders in response to this clear direction from the fellowship."

Palliative care doctor Rachel Clarke said the result showed "the severity of the disconnect between RCP leadership and the members and fellows that those leaders purport to represent." She told *The BMJ*, "The college has failed to read the room from the outset, grossly underestimating both the strength of members' concerns around PAs and our incredulity at college conduct during the EGM."

Clarke had been so upset by the EGM that she has decided no longer to be a keynote speaker at this year's RCP annual conference. "Even now, the college has failed to apologise for misrepresenting data from the members' survey, referring only to 'confusion' around how they chose to present the data, rather than what actually occurred—namely, a deliberate attempt to cover up members' negative views of PAs by conflating 'neutral' and 'positive' responses," she said.

"This is a probity matter—a clear attempt to gerrymander a democratic vote."

She added that she could not see how Sarah Clarke could remain as RCP

(Continued on page 466)

Sarah Clarke, RCP's president, is facing calls to resign after the college was accused of "gerrymandering" the ballot

LATEST ONLINE

- Global leaders call for negotiators to push through pandemic accord ahead of May deadline
- Long waits in child mental health are a "ticking time bomb," regulator warns
- UK foundation programme: why are some trainees so unhappy with the new allocation system?

SEVEN DAYS IN

Junior doctors in England back six more months of strike action over pay

YUI MOK/PA/ALAMY

Junior doctors in England have overwhelmingly voted in favour (98%) of extending their mandate for industrial action for another six months, meaning they can now strike up to 19 September, the BMA has announced. The ballot also approved action short of striking.

Nearly 34 000 doctors (62%) voted in the ballot, around 10 000 fewer than last August's turnout of 43 440 (71.25%), although this is still well above the 50% minimum turnout needed for a mandate.

The co-chairs of the BMA Junior Doctors Committee, Robert Laurenson and Vivek Trivedi (far left), said, "The government should see the urgency of the situation. Rather than waste time dragging out talks, they can come forward with a credible offer on pay right now. The re-ballot shows doctors understand that reversing this means being in the struggle for the long haul."

It has been a year since junior doctors began their action, with 10 strikes since March 2023. They are calling for a 35% rise over time to restore their pay to 2008 levels.

A health department spokesperson said, "We again urge the BMA Junior Doctors Committee to demonstrate they have reasonable expectations so we can come back to the negotiating table to find a fair deal that works for the NHS, doctors, and patients."

Elisabeth Mahase, *The BMJ* Cite this as: *BMJ* 2024;384:q717

Social care

Ministers have left sector on its knees, MPs warn

The social care sector has been brought "to its knees" with severe staffing shortages, rising waiting lists, and uncertain finances, said MPs who questioned the progress of the government's promises to reform and improve the sector. The government's plans for adult social care, set out in a 2021 white paper, have gone astray, with charging reform delayed, system reform scaled back, and funding for both diverted, concluded a report from the House of Commons Public Accounts Committee.

Whooping cough

Surge in cases reported in Czech Republic

The Czech Republic is experiencing a significant outbreak of pertussis, also known as whooping cough, with more than 3000 cases reported so far this year. The country's deputy minister for health, Josef Pavlovic (right), called on parents to check their children's vaccination status and come forward if there are gaps. Uptake of the vaccine, which is mandatory in the country, is around 97% among infants. Matyáš Fošum, director of the ministry's public health protection department, said that after temporary shortages there were now "plentiful" vaccines.

Military health

RCGP wants more support for armed service veterans

The Royal College of General Practitioners launched a drive to improve veterans' access to healthcare services, in response to data indicating that thousands of former armed services personnel may be experiencing mental or physical health problems but not seeking help. The initiative aims to encourage practices to sign up to become "veteran friendly," providing extra resources to help identify, understand, and support veterans and refer them to dedicated veterans' healthcare services where appropriate.

Regulation

CQC is urged to reform its processes

NHS Providers has published a report advising the Care Quality Commission on how it could improve its approach to regulation. Produced in response to feedback from trust leaders indicating declining confidence in the regulatory body, the report urges the CQC to build relationships between its local teams and providers, improve the training, attitude, and behaviours of CQC inspection teams, do more to reflect challenging operational circumstances in its reports, and review the effectiveness of its single word ratings.

Public health

Smokefree bill is introduced to parliament

A bill to protect future generations from the harmful effects of smoking was introduced to parliament on 20 March. Under the Tobacco and Vapes Bill, children turning 15 this year or younger will never legally be able to buy tobacco. The bill will also introduce new powers to restrict vape flavours and packaging that are marketed at children. England's chief medical officer, Chris Whitty, said, "If passed this will be a major public health measure which reduces illness, disability, and premature deaths for children today and future generations."

Campaign to help parents bond with babies

The government launched a campaign to support parents in nurturing the bond with their baby to help the child's future mental health. The campaign aims to raise awareness that babies' expressions, reactions, noises, and cries are how they communicate their needs and feelings. Clinicians will also receive guidance on how to start conversations with parents about building a relationship with their baby.

Strikes

Junior doctors in Wales stage 96 hour walkout

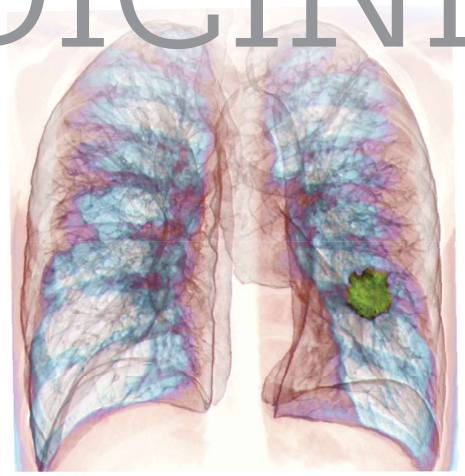
Junior doctors in Wales staged a third round of strike action. The 96 hour walkout, the longest yet, began on 25 March. Oba Babs-Osibodu and Peter Fahey, co-chairs of BMA Cymru Wales's Junior Doctors Committee, said, "We want to reiterate that the strikes can be called off at any time if the Welsh government put forward a credible pay offer to form the basis of talks. While we are undervalued and disregarded for our work, our resolve to restore our pay remains unbroken: enough is enough."

MEDICINE

Lung cancer

Researchers secure funding to develop vaccine

Researchers seeking to develop the world's first vaccine to prevent lung cancer in people at high risk of the disease have secured up to £1.7m from Cancer Research UK and the CRIS Cancer Foundation to fund the work. The LungVax vaccine—developed by scientists from the University of Oxford, the Francis Crick Institute, and University College London—will carry a strand of DNA to activate the immune system to recognise lung cancer cells, known as neoantigens. The vaccine will then activate the immune system to kill these cells and stop lung cancer.



Researchers in Oxford and London have secured £1.7m to develop a lung cancer vaccine

Travel infections

Numbers are close to pre-pandemic levels

Travel associated mosquito-borne infections such as dengue and malaria are returning to pre-pandemic levels, data from the UK Health Security Agency suggested. The agency highlighted the need for travellers to take precautions to

reduce health risks while abroad, such as using insect repellent and covering exposed skin. In 2023, 634 dengue cases were reported in returning travellers throughout England, Wales, and Northern Ireland, comparable with the 790 cases reported in 2019. Some 1637 malaria cases were confirmed in England from January to October 2023, similar to 1719 cases reported in the UK in 2019.

