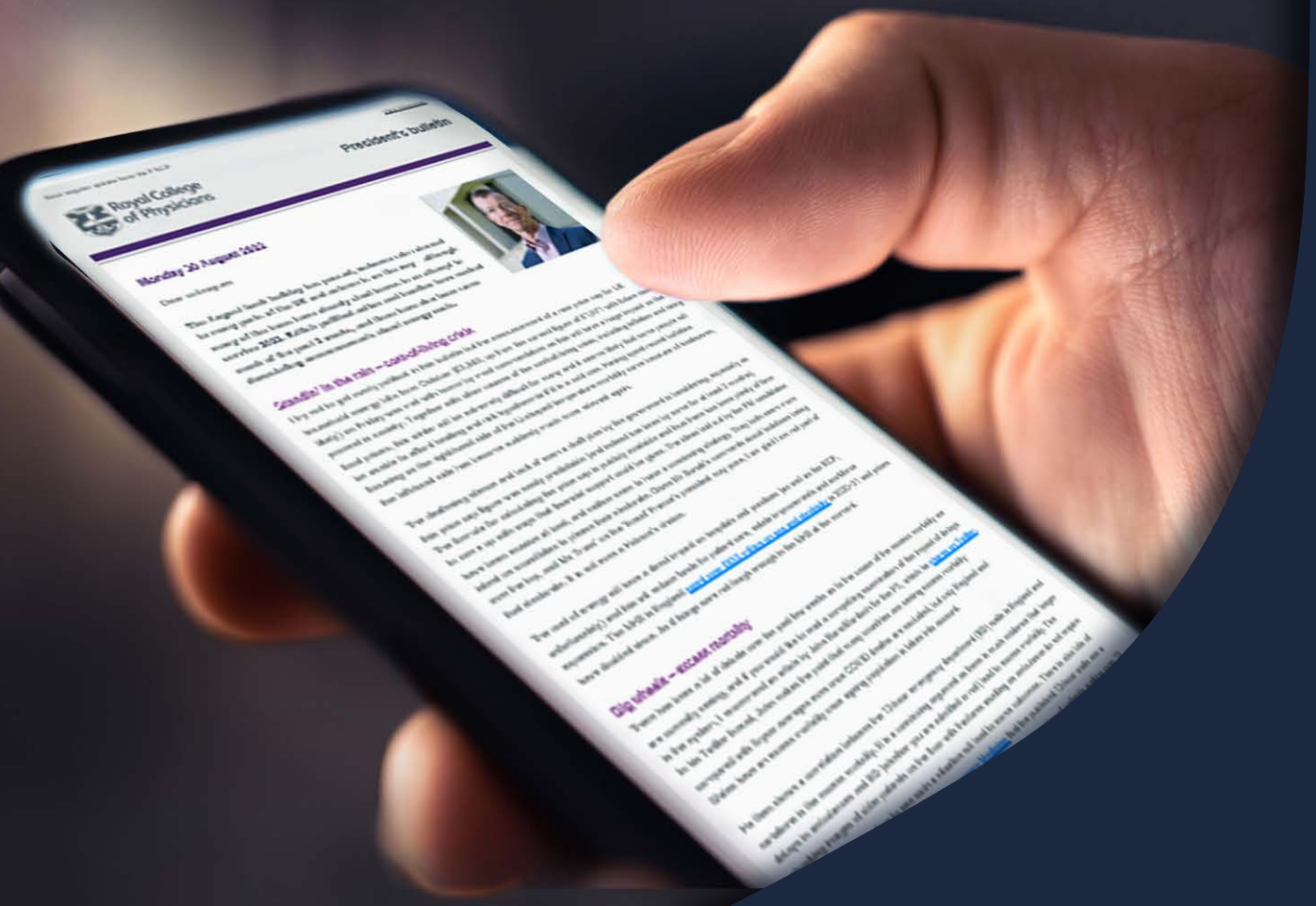
Times like these

A collection of bulletins by **Sir Andrew Goddard**, RCP president 2018–22



Royal College of Physicians

About this book

This book is a collection of the bulletins written by Sir Andrew Goddard during his time as president of the Royal College of Physicians (RCP) and emailed to all members and fellows. It spans the period from October 2018 to September 2022, much of which was dominated by the COVID-19 pandemic creating some of the most challenging times experienced by healthcare professionals in living memory.