Patient data

Security reminder for healthcare organisations

The Information Commissioner's Office issued a reminder to all healthcare organisations about the importance of keeping patient data secure, after reports of a data breach at the London Clinic in connection with the Princess of Wales's private medical records. The ICO said that organisations should ensure that staff are thoroughly trained in data protection training, that appropriate measures such as passwords and access controls are in place to ensure that personal information can be seen only by people who need to use it, and that staff are clear on the process for reporting a data breach.

International

WHO issues warning over health situation in DRC

The overall health situation in the Democratic Republic of the Congo is worsening, exacerbated by a combination of armed conflict, severe flooding, and epidemics, the World Health Organization has warned. Poverty and hunger affect a quarter of the population, equal to 25.4 million people. The country is facing its worst cholera outbreak since 2017, with 470 deaths recorded in 2023 and 174 deaths reported so far this year. Women and girls are paying a high price during the armed conflict and resulting displacement, with 30 000 cases of gender based violence reported last year.

Cite this as: *BMJ* 2024;384:q735

NHS

Under a quarter of people (24%) were satisfied with how the NHS was run in 2023, down from 29% in 2023. More than half (52%) of respondents said they were dissatisfied with the NHS *[British Social Attitudes survey]*

SIXTY SECONDS ON . . . PIG KIDNEYS

WHAT'S THIS ALL ABOUT?

Massachusetts General Hospital in Boston has announced the world's first successful transplantation of a genetically edited pig kidney into a 62 year old man with end stage kidney disease. Richard Slayman is recovering well from the four hour operation. The hospital said the procedure was a milestone in the quest to provide more readily available organs to patients.

IS IT THE FIRST PIG TRANSPLANT?

It's actually the third transplant of a pig organ into a living human. The first two, in 2022 and 2023, were pig hearts which were transplanted into patients who had run out of other options. Both patients died weeks after receiving their organs, however.

SO IT'S STILL EXPERIMENTAL?

Although pig kidneys are very similar to humans' it has been difficult to work out how to prevent the human immune system from rejecting them. To stop this happening the pig kidney was genetically edited using CRISPR-Cas9 technology to remove harmful pig genes and add certain human genes to improve its compatibility.

DO BOAR US WITH THE DETAILS . . .

Scientists also inactivated porcine endogenous retroviruses in the pig donor to eliminate any risk of infection in humans. Drug companies have also produced special monoclonal antibodies to prevent rejection.

WHY GO DOWN THIS ROUTE?

Slayman had previously received a kidney transplant from a human donor but this showed signs of failure around five years later. Since resuming dialysis he experienced recurrent vascular access complications requiring visits to the hospital every two weeks for declotting and surgical revisions. This is a common problem among dialysis patients and severely effects quality of life.

SOW-ING SEEDS OF HOPE?

Xenotransplantation—transplanting animal organs into humans—is still in its infancy and far more research is needed. It could, however, potentially offer hope to thousands of people waiting for donor organs. NHS Blood and Transplant estimates that there are more than 5500 people in the UK in need of a kidney and the average wait is between two and three years.

Jacqui Wise, Kent

Cite this as: *BMJ* 2024;384:q731

(Continued from page 463)

MOTIONS PASSED RCP EGM

Motion 1 96.9% said PAs are not doctors nor replacements for doctors

Motion 2 95.6% said doctors are responsible for decisions on treatment/diagnosis

Motion 3 96.1% said RCP must produce evidence on PAs

Motion 4 95.9% said RCP must document impact of PAs on doctors' training opportunities

Motion 5 78.7% backed pause on PA roll out

president. "The data misrepresentation alone is disastrous—but the PA project she is spearheading has been proven to be radically at odds with the views of members. She does not represent us, and neither, I believe, does the college currently meet the high standards of professionalism and probity the public rightly expects from all doctors."

Trish Greenhalgh, professor of general practice at the Nuffield Department of Primary Care Health Sciences at Oxford University, said, "I have been shocked at the unfolding of what I interpret to be serious breaches of governance at the heart of the college." She told *The BMJ*, "I remain concerned that the partial and distorted presentation of data at the EGM may have been a deliberate attempt to deceive. I understand there is to be an independent inquiry and I hope this will be the start of a transformation for the better in college leadership."

Partha Kar, consultant in diabetes and endocrinology at Portsmouth Hospitals NHS Trust, welcomed the vote. "It is time for senior leadership to reflect, listen to members, and work on matters regarding PAs, especially around safety, presence on rotas, and development of scope. A pause is the right thing for many reasons—most importantly to take stock of this healthcare intervention and review it in light of patient safety flags," he said.

There are around 3000 PAs working in the UK. NHS England's long term workforce plan aims for an expansion in numbers over the next decade.

The RCP president recently wrote an opinion piece for *The BMJ* arguing there is a role for PAs in the NHS.

Jacqui Wise, Kent

Cite this as: *BMJ* 2024;384:q732

Ministers criticised for ignoring patient safety recommendations

Experts have rebuked the government for failing to implement accepted patient safety recommendations—some nearly a decade old—made by several major inquiries.

An expert panel convened by the Health and Social Care Committee highlighted shortcomings across three policy areas—maternity care and leadership, training of health and social care staff, and safety culture and whistleblowing.

It noted a "worrying" decline in the proportion of NHS staff who feel safe raising concerns about patient safety and said ministers had failed to provide adequate funding to train staff to take up targeted interventions on leadership and organisational values.

Steve Brine, chair of the committee, said it was "disturbing" to hear of delays in fully implementing important patient safety measures.

The panel was commissioned by MPs in the wake of the Lucy Letby case to measure what progress the government had made in acting on the findings of independent inquiries that featured major patient safety incidents, including loss of life.

It is disturbing to hear of delays in fully implementing the majority of the measures
Steve Brine (below)

Its evaluation covered the report of the Morecambe Bay investigation (March 2015), the report of the Mid Staffordshire NHS Foundation Trust public inquiry (February 2013), the Leadership for a Collaborative and Inclusive Future report on health and social care (June 2022), and the Freedom to Speak Up review (February 2015).

The panel said that there was "good performance" and "imminent progress" in some areas but gave the government a "requires improvement" rating across all recommendations, having looked at five commitments across the three policy areas.

"Nine or more years have passed since these recommendations were accepted by the government of the day. We are concerned about delays to take real action to implement them," said panel chair Jane Dacre, a past president of the Royal College of Physicians.

The panel acknowledged progress on a recommendation from the Morecambe Bay

Drug company and former director convicted of submitting falsified data to MHRA

The drug company Kappin and its former director Kamlesh Vaghjiani have been successfully prosecuted for knowingly providing false data to the UK's drug regulator, the Medicines and Healthcare Products Regulatory Agency (MHRA), to obtain and then retain marketing authorisation for a hypothyroidism treatment.

In a UK first, Vaghjiani and Kappin have been fined £50 000, having previously paid out nearly £1.1m that they made in profits from the crime. The drug company must pay the prosecution costs of £82 262.

At Southwark Crown Court in London on 15 March Vaghjiani was also given two concurrent suspended sentences of eight months and seven months for two counts of falsifying data. Last October he and Kappin changed their pleas to guilty on all charges.

KAPPIN must pay the prosecution costs of **£82 262**

The MHRA's deputy director for criminal enforcement, Andy Morling, said, "This is a shocking case of a pharmaceutical company that thought it was above the law and was not required to uphold our stringent standards for safety, quality, and effectiveness."

The MHRA's investigation began in 2008 after it

investigation to improve maternity care and leadership to tackle the lack of independent oversight of perinatal deaths or maternal deaths. But it said, "Although we recognise that there are now several more mechanisms in place to facilitate independent scrutiny of perinatal and maternal deaths, we do not agree that this recommendation has been fully met."

The 2013 report of the Mid Staffordshire public inquiry, chaired by Robert Francis (above), recommended a common code of ethics, standards, and conduct for senior board level healthcare leaders and managers, with staff obliged to comply with the code and employers to enforce it. The panel's report said general principles on a code existed in guidance and frameworks but there were gaps in implementation and enforcement, so the government's performance required improvement.

It also reported considerable variation between organisations and trusts in implementing freedom to speak up (FTSU) guardians. Specific guidance on the rollout of FTSU guidance in primary care has been delayed, despite the recommendations being made in 2015.

The Department of Health and Social Care insisted it had made significant progress to improve care, including publishing the first NHS patient safety strategy. A department spokesperson said, "We recently announced the first phase of Martha's rule, which will give patients or family members in 100 NHS sites the right to a rapid review of their care if they are concerned their condition is worsening.

"We have also established an independent body to investigate and learn from serious patient safety incidents, and we have made progress in improving maternity services, reducing the stillbirth and neonatal death rate by 23% and 30% respectively since 2010."

Matthew Limb, London

Cite this as: *BMJ* 2024;384:q727

received reports Kappin's hypothyroidism treatment Evotrox, which was licensed two years earlier, was not stable for the whole duration of the shelf life that had been claimed in the original licence application. At that time Vaghjiani was the company's quality assurance manager.

Cover-up

During the regulator's investigation it said Kappin "continued to submit falsified data" to try to "support the medicine's stability and effectiveness." MHRA testing and detailed analysis of the data retrieved from laboratory computers then "brought the deceptions to light." The marketing authorisation for Evotrox was terminated in 2013.

"The lengths to which they were prepared to go to cover up wrongdoing are completely unacceptable," said Morling. "While the MHRA found no evidence patients were harmed, that the manufacturers were prepared to put them at risk by knowingly supplying a substandard product is very concerning."

Elisabeth Mahase, *The BMJ*

Cite this as: *BMJ* 2024;384:q709

Paediatricians call for expedited infant RSV vaccination programme

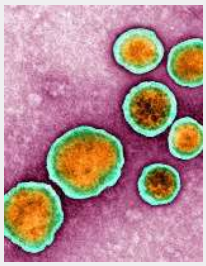
The Royal College of Paediatrics and Child Health (RCPCH) has called on the UK government not to wait until after the upcoming general election to approve an infant immunisation programme against respiratory syncytial virus (RSV), so that babies can be protected next winter.

In June 2023 the Joint Committee on Vaccinations and Immunisations (JCVI) recommended developing an RSV immunisation programme for infants and for older adults. But the government has yet to make a final decision.

A letter signed by more than 2000 paediatricians and health professionals says the sooner a full vaccination programme is implemented the more effective it will be and that it "could save child health services reaching breaking point." It says the UK risks falling behind other countries that have already introduced programmes.

The open letter addressed to the UK health secretary, Victoria Atkins, says, "You can act now to relieve pressure on health services this coming autumn and winter as well as help prevent infant and child mortality. We call on you to approve an RSV vaccination programme urgently."

In the UK RSV peaks in December and causes around 33 500 hospital admissions in children under 5 every year. It is linked to 20-30 childhood deaths a year. Rolling out a vaccine to infants could result in 108 000 fewer GP consultations, 74 000 fewer A&E visits, and 20 000 fewer admissions solely in children aged under 1, the letter says.



DO NOT WAIT UNTIL AFTER THE UPCOMING ELECTION. RSV WON'T WAIT
Camilla Kingdon

"Every year our child health services grind to a halt with high levels of RSV and other winter bugs. We now have an opportunity to turn the tide on this trend," said Camilla Kingdon, president of the RCPCH.

"No-brainer"

"We simply cannot have another winter like the last. The chancellor and health secretary are staring a no-brainer in the face—they must heed the advice of doctors. Together with 2000 of my colleagues, I urge them to seize this opportunity and not wait until after the upcoming election. RSV won't wait."

Nirsevimab (Beyfortus), a long acting monoclonal antibody for passive immunisation against RSV infection, was licensed by MHRA in November 2022. A study of more than 8000 infants showed it reduced RSV associated hospital admissions in infants by 83%.

Abrysvo, a bivalent maternal vaccine developed by Pfizer, was also approved by the agency last November. It is intended for use by pregnant women to protect their infants, as well as for adults over 60.

A spokesperson for the Department of Health and Social Care said a decision on a potential RSV vaccine programme would be made in the coming months.

Jacqui Wise, Kent

Cite this as: *BMJ* 2024;384:q706

Hospital leaders warned that failure to recall striking doctors risked patient safety in some trusts, documents show

A *BMJ* investigation has shed new light on the process of derogation, which is designed to protect patients during industrial action by healthworkers. **Gareth Iacobucci** reports

There seemed to be almost no circumstances in which the BMA would agree to requests
Danny Mortimer

EXCLUSIVE An investigation by *The BMJ* has revealed new details of requests to recall striking junior doctors from picket lines for patient safety reasons. While most trusts in England did not make such requests, those that did were rejected by the BMA in most cases.

Some of the trusts that made requests warned of potential harm to patients from cancelling operations at the last minute and short staffing.

The BMA said it took concerns around patient safety "incredibly seriously" and that poor planning by some trusts had led to some routine care being inappropriately booked in on strike days. In other instances, said the BMA, trusts had failed to make sufficient effort to draft in the necessary cover for strike days.

Documents disclosed to *The BMJ* show that over 90% of NHS trusts (83 of 90 respondents) that responded to a freedom of information (FOI) request did not make any derogation applications during the first nine strikes by junior doctors from March 2023 to January 2024. The remaining seven trusts made 27 derogation requests between them, of which 24 (89%) were rejected by the BMA, one (4%) was approved, and two (7%) were withdrawn by the trust.

The BMJ sent FOI requests to 135 NHS trusts in England and received 90 responses (a 67% response rate) to better understand the performance of derogation—the process designed to keep patients safe during times of industrial action. Derogation allows trusts to ask for staff to be exempt from strikes if they believe that patient safety is at risk.

The documents show that in some cases trusts that submitted derogation requests were able to find last minute cover to minimise the impact on patients. But in other cases surgical procedures for breast cancer, abdominal hysterectomy due to cancer, and hemicolectomy were cancelled at the last minute, alongside diagnostic procedures such as endoscopies, hysteroscopies, and biopsies. In other cases trusts identified potentially avoidable harm to patients in critical care and raised concerns around safe staffing (boxes 1 and 2).

BOX 1 | "SIGNIFICANT PATIENT SAFETY RISKS"

Lewisham and Greenwich NHS Trust made six requests during the strike on 3-9 January. Three were rejected, two were withdrawn, and one was approved—for a doctor in specialty training to staff the neonatology department at University Hospital Lewisham on 5 January.