The collated bulletins provide a unique account of the issues affecting the physician workforce during the pandemic and how these changed over time. Each bulletin included links to relevant research, news and statistics, and was followed by listings of current opportunities and events (omitted from this book).

They were enormously valued by RCP members and fellows, who described them as invaluable, inspirational, entertaining and educational, and also appreciated their honesty and humour.

Acknowledgements

The bulletins were written by Sir Andrew and reviewed by the RCP senior officer team and infectious diseases experts. They were supported by the RCP communications and policy teams.

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Foreword

This is a collection of my bulletins to members in the 4 years (2018–22) that I was president of the Royal College of Physicians and covers some of the most challenging issues the RCP has faced.

I started writing bulletins every 2 months for members when I was registrar of the RCP and the first one went out in November 2016. Those bulletins got a warm reception and seemed to hit a nerve, especially with our international fellowship who found it valuable hearing about life back in the UK. When I became president, I decided it was a good way for me to communicate with as many members as possible and increased the frequency to monthly. The next 15 months saw events such as the survey on assisted dying, Brexit and a new government.

Then the world changed when the COVID-19 pandemic hit. The paucity of accurate and reliable information in the media and the rapidly changing situation made the bulletins an ideal form of communication and I started doing them weekly, slowing down after the first wave to fortnightly, with occasional bursts of weekly again when needed.

Many members have told me that the bulletins kept them informed and were a ray of light during some of the darkest days of the pandemic. If one should be proud of such things, I am, and while it has been at times a labour of love/hate I am glad it has created a strong connection with physicians across the UK and rest of the world.

I generally wrote them on a Saturday morning, spending time to collate my thoughts and check the links I used (often to sources of data or important papers). This didn't always go down well in the Goddard household (I used to do the Saturday morning shop) but it did allow me to get my thoughts in order, decompress some of my own worries and let off some COVID-19 steam.

The comms team at the RCP were great editors and only stopped me saying a couple of things in the whole 4 years – and in retrospect it was wise counsel. I always passed the draft by the RCP senior officers and infectious diseases experts to make sure I wasn't talking nonsense. Everyone was so generous with their time.

One of the most 'loved' aspects of the bulletin was the 'band of the week' theme, introduced tentatively in 2019 and then more consistently from May 2020. Each section had a subtitle with a song track by that band. Most readers realised this during the 4 years, although I think there are still a few who don't know. This allowed me to share my love of music as well as make a few cheeky implications as I went along. People often emailed me to say they enjoyed the tracks that week – the most popular band being Manic Street Preachers. Make of that what you will.

When asked what I learned most from my time as PRCP, it has to be that communication is critically important. I was so lucky to have the opportunity to use my bulletins for that purpose.

Sir Andrew Goddard
RCP president 2018–22

2018

October 2018

This is my first president's bulletin, so for those of you who have not read anything I have written before, hello (and to those of you who have, hello again). I've only been in post a week, but it has been a busy week, so there is lots to update you on.

As I write this, I am on the train returning from the Conservative Party conference in Birmingham. BBC News implied that Brexit was the big issue, but it hardly featured in all the health events that I attended. Workforce, however, came up again and again. The RCP hosted a very successful round-table event specifically on that topic, which seemed to resonate with the parliamentarians and other policy leaders present. I sense a tipping point is being reached, when even the government realises that something needs to give.

I've only ever been to the Labour Party conference before and there was a remarkably different feel to the Tory one – many more press and armed policemen, for starters. Most people were in suits and no one called me comrade (something I have always found a bit weird). Most amusing were the large retinues of advisers, special advisers and others of unknown role who followed the ministers around. A bit like a Sir Lancelot Spratt ward round.