Patient safety mitigation forms submitted by the trust as part of the derogation process highlighted "significant patient safety risks" that could arise if requests were not met. The trust warned that failure to meet three requests for cover would lead to a "very high" chance of "death or permanent incapacity." The three requests were rejected. In one form for 8 January the trust highlighted that "potential avoidable harm has been identified for 3 patients admitted to critical care on 3/4 January."

The three rejections—and the BMA's reasons

Request 1: For three junior doctors to cover the general medicine ward at Queen Elizabeth Hospital from 8 am to 8 pm on 4 January

BMA response: Rejected because significantly more people were covering the shift (42) than normally required for a bank holiday shift (16)

Request 2: For three doctors to cover the general medicine ward at Queen Elizabeth Hospital from 8 am to 8 pm each day on 6 and 7 January

BMA response: After a request for more information this was rejected, as NHS England confirmed that the department was staffed to non-strike day levels

Request 3: For two doctors to cover the general medicine ward at Queen Elizabeth Hospital from 8 am 8 pm on 8 January

BMA response: Rejected, as it was not clear whether all staff had been communicated to appeal for availability to work. NHS England withdrew the request

Responses

For example, Lewisham and Greenwich NHS Trust disclosed a patient mitigation form in which the trust's

DOCUMENTS showed that over **90%** of 90 respondents did not apply for a derogation in the first nine strikes

chief medical officer said that three patients were admitted to critical care on 3 January, "where it appears that there was a delay in recognition/escalation of care . . . related to the increased demand across the site." Lewisham and Greenwich Trust declined to comment further about the effect on patients.

In October 2023 the Department of Health and Social Care said that 22 critical incidents had been declared in the NHS in England from December 2022 (when nurses were the first healthcare workers to strike) to October 2023 because of disruption caused by industrial action, including having to transfer critical care patients to other hospitals. The department also disclosed that 17 derogation requests were rejected during the strikes in August 2023. The FOI data gathered by *The BMJ* show only four derogation requests in that month; the figures reported by *The BMJ* are therefore likely to be an underestimate, as 33% of trusts did not reply to the FOI request.

Amid growing disagreement with the BMA over how and when the derogation process should be deployed, NHS England said that it would start recording harm caused to patients during strike action where derogations had been rejected by the BMA. NHS England disclosed some of this information to *The BMJ* under the Freedom of Information Act. It showed that rejecting derogations had led to patients being distressed by delays to cancer surgery and diagnostic procedures and being delayed in being discharged from hospital (box 3).

NHS data showed that rejecting derogations had led to patients being distressed by delays to cancer surgery and diagnostic procedures

The reports of critical incidents and safety issues have led to some NHS leaders questioning whether the process of derogation is meeting its objectives. Danny Mortimer, chief executive of NHS Employers, said, "The process for requesting derogations during action by junior doctors undoubtedly caused many trusts to decide not to submit requests, as there seemed to be almost no circumstances in which the BMA would agree to requests whatever the concerns that were raised."

BOX 2 | DELAYS TO CANCER TREATMENT

Great Western Hospitals NHS Foundation Trust in Swindon had five derogation requests rejected for the strike from 3-9 January 2024. Documents show that the trust's medical director identified "significant risk to patients not having timely cancer surgery, and diagnostics, which if delayed could lead to risk to life."

Great Western Hospitals' requests—and how the BMA responded

Request 1: One junior doctor to cover general surgery to free up a consultant to do P2 cancer surgeries (patients assessed as needing treatment within a month). Rejection led to rescheduling of two hemicolectomy operations and one transanal endoscopic operation

Request 2: Two junior doctors to cover gynaecology to enable consultants to do five P2 surgeries. Rejection saw rescheduling of four diagnostic hysteroscopies and biopsies, two MyoSure TCI, and one total abdominal hysterectomy due to cancer

Request 3: One junior doctor to cover breast surgery to free up a consultant breast surgeon to do surgeries. Rejection led to two patients on the breast cancer pathway having surgery delayed

Request 4: Two junior doctors to free up consultants covering gastroenterology wards to do two week wait cancer referral pathway endoscopy lists. Rejection led to six endoscopy lists being rescheduled

Request 5: One junior doctor to cover obstetrics to free up consultants to run urgent, time critical antenatal clinics. The trust identified specific risks to high risk pregnant women and said that previous cancellations during the last strike period had increased the risk. On the day, however, additional junior doctors opted to work so that the clinics could go ahead

BMA response to requests 1-4: P2 activity should not be scheduled for strike days, and non-urgent care should be rescheduled around strike days to allow P2 activity to take place then instead. Meanwhile, information was not made available to the BMA or shared in time

BMA response to request 5: BMA understood that the number of junior doctors working exceeded those expected to be absent. The trust was able to secure staff to deliver an urgent clinic on Monday

Asked to assess the impact after the event, a spokesperson for Great Western Hospitals NHS Foundation Trust said that the rejections affected "the care we were able to provide to some of our patients whose planned appointments, treatments, and procedures had to be rescheduled for a later date."

BMA defends role

The BMA has defended its role in the process and provided *The BMJ* with summaries of why requests were turned down (see boxes 1 and 2).

The union's chair of council, Phil Banfield, said, "Throughout industrial action we have engaged thoroughly and in good faith with the derogation process, considering each request carefully to ensure that granting a derogation is necessary and the last and only option. The figures from these FOI requests show that only a small number of derogation requests were submitted over the last year, thanks to good planning by trusts."

BOX 3 | INFORMATION GATHERED BY NHS ENGLAND ON PATIENT HARM DURING STRIKE ACTION

Breast cancer surgery
A very small number of patients on the breast cancer pathway experienced notable distress owing to the delay of their surgeries. The emotional toll of these delays, while not quantitatively measured, represents a significant impact on patient wellbeing.

General surgery
Patients awaiting hemicolectomy and transanal endoscopic operations experienced delays, causing distress.

Gynaecology
Delays in diagnostic hysteroscopies, biopsies, and surgical procedures such as MyoSure and total abdominal hysterectomy owing to cancer caused considerable patient distress. The impact of delays in these critical procedures is unknown at present.

Gastroenterology
The emotional and psychological impact of delays on patients scheduled for endoscopies was noted.

Emergency medicine
Instances of departments operating below minimum safe staffing levels were noted, introducing a heightened risk of harm related to delays, as well as remarks around potential increases to the length of stay for patients in the emergency department. The circumstances described suggest an environment where patient safety could be compromised.

Medical specialties and general medicine
Increased length of stay and delays in patient reviews and investigations were linked to a perceived increase in patient harm.

Source: BMJ FOI request to NHS England. Data were supplied to NHS England by six anonymous trusts across nine specialties.

Banfield added, "We take concerns around patient safety incredibly seriously. We also recognise that industrial action causes disruption, and it is for that reason that any proposed industrial action is taken only as a last resort. During the junior doctor strikes more senior doctors—consultants and SAS doctors [specialists, associate specialists, and specialty doctors]—who are not on strike can be available to ensure safe patient care."

But he added that some trusts, as well as NHS England and NHS Employers, had not demonstrated "the same good faith that we have" when using the process. For example, he said that poor planning by some trusts had led to non-urgent activity being booked in on strike days.

"In other cases, trusts have been unable to demonstrate they've gone to all possible efforts to cover urgent and emergency care on strike days, including offering increased rates of pay or time off to consultants and SAS doctors," he said. "This has not been helped by NHS Employers telling trusts that they do not need to provide such information to us."

He added that the BMA had received some derogation requests, only for consultants on the ground to tell the union that departments were staffed safely or for trusts themselves to confirm "that departments had more staff working than they normally would on non-strike days."

Medical directors of several trusts that disclosed details of rejections were approached for comment but declined to speak to *The BMJ* about the process. Commenting on the derogation process, Mortimer said, "It is for the BMA to state whether they are happy with the process, particularly in the light of evidence in this article and in the information shared with them in recent months by NHS England."

Derogation disagreements

When the industrial dispute between the government and junior doctors began last year the BMA agreed the voluntary derogation process with NHS England. It allowed trusts to recall striking doctors in the event of safety concerns arising from "unexpected and extreme circumstances" unrelated to industrial action. Under this approach the medical director or nominated executive director of the trust contacts NHS England, which passes details to the BMA. The BMA then has to agree the incident can be mitigated only by recalling junior doctors.

Each request is considered carefully to ensure that granting a derogation is necessary and the last and only option
Phil Banfield

Similar agreements have been in place for previous strikes including the 2016 junior doctors strike whereby trusts could escalate concerns through NHS England. But the BMA said that this was not the same as the derogation process used over the past year.

The BMA initially reported the process was working well. More recently, however, relations with NHS England have become fraught. During strike action in early January the BMA accused some trusts of requesting derogations without giving the BMA the necessary information to recall striking doctors. NHS England said it was "regrettable" that the BMA had questioned "the integrity and motive of local clinical leaders."

"What better planning can achieve"

Banfield highlighted that in the most recent round of strike action by junior doctors NHS England had asked the BMA to provide national derogations for some cancer care. "Ultimately, NHS England worked more closely with these specific sites, and no derogation requests were necessary—demonstrating what better planning can achieve," he said.

"We continue to be more than willing to work with NHS England on clarity around planning, prioritisation, and rescheduling, and we will continue to engage constructively and responsibly with the derogation process, should there be further industrial action. All we ask is that NHS England and trusts do so in the same spirit, which carefully balances the need to prioritise patient safety and allow doctors to exercise their legal right to take industrial action."

An NHS England spokesperson said, "NHS staff, including junior doctors, have worked incredibly hard to maintain the safest possible level of vital services such as cancer, maternity, and urgent and emergency care on strike days. We continue to have active discussions with the BMA to ensure that, in any future periods of action, requests by local clinical leaders for patient safety mitigations are considered quickly and consistently."

Gareth Iacobucci, *The BMJ*

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EDITORIAL

Prison healthcare is in perpetual crisis

Reform and investment are urgently needed in England and Wales to improve outcomes and save lives

The global prison population is around 11.5 million people,[1] and more than 30 million people move between communities and prisons each year.[2] Prisoners experience a disproportionate burden of ill health, including high levels of long term physical and mental illness, bloodborne virus infections, and substance misuse.[3]

Healthcare delivery is difficult in overcrowded, often outdated prison estates facing security, staffing, and funding challenges.[4] Prisoners experience variable care quality,[5] delays to assessment and treatment,[6] stigma and discrimination,[7] and poorer health outcomes, including excess mortality.[8] People in contact with the justice system often experience health inequalities whether living in custody or the community.[9] The principle of equivalence—that prison healthcare "should be of the same scope and quality" as in the community—is well established[2] but remains aspirational.

Two organisations that review standards of care have published hard hitting reports on healthcare in prisons in England and Wales. The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) review of "natural" and "non-natural" deaths identified that 22% of the 247 deaths in 2019-20 were avoidable and many were premature; the median age for natural death in prisoners was 67.5 years compared with 86.7 years in the general population.[10] Natural deaths could have been prevented by earlier identification of deterioration, and non-natural deaths by reducing illicit drug use.

The report recommends six priorities for improvement: healthcare assessment and monitoring, recognition of deterioration, transfer to hospital, cardiopulmonary resuscitation training, end-of-life care, and learning from independent clinical reviews of deaths.

A second report, from prison independent monitoring boards (IMBs), described inhumane conditions and treatment delays for men with mental illness.[1] Many are placed in segregation units because of a lack of capacity in prison healthcare units and secure hospitals. Inappropriate, prolonged segregation—more than 800 days in one instance—resulted in deteriorating health and behaviour.

Poorer health outcomes are associated with deficiencies in how prison healthcare is organised, resourced, and staffed

The report calls for more secure hospital beds, reinstatement of the proposed mental health bill to accelerate transfers to hospital, and improved community mental health provision. Core to both reports is staffing: NCEPOD's primary recommendation is to provide enough skilled prison healthcare staff,[10] and the IMBs describe how low staffing undermines care quality.[11]

Inadequate staffing

Poorer health outcomes are associated with deficiencies in how prison healthcare is organised, resourced, and staffed.[12] Although the expertise, commitment, and teamwork between prison officers and healthcare staff is recognised,[13] enduring problems with recruitment, retention, and attrition of the combined workforce since 2010, partly through austerity, has led to destabilisation of prison healthcare.[14]

Vacancies across prison healthcare are at an all-time high.[15] Chronic understaffing was a dominant organisational influence on quality of and access to healthcare in prisons in the north of England.[12] Combined with dependence on locum staff, this can lead to reactive, crisis led healthcare.[12] A lack of prison officers directly affects healthcare as staff are unable to escort prisoners to appointments. In 2017-18, 40% of hospital outpatient appointments for prisoners in England and Wales were missed.[16]

Prison healthcare careers often have negative preconceptions,[17] a demanding, sometimes discriminatory environment,[18] and an atypical career structure with no mandated training. NHS prison healthcare in England and Wales varies by site and is delivered by competing NHS, private, and third sector providers. The terms offered by some providers (including pension provision, sick pay, and holiday pay) compare unfavourably with clinical careers in the wider NHS.

Both reports highlight serious shortcomings in a closed prison system where people largely depend on a depleted body of health professionals and prison staff to ensure their safety. The findings are of national and international importance, augmenting existing reports and guidance[15 21] and amplifying longstanding concerns that the UK government is in breach of duty of care towards prisoners.[22]

Prison healthcare is continually in crisis, and change will require coordinated, evidence informed action across sectors. For example, improving information sharing and tackling health inequalities through "population health management,"[23] and reducing the prison population through changes to sentencing.[24]

Obstacles to change include political and societal indifference to prison healthcare and lack of understanding of the relation between unmet health needs and reoffending.[25] High quality contact with healthcare provides a crucial opportunity to confront these needs and improve outcomes. A combined focus on the inextricably linked issues of staffing and quality of prison healthcare is now required.

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THE BIG PICTURE

Covid remembered in NHS portraits

Experiences of working through the pandemic in Stockport have been captured in portraits of NHS staff by local artists.

Clinical and non-clinical staff, who worked during the covid crisis at Stepping Hill Hospital and in community services run by Stockport NHS Foundation Trust, are represented in the exhibition, which forms part of the town's Covid Community Commemoration Project.

The stories accompanying the paintings give insights into the challenges and struggles the subjects faced at the height of the pandemic, and the terrible impact which the virus had on the lives of local people.