Before heading off to Birmingham, I was in Northern Ireland for a couple of days. There, Brexit really is a big issue and the problems that a hard border would create cannot be underestimated. Patient care would undoubtedly be endangered if that came to pass. I visited Ulster Hospital, which was interesting. They have a new building with impressive IT support, single rooms and lots of space. No doctors mess though, which I can't help feeling is a bit short-sighted.

The Sunday before last was the RCP's 500th birthday itself. I spent much of it avoiding rain and potholes in London on my bike with ten other hardy souls. Our efforts were rewarded, though, on return to the RCP, where the sun was shining and we were greeted by a reception party of what felt like a hundred people. It was the end to my 2,018-mile odyssey for Physicians for Africa with the RCP500 charter and what a fabulous end it was. We then had a dinner to celebrate the birthday with a randomly selected cross-section of trainees, college tutors, regional advisers, examiners and other fellows. It was a great occasion and I had the pleasure of sitting opposite an ever-young (he is 97!) Michael Tibbs, who was college secretary for many years and saw the 450th birthday in.

As part of our RCP500 activities, we will soon be launching a new code of conduct for members and fellows. This work has been led by Emma Vaux, our senior censor. Given the negative culture that seems to be present in too many hospitals, this is a breath of fresh air. More details in my next bulletin.

Here follows a round-up of notices that you may be interested in. I was particularly amused to see the advert for doctors from Bear Grylls. Does he not know that surviving on his island is a walk in the park compared with the medical take (and not as interesting)?

November 2018

It's week 7 of my presidency and things continue apace. In the past month I've been to Birmingham, Walsall and Southampton for regional updates, Bristol for the British Association of Physicians of Indian Origin (BAPIO) conference and I've even managed some time in Derby to catch up on on-call work.

There have been some very big issues to think about, including the budget, cannabis, clinically assisted nutrition and hydration, artificial intelligence (AI) and – of course – workforce. This bulletin is meant to be punchy and short, so I can't cover these in depth here. However, I've written more in my President's perceptions' blog for those who are interested.

Feedback from this year's RCP conference at ExCeL London was really positive. The content went down well and people are keen for us to continue with a yearly conference that includes practical demonstrations, 'big gun' speakers and updates for all physicians. Therefore, I'm pleased to announce that today we launch programme highlights and registration for next year's RCP annual conference, Medicine 2019, in Manchester on 25–26 April. You'll be pleased to know that some fees will be substantially lower than last year (the ExCeL venue charges were eye-watering). I hope to see you there.

Talking of seeing, if you didn't see it, on Monday we published our Medical CCT class of 2016 report. This is our annual survey reporting the experiences of, and outcomes for, holders of the certificate of completion of training (CCT) within 1 year of gaining their CCT. I started this survey in 2009 when I was in the Medical Workforce Unit and, under others' leadership, it has improved year on year. In this year's report there are lots of headlines about how training is perceived, the transition from trainee to consultant and the consultant application process.

The latter has caused some headlines in its own right. For 3 years in a row, we have found that CCT holders who describe themselves as being of white British ethnicity apply for 29% fewer posts, but are more likely to be shortlisted and offered a post, than other groups. Black and minority ethnic (BME) women appear to be particularly disadvantaged. There are many possible explanations for this, but it is obviously a significant concern. It suggests that the consultant application process could do with some scrutiny and we are working with several organisations, including NHS Employers and NHS Improvement, to achieve this.

I was pleased to see that Matt Hancock said that prevention is his main priority for the future of the NHS and that he laments the lack of investment in public health and prevention. He focuses on some important topics, such as childhood obesity, but misses out on some blindingly simple 'quick wins' (sorry for management speak), including minimum unit pricing for alcohol. I also worry about the idea that whole-genome sequencing is an important preventative strategy.