Nic Firth, the trust's chief nurse, said, "These were extremely hard times for all of us, and that certainly comes over in the stories. This exhibition offers a chance to reflect on one of the most turbulent times in NHS history."

The free exhibition is running at the gallery until Thursday 11 April, when the portraits will be returned to Stepping Hill Hospital for permanent display.

Alison Shepherd, Kent Cite this as: *BMJ* 2024;384:q741

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1. **Mike Mantle, a domestic in a covid ward at the hospital, painted by Gordon Deacon**
2. **Nesta Featherstone, associate nurse director infection prevention and control, by Brigid Brind**
3. **Deb Sivori, antenatal and newborn baby screening midwife, by Katie Patel**
4. **Patriot Ofori-Aning, charge nurse on ward E1, by Jackie Jamieson**
5. **Lynne Wareing, pathology quality manager, by Alison Murdoch**

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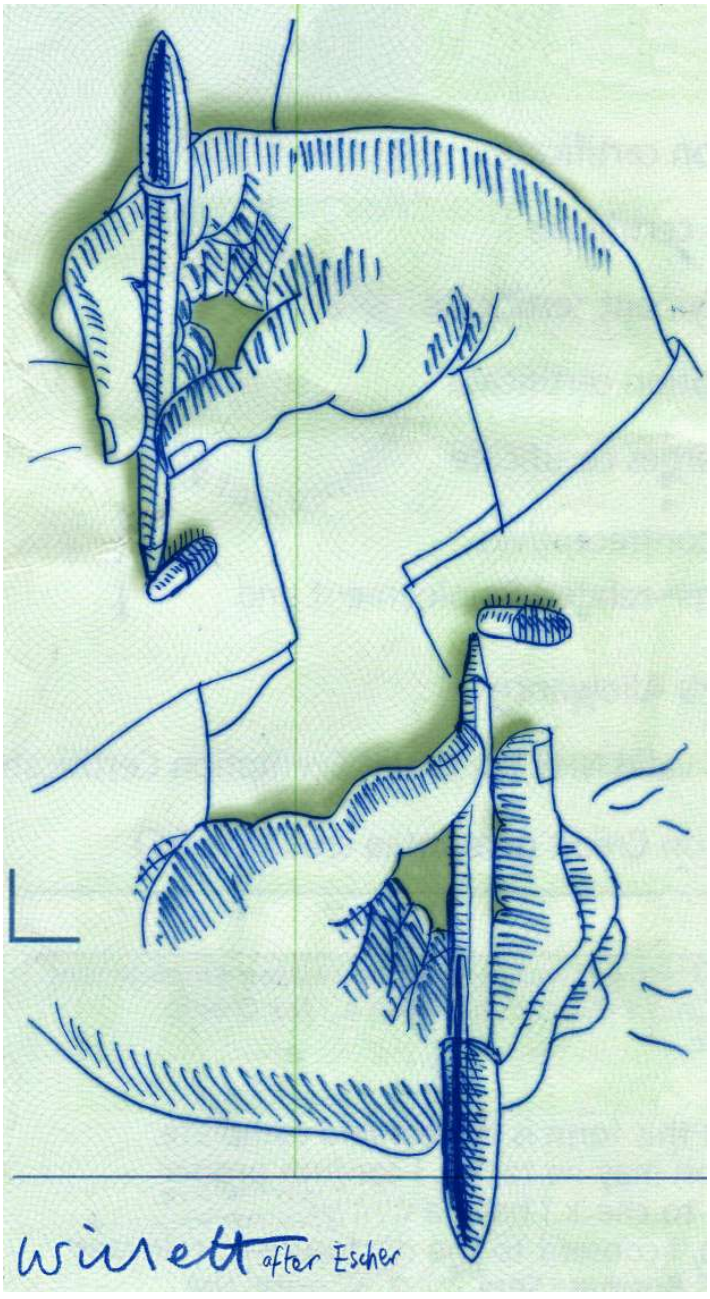
STOCKPORT COUNCIL

SCIENCE PUBLISHING

Frontiers' journals had large scale retractions—where does that leave its reputation?

The for-profit, open access publisher has struggled with the perception that it has low editorial standards and weak peer review. But is that true, asks **Brian Owens**



We are a recognised, world leading open access publisher… It's frankly baffling that this defamatory term 'predatory' persists in some circles
Anastasia Long

In September 2023 Frontiers—one of the world's largest open access scientific publishers, with a stable of 230 journals covering just about every field of science—retracted 38 papers. All had been linked to the "unethical practice of buying or selling authorship on research papers," known as "authorship for sale," in which authors, during the review process, sell coauthorship to people who have not contributed to the research.

In response to the scandal the company changed its policy on requests for changes to authorship after a paper has been accepted. The new policy states that requests for changes to the author list will be accepted only "under exceptional circumstances and after in-depth assessment by the Frontiers' research integrity unit."

Frontiers also said it would maintain a record of all such requests to identify suspicious patterns and trends. And it pledged to monitor websites where authorships are known to be put up for sale for any mention of Frontiers content.

Anastasia Long, the company's public relations manager, says that authorship for sale is an industry-wide problem, potentially affecting more than 10 000 papers. "As with all attempts to systematically breach codes of ethical conduct, publishers must work together to put a stop to this practice," she tells *The BMJ*. "This is why we also share details of our investigations and the methods we use to identify authorship-for-sale papers, and 'paper mill' papers, with publishing organisations."

Helen Macdonald, *The BMJ*'s publication ethics and content integrity editor, says: "*The BMJ* considers the sale of authorship to be unethical and unacceptable. Were there evidence of this before publication then the content would be rejected. If concerns arose after publication we would consider whether the content required post-publication changes, such as a correction, expression of concern, or retraction. We would consider further action, such as contacting the authors' institution."

This is not the first time Frontiers has been involved in controversy. In 2015 the publisher was added to the now defunct "Beall's list" of predatory publishers after the editors of three of the company's medical journals complained that it was interfering with editorial independence and had "unacceptable peer review procedures," such as allowing authors to

Fraud is rampant throughout the publishing ecosystem
John Dupuis

The sale of authorship is unethical and unacceptable
Helen Macdonald

Without the people the industry is setting itself up to fail
Ivan Oransky

pick which associate editor handles their paper and sometimes allowing Frontiers staff to override editorial decisions. In response Frontiers removed 31 editors and strongly denied any editorial interference.

Long says, "Even a superficial fact checking of our editorial programme makes clear that we are a recognised, world leading open access publisher, with clear and transparent editorial processes alongside dedicated and extensive research integrity resource and investment. It's frankly baffling that this defamatory term ["predatory"] persists in some circles."

Although some websites still list Frontiers as a predatory publisher, to which Frontiers has publicly objected, many in the industry say the reality is more complex.

Not so simple

"Frontiers is a really interesting case," says John Dupuis, a librarian in the science and engineering library at York University in Toronto, Canada. "Some of its journals are quite good and have a decent reputation in their field, others not so much."

Ivan Oransky, cofounder of Retraction Watch, is not a fan of the "predatory" label either, for Frontiers or any other publisher. "We should eschew false binaries," he says. "Everything is a continuum, and the quality of publishers is no exception."

In fact, he says, there is probably a bigger difference in quality between journals at any given publisher than between different publishers.

That reflects the experiences of researchers who have written, reviewed, or edited for Frontiers' journals. Keith Brunt, who studies translational medicine at Dalhousie Medicine New Brunswick in Saint John, Canada, has been an associate editor at *Frontiers in Physiology* for 10 years. He says he has had both good and bad experiences working with the publisher. He disagrees that it is predatory and says the fact that editors and reviewers are named on each paper improves accountability.

But he says it can be more difficult, when peer reviewing for Frontiers, to reject papers that receive poor peer reviews than for other journals. Associate editors do not have enough power to set minimal criteria or to reject on the basis of suspected fraud, and there is no limit on the number of times authors can re-submit, sometimes leaving reviewers frustrated and overwhelmed. "It is not impossible to reject; it just takes a bit more effort and being direct—for example, by saying 'address this or it's a no-go,'" he says.

Long says the company does not get involved in peer review and editorial decisions. She tells *The BMJ*, "Frontiers' approach to publishing is to put the editorial responsibility squarely in the hands of the editorial board, who collectively make acceptance or rejection decisions and have the independence to shape the direction of research in their journal."

The company's data show that, after authors' revisions during the review process, handling editors follow the recommendations of the first two reviewers about 90% of the time, says Long. And rejection rates have been rising as Frontiers enhances its quality controls, she adds. In 2023 the desk rejection rate was 33% and the overall rejection rate was 56%. A survey of visitors to the Frontiers website found that 92% of researchers rated the company's peer review as excellent or good.

Impossible scale

Failure to detect scientific fraud is hardly unique to Frontiers, Dupuis points out. All the big publishers, such as Elsevier and Springer Nature, have faced huge retractions in recent years involving hundreds of papers. "The issue is rampant throughout the entire publishing ecosystem," he says.

And that is largely because the industry has grown so much in recent decades, probably beyond its ability to review all research to the desired level, says Oransky. "The elephant in the room is the impossible scale," he says. "There are not enough people to do all the peer review needed. The industry is setting itself up to fail."

The huge number of journals out there is part of the reason predatory publisher blacklists, or alternative whitelists of trustworthy journals, are so popular, to take some of the guesswork out of deciding where to submit a paper. But even the people who run those lists warn that they are not a substitute for an author's own critical thinking.

For example, most of the Frontiers titles indexed in the Directory of Open Access Journals (DOAJ), an independent, community run listing, have been awarded the "DOAJ seal," something that less than 10% of journals in the directory achieve. The seal indicates that the journals are adhering to best practices in open access publishing, says Judith Barnsbury, head of editorial at DOAJ, such as using a Creative Commons licence, authors retaining copyright, and providing article metadata to DOAJ. But, she says, the seal isn't intended to imply anything about editorial quality.

Because it is often interpreted that way, DOAJ spends a lot of time reviewing the journals that apply for the seal, to make it as much of a whitelist as possible. "We don't want to include predatory publishers," says Barnsbury. Journals can have the seal removed if people report serious concerns, but that has not happened with any Frontiers titles recently, she says.

No list, black or white, is going to be infallible, so resources such as the Think Check Submit website (thinkchecksubmit.org) provide a good reference guide when thinking about where to publish your research, instead of relying on lists that are by design binary, says Dupuis. "I understand that the lists save time and mental effort, but they can lead you down the wrong road," he says. "It's more mental effort to do your due diligence, but it's worth it."

That due diligence might need to be more stringent when considering a Frontiers journal rather than a big commercial or scholarly society journal that you know well, says Dupuis, but it still needs to be done even for high profile publishers, such as Elsevier and Springer Nature, whose publications can very a lot in quality.

"I don't have a lot of sympathy for the idea that Frontiers is any worse," he says.

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MARMOT PLACES: **the areas taking a proactive approach to health inequalities**

Amid a "bleak" national picture, more than 40 local authorities across England and Wales have committed to making a long term difference to the health of their communities, writes **Erin Dean**

Yorkshire GP Hasantha Jayasinghe knows exactly what health inequality looks like. He sees it in many forms, but what springs to mind most are the children with chronic, difficult-to-treat asthma he sees in his practice in a deprived, inner city area of Leeds. "These children live in houses that are dreadful; there is damp, decay, mould, parts falling down," he says. "Housing is a big problem we have around here."

He is not alone in worrying about the effects of health inequalities in Leeds: last June (2023) the city became a Marmot Place. This means following the eight principles (box) set out by the influential Michael Marmot, professor of epidemiology at University College London, whose work has focused on the effects of inequality on health for more than 40 years. Jayasinghe's work looking at how GPs might be able to help their patients struggling with the effects of health inequalities has now become part of the work across the city to tackle these deep rooted problems.

The Marmot review in 2010—*Fair Society, Healthy Lives*—emphasised that health inequalities result from social inequalities: tackling health inequalities requires action across all the social determinants of health, including improving housing, education, and employment opportunities.

The review found that people in England dying each year prematurely because of health inequalities would have enjoyed up to 2.5 million extra years of life if they didn't experience those inequalities. When Marmot revisited the review 10 years later, he found that health inequalities had widened overall.

Our approach says reduce child poverty, invest in education, fix the housing stock
Michael Marmot

There are now nine Marmot Places, covering more than 40 local authorities in England and Wales (out of a total of 339), with three more areas starting this year. These places have committed to making a long term difference to the health of their communities who face deep inequality across many aspects of their lives. In the context of challenging financial circumstances for the NHS and local authorities, what changes are they able to make—and can they make a difference?

The causes of the causes

The first Marmot Place was Coventry, where in 2013 local authority leaders independently decided to use the findings of the Marmot review to guide their planning. They approached the UCL Institute of Health Equity (IHE), which is led by Marmot, and asked for help. "I was really pleased, as by that stage it was clear that the government policy of austerity was going in the wrong direction," Marmot tells *The BMJ*. "And a city government is much closer to where people live and work. They recognise the reality of people's lives."

Other areas followed Coventry's lead, with Greater Manchester, Cheshire and Merseyside, Lancashire and Cumbria, Waltham Forest, Luton, Gwent, Leeds, and the South West of England all joining by the end of last year. Wokingham, Medway, and Northumberland are all due to start this year, according to the IHE.

When an area chooses to become a Marmot Place, staff from the IHE are commissioned and paid by the local authority or public health team leading the work to assess the extent of inequalities. IHE staff work closely with local bodies to look at work that is already happening to tackle inequalities, identify gaps in existing actions, and look at where they can go further. They make recommendations on how partners in a place can work together more effectively to achieve greater effects, even with the current funding difficulties.

Reducing health inequalities can be seen as people being told to look after themselves by eating healthily and stopping smoking, Marmot says. But Marmot Places look more widely at the problems. "The reason our approach is a bit different is

The Marmot principles

Marmot Places develop and deliver interventions and policies to improve health equity based on eight principles:

- Give every child the best start in life
- Enable all children, young people, and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure a healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill health prevention
- Tackle racism, discrimination, and their outcomes
- Pursue environmental sustainability and health equity together

CHRISTOPHER FURLONG/GETTY IMAGES

because most of the focus tends to be on the healthcare system, but we are dealing with the causes of the causes," he says.

"Our approach says reduce child poverty, invest in education, fix the housing stock—make it affordable, available, and to a good environmental standard." Marmot's work has emphasised proportionate universalism, with actions that are universal but at a scale and intensity that is proportionate to the level of disadvantage.