I am also concerned about the direction that NHS England is taking with national audits (a mainstay of RCP work, as well as others). It appears that there will be no pre-release engagement with stakeholders. This looks like a big own goal. In order to improve care, we must first measure it and this will almost certainly identify some areas that need improvement. Engaging with the specialties and patient groups before the release of such audits allows an action plan to be drawn up. If everything was perfect, we wouldn't need quality improvement (QI).

QI was the topic of the Harveian Oration this year, given by Professor Mary Dixon-Woods from Cambridge. I learned much, including that the World Health Organization surgical checklist study published in the *New England Journal of Medicine* by Atul Gawande included a table showing that this checklist didn't work in most of the hospitals studied. I also learned that the evidence for 'lean' processes improving care is non-existent. It is scary how both ideas have become ingrained in the NHS without evidence. Next, we'll be using AI-supported software as a symptom checker without testing it on patients first …

We are always looking to improve our services to fellows and members, and next week we will be introducing a jobs board – Medicine Jobs – advertising vacancies for consultant and specialty and associate specialty (SAS) posts. Do look out for this on our website. We are also introducing a kitemark for job plans that we have reviewed over the next few months as well.

I mentioned it last month, but yesterday we formally launched the RCP500 Code of Conduct. Developed by our RCP censors and the vice president for education and training, Dr Emma Vaux, the code encourages us to think about the impact of all types of behaviour on others.

December 2018

Happy Christmas everyone, and for those with a different theological view, sorry that you have to put up with all of the commercial rubbish that often surrounds this festive season. It is a time to think of family and others though, which is a good thing.

It has been quite an eventful month for me. Cannabis has taken up a lot of time (from a professional view that is). There was a public perception that moving cannabis-based products for medicinal use (CBPMs) out of 'Schedule 1' (ie illegal drugs) would make it easy to prescribe cannabis. This is very much not the case and major issues have arisen as everybody realises how complex the situation is. Firstly, it requires the product to be manufactured for medicinal use (there are not many), prescribed in secondary care and have medical director or prescribing committee approval. Secondly, no funding has been set aside and these drugs are expensive (eg £20–25k per year for Epidiolex). Thirdly, the evidence for use is very limited, hence the rather guarded guidance that we published last month.

Seeing CBPMs as medicines is an important first step in introducing them into routine clinical practice. However, it is only the first step of a long journey and until a good evidence base, registry and funding model is created there will continue to be tension between the proponents of cannabis and the NHS.

Working with government on the issues that are important to members and fellows is all part of the job, and, following a recent survey of what those issues should be, we now have an 'agreed at Council' list of priorities for 2019. I know we have sent a few surveys your way recently but these do help us influence and get media interest. Our very recent survey on winter pressures is a great example. If you want to know more about our policy and campaigns work and the ways in which you can contribute, please contact policy@rcplondon.ac.uk but most importantly THANK YOU for filling in the surveys.

The winter survey has shown how vexed people feel about winter pressures and how hard the working environment is at this time of year. It is important, though, that we don't miss the opportunities for teaching and learning that present themselves each day. The RCP Education Department (and in particular Hussain Basheer, one of our two education fellows) has just produced a resource called *Never too busy to learn*, which has lots of examples of such opportunities and how to make the best of them. If you send e-cards for Christmas you could include a link to this as an added bonus.

If this RCP report doesn't whet your whistle, how about one all about professionalism? *Advancing medical professionalism* underlines how essential professionalism is in increasing job satisfaction, improving patient care and raising productivity, while pointing out that doctors currently have very little formal education, training and support for professionalism compared with their education in clinical skills and knowledge. If you don't believe in professionalism before reading it, you will afterwards.

As promised, Medicine Jobs, the RCP jobs board that I mentioned in the last bulletin is now live – this is a major new development for us as a college, and you can not only view the latest vacancies, but also sign up for the monthly jobs bulletin by contacting aac@rcplondon.ac.uk.

I met with colleagues at Pathway a couple of weeks ago. Pathway is a charity that supports healthcare for homeless people, and in particular hospitals and clinicians, to come up with systems to help this very vulnerable group. If you were not aware (and I wasn't), legislation has recently come into force in the UK mandating referral to local authorities of anyone who is homeless or at risk of becoming homeless in the next 56 days. This will allow housing support to be put in place. The RCP and the Faculty for Homeless and Inclusion Health have published practical guidance, referral forms and links to Department of Health guidance to support care for this vulnerable group of patients.

About 6 months ago I looked into the benefits of housing as a 'treatment' in homelessness, focusing on health outcomes. The success of such policies in Canada is impressive and more than cost-effective – you could call it a 'Canada-plus-plus' model, and one that the UK would do well to adopt.

Talking of Canada-plus-plus models, this may be the last Christmas for the UK as part of the EU. Then again, it may not – we are unfortunate to be living through 'interesting' political times. I've spoken to many patients and healthcare professionals with widely differing views on Brexit. The only thing that I am reasonably confident about is that a no-deal Brexit would be disastrous for the NHS. Let's hope that our politicians see this and come up with a solution.

On a more positive note, the NHS long term plan will be out (we think) in the next week or so. It looks like there will be support for expanding the Medical Training Initiative which would be a major win for the RCP's lobbying efforts over the past year or so – I'm glad that the government is listening to us. I hope that this rumour is true as more doctors and better links with our international partners would be two presents I would like to find under my Christmas tree.

2019

January 2019

Happy New Year to everyone, although I suspect if you live in the northern hemisphere you will be in the depths of midwinter and perhaps the message should be 'hope you are surviving'. I was on duty over New Year's Eve and Day and my hospital was the busiest it has ever been. Apparently having Christmas Day on a Tuesday is the worst possible scenario for hospitals but I was impressed by the can-do attitude of everyone I was working with. It was tough but as a team we managed.

Yesterday saw the publication of the NHS Long Term Plan. While there is much to welcome in the headlines, the key to its success will be the workforce to deliver it. Solving the workforce crisis in the NHS and social care will take wider action across government, and will be crucial to making the Long Term Plan a reality. Without a significant increase in workforce it will struggle to achieve any of its aspirations. Keep an eye on our website for our views on key aspects of the plan as we look at it in detail over the next few days.

I was recently savaged by certain parts of British society when we went public with the RCP's call to make obesity a disease. We agreed this position at RCP Council in the autumn and as I have learned more about the genetics of obesity, the (dire) metabolic consequences and the relationship with social inequalities I am now convinced this is the right thing to do. It has certainly got people talking and hopefully will mean we can improve bariatric services in the UK and reduce the stigma that means that 42% of obese people are too ashamed to discuss it with their GP. People still need to take personal responsibility for their diet and the amount of physical activity they do but society also has to recognise its pivotal role in the problem.

I am expecting a bit more media attention in February and March as we will be surveying all members and fellows about their views on assisted dying. This is a polarising subject and one reason for doing another survey (our last was in 2014) is that we need to have contemporaneous data to support our position. RCP Council has decided that the key question will be 'what should the RCP's position be?' Three options will be given – in favour, neutral, or oppose. Over the years since our last survey both sides have added the neutral position to their proportion to support their argument. We are therefore clear that if the RCP is to either be in favour of or oppose assisted dying a supermajority of two-thirds will be needed.

There will be lots of supporting information provided with the survey including a summary from our Ethics Committee and position statements from supporters of both sides of the debate. The survey will be carried out in February and we will release the results in March after discussion at Council. This will be before the 29 March …

I have been doing my job planning this month, always a joy. Many people are unaware of the role the RCP has in job planning. We review all new post job plans (864 last year) and 58% get changed and hopefully improved as a result of our input. Key changes are usually around the amount of time for supporting professional activities. This work is done through our Advisory Appointments Committee team and the regional advisers. A very big thank you to all involved.

Part of successful job planning is ensuring we all get time to do a bit of something that we feel passionate about. For many (including me) clinical research is part of that, although funding for this is often lacking. So I was really pleased to see that a new stream of funding called 'CARP' (Clinical Academic Research Partnership) is being made available for clinical research. This doesn't get away from the need for CRN studies to focus more on paying for clinician time (something I will be pushing for). If this is an area you are interested in there is a good summary of the issues by the RAND corporation.

And finally, don't forget the early-bird rate for Medicine 2019 ends on 31 January, so do book now to join us to share best practice and debate the future shape of the NHS. See you there!

February 2019

February is one of those months when you hear a lot from me. I've just written my piece for *Commentary* magazine in which I have covered Brexit and our concerns about medicines shortages. You'll get that in the post in a couple of weeks. UK fellows and members will have also had an email update about our survey on assisted dying and the invitation to participate in the survey itself. If you are a UK member or fellow please do complete the survey if you haven't already. If you haven't received an email, do remember to check your spam folder, then contact policy@rcplondon.ac.uk.

This issue has been high profile and the result is awaited with much anticipation. The fact that it has resulted in front-page headlines shows that the RCP is a voice people are listening to. We plan to close the survey at the end of February, but we also want to make sure we have a similar return as in 2014, when over 6,500 people responded. The outcome will be discussed at Council on 21 March, and we'll publish the results shortly after.

While assisted dying is an important topic I am becoming increasingly concerned about the provision of palliative care services in the UK and the issue of early conversations about dying. There has been some great TV coverage of this recently but as I watched it I was struck by how we as a society rely so heavily on the charity sector to fund hospice care. Macmillan, Marie Curie, Sue Ryder and their fellow charities all rely on public donations to do the fantastic job they do. However, the charity sector is struggling as the economy struggles and this worries me. There was scant mention of end-of-life care in the NHS Long Term Plan and it's about time it got the attention and investment it deserves.

I've also been worrying more about the mental health of our trainees and colleagues. I went to a remarkable meeting about suicide in trainees recently. Several parents gave their personal stories, which was both brave of them and humbling for me. The system really lets our trainees down when the pressures of life and work are too much. We must do more about our occupational health services and more to raise awareness of the mental health aspects of being a hospital doctor.

An increasingly recognised problem is that of the 'second victim', whereby the psychological effects of a serious incident at work cause physical and mental illness in the staff involved. I have a problem with the term 'second victim' (and please let me know if you can think of a better term) as it doesn't sit right with me. However, that the issue is being recognised is a very positive thing and I would recommend the website second victim support if you know anyone who has been affected.

After 16 years of work at the forefront of clinical informatics, the Health Informatics Unit (HIU) will close for business on 29 March 2019. The closure of the unit has been a difficult decision for the RCP but comes as a result of renewed and different thinking on how, as a professional body, we contribute to the increasingly fast-moving digital and new technologies agenda, and how we ensure financial sustainability for these developments. I am keen that we develop a network of experts in this field and we will be producing a strategy for digital health this year.

I would like to pay particular credit to the leadership of the HIU, especially its clinical director Prof John Williams CBE, programme manager Jan Hoogewerf, and the many associates who have given their time so generously since it opened in 2002. John is a leader in the field, and we are delighted that he will be supporting us with the recruitment of the new clinical director for digital health, which will be advertised shortly.

New technologies and AI will be a strong theme at our conference in April, Medicine 2019. The RCP annual conference is an opportunity for us to get together as the physician family and celebrate what it means to be a physician as well as showcasing what is great about medicine. The programme has something for everyone and even if you just want to use it to bend my ear or those of the leaders of the NHS, do come along.

I started this bulletin taking about *Commentary* and we have just appointed two new editors-in-chief (EiC) for our other publications, Anton Emmanuel for *Clinical Medicine* and Kevin Fox for the *Future Healthcare Journal*. Anton is a gastroenterologist at University College London Hospital and spent 9 years as EiC of *Frontline Gastroenterology*. Kevin is a cardiologist, currently dividing his time between Imperial College Healthcare NHS Trust and NHS Orkney.

We had a big meeting last week to plot/plan the future of the journals and the room was buzzing with ideas. In short, they will be multi-format, personalised and easy to access. As part of that, I'm delighted to announce that the entire back catalogue of *Clinical Medicine* (back to issue 1 when it was known as the *Journal of the Royal College of Physicians of London*), is now available on PubMed Central (PMC). This makes it much easier for you to access valuable research content, and the journal benefits from the integration of its full text with citations in PubMed and the increased exposure that this brings. PMC deposition for *Future Healthcare Journal* will be coming soon!

March 2019

The past few weeks have been really busy and quite negative, what with the workforce meetings around the NHS Long Term Plan, the RCP assisted dying survey and Brexit. I've therefore tried to enjoy the good times when they have happened. But to dwell on Brexit for just a moment, today I've sent a letter to MPs ahead of key votes on the UK's withdrawal from the EU. It's a final appeal to them to stop the UK leaving the EU without a deal. I hope you agree it's the right thing to do, and I urge you to forward it to your MP with a personal message.

I attended the RCP regional update in Loughborough last week and visited the Leicester Royal Infirmary site the day after. This is my local patch so I'm obviously a bit biased, but it was a great meeting. There were some fascinating talks at the update but the two that hit the spot for me were one on epilepsy and one by the chief registrar in my own hospital, Huda Mahmoud. I've always found which drugs to use for epilepsy a bit confusing but now have a much better grasp. It is good to be reminded that seizures tend to be stereotypical and that reducing seizure frequency helps but is not the goal for most patients – they want to be seizure free. I was surprised to learn that only two-thirds of patients achieve this.

Huda's talk was inspiring as she laid out all the work done by the RCP's college tutors, associate college tutors, and clinical fellows in improving the lives and training of CMTs and registrars in Derby. After 3 years of work, 97% of medical trainees would recommend working there. It was a huge pleasure to award Huda a plaque as the first-ever Turner-Warwick lecture presenter. Well-deserved.

Attendance at regional updates has been increasing substantially over the past couple of years and it is interesting to conjecture why. Could it be that meeting with like-minded colleagues and old friends in a safe (and pleasant) environment listening to fascinating talks on medicine is a better educational experience than mandatory e-training? I just wonder.

The visit to Leicester was fun. They have a brand new urgent care building with ED, AMU, Frailty Unit and, most importantly, space. The areas are close to each other and this undoubtedly helps communication and collaborative working. The lack of places to park trollies is a clever idea to encourage flow but most of all the building reminded me that the working environment is an important part of how happy we are at work. Shiny (hospital) happy people may overstate it but it sure helps.

In my last bulletin I talked about wellbeing and how we look after each other when things go wrong. This has sparked a lot of positive email conversations. I was delighted to hear that Ian Sabroe, a consultant in Sheffield, has been awarded a Churchill Fellowship to visit programmes including 'Medicine and the Muse' in Stanford, California. Such programmes use the arts and humanities to explore the uncertainties and challenges in medical care and training. Ian obviously subscribes to Albert Einstein's view that we mustn't keep doing the same things again and again and need to think of novel ways to tackle the challenges we face. I'm looking forward to hearing his insights.

The week before my busman's holiday in the East Midlands I spoke at the MSc in Medical Leadership course that the RCP Education Department runs with Birkbeck University. This is an impressive course, as were the individuals I met who were doing it. The talk allowed me to reflect on leadership and how I got to be writing the president's bulletin. I think that leadership is a bit of an overused buzzword in the NHS at the moment and is not the panacea to all the NHS's problems. However, I also think that we need to encourage people to take up 'leadership' positions – not only as it is good for the system but also good for them. My main reflection was that all the roles I have had at the RCP have made me a better NHS clinician (my colleagues might argue!), as a varied career has made me happier in both jobs. I also reflected that serendipity