Longer term planning

Critically, being a Marmot Place does not bring any extra funding with it, and they're being established at a time when public services are struggling financially. "The more deprived the city, the steeper the cuts have been to local authority spending," Marmot says.

Between July 2015 and 2024, the public health grants received by councils to pay for essential care including sexual health services, drug and alcohol teams, and specialist community nursing have been reduced in real terms by £858m, according to the Local Government Association. The IHE team sees the constant funding and capacity pressures in the areas it works, with the services needed to carry out changes, such as housing and social work, being cut back.

One region that is using Marmot's principles to improve health inequality is Torfaen, one of the five local authorities in Gwent, which is the first Marmot Place in Wales. Stephen Vickers is chief executive at Torfaen County Council, an area with some deep, persistent deprivation and generational poverty; he says that being a Marmot Place has allowed the five local authorities and other stakeholders, including health services, to work together and develop plans that are all focused on improving health inequalities.

The long list of about 70 recommendations for Gwent provided by the IHE's review importantly included which local body should lead on them and has directed Torfaen's long term strategic planning, he explains. "Our healthy life expectancy, particularly for women, is substantially below other areas," Vickery says. "We're tackling antisocial behaviour and drug and alcohol problems. Education is a challenge. But we are making real progress in these areas."

They are breaking away from short term cycles of planning that focus on the four years between local council elections, he adds. They are currently developing a master plan for Torfaen that is built around the eight Marmot principles, and all council planning is then benchmarked against this plan to check that it is supporting the work to tackle health inequalities. "It has really made a difference and focused us. We are currently looking at 20 years ahead, which lets us focus on issues over the long term."

We are looking at 20 years ahead, which lets us focus on issues over the long term
Stephen Vickers

Top down and ground up

When it comes to what will help a place make changes, Marmot says that support and ownership from the very top of the local government are needed. In Greater Manchester, for example, the move was backed by high profile mayor and former Labour health secretary Andy Burnham.

It is also important to listen to what matters most to local communities when planning work to reduce inequalities. "Local priorities and the voice of lived experience are important," Marmot says. "When we started working with Leeds last summer, the local government told us their two priorities were children and young people and housing, and we are happy to work with them on those."

Properly capturing the experiences of people who use services has long been a focus for Jo Trask, patient experience and health inequalities manager at the Cheshire and Merseyside Cancer Alliance. But its importance has been more widely appreciated since Cheshire and

Merseyside became a Marmot Place, she says.

Her team asks each member of staff to change one thing that will improve their service for people facing barriers to care. "We host an in-depth workshop on health inequalities where we discuss at length the barriers that prevent patients coming. In England, one in six people have very poor literacy skills, so maybe they couldn't read the letter. Extreme financial challenges mean that some people are having to make a choice between putting the heating on and feeding their children or taking a bus to hospital."

She says that doctors are "genuinely astonished" by the real life examples her team present about why patients couldn't make an appointment—such as patients living in their car or worrying that they could lose their job if they take time off to attend. "What the doctors often don't realise is that these are not one or two extreme examples. That's how people are living."

Slow and incremental

Those involved in Marmot Places point out these are long term plans, and effects will not be seen quickly.

An evaluation of the progress in Coventry published in 2020 found some positive progress in the first six years. Life expectancy for women held steady and improved fractionally for men, while it had declined for both genders nationally, and the number of neighbourhoods among the 10% most deprived in England reduced slightly. Steering group members reported a "sense of shared purpose" that encouraged them to work together, but there were also "concerning signs" of widening inequality in early years' outcomes.

Doctors might struggle to see how they can make a difference against such a complex issue. Back in Leeds, Jayasinghe is focusing on developing a new tool that could support GPs to help patients struggling with some of the social causes of health inequalities. "The Marmot principles are great, but they are very strategic, so I wanted to translate that into something that would be useful for a jobbing GP," he says.

Doctors are astonished by our examples of why people miss appointments
Jo Trask

"Patients don't turn up with a condition called health inequalities, but they do turn up with asthma that is terrible because of their housing, or they're depressed because their work is intolerable, or even worse, they don't turn up at all. But when it comes to health inequalities, GPs can be left feeling overwhelmed because they don't know where to start or think that it isn't their issue to get involved in."

The health inequalities tool for primary care that he is working on will give GPs easy access to templates they can use to try to improve an area affecting their patient's health. This could be a letter to a housing association or private landlord saying that the poor state of a family's social housing is affecting their health. "What we really don't want this to be is to make people think it's the GP's responsibility to tackle all health inequalities," Jayasinghe says. "This is a tool if they want to use it. The only way you can do this is through cooperation."

Jayasinghe is heartened by being part of a Marmot Place. "It has great potential if there's the energy and the commitment to keep going," he says.

Marmot highlights the work of the East London Foundation Trust, which provides mental health, community, primary care, and learning disability services and has become the first Marmot Trust, to show how individual organisations can commit to tackling health inequity.

For Marmot, these communities carrying forward his ethos offer a gleam of positivity. "The national situation looks bleak, things are moving in the wrong direction," he says. "But these Marmot Places show that change is possible, and that does give me hope."

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CASE STUDY: A "golden thread" to join up inequality work in Knowsley, Merseyside

Being a Marmot Place gives us a hook for all our work
Sarah McNulty

The borough of Knowsley, Merseyside, has some of the highest levels of poverty in England, with one in four households classed as "income deprived." This is an area that feels the full brunt of health inequalities.

Knowsley is part of Cheshire and Merseyside, which became a Marmot Place in 2021 after requesting a review of health inequalities from Marmot's Institute of Health and Equity. The report was commissioned by the Cheshire and Merseyside Health and Care Partnership and involves all nine local boroughs and many partners to support work to reduce health inequalities.

In Knowsley the impetus from Marmot has allowed the NHS, local authorities, and integrated care board partners to develop clear strategic priorities, says Richard Holford, consultant in public health for Knowsley Council. Although this is an evolving programme, it has already resulted in improvements to green spaces, local employment opportunities, and improved engagement with prevention services, he says.

It has seen the launch of a ban on council owned billboards for unhealthy food and efforts to speed up hospital discharges and reduce the risk of readmission by ensuring that people's homes are warm and suitable to move back to. This has meant insulating homes and fixing broken boilers and joint work between housing and NHS organisations that wouldn't have happened before.

Working with the local community, whose voices have rarely been heard, has been a key part of the work in looking at what will improve health, says Sarah McNulty, council director for public health. Yet despite the passionate commitment to Marmot, there are plenty of challenges. Part of which is the sheer scale of change needed and needing a long term commitment to do it, says Holford.

Knowsley, like other Marmot Places, measures its progress against beacon indicators. These include life expectancy, employment rates, activity levels, and school readiness for 4 year olds. "Even after two years, if you look at those, you won't see much progress yet because these changes take a long time to have an impact," Holford says.

There is no funding attached to becoming a Marmot Place, and little funding available throughout the multiple systems that the work covers. "But it allows us to direct resources that are available to the areas that are highlighted by Marmot's report,' says McNulty.

McNulty and Holford think that it is guiding their area in the right direction, providing a valuable focus for their work. "Being a Marmot Place gives us a hook for all our work," McNulty says. "It gives us an evidence based framework, and it is the golden thread that we can link through all our work on health inequalities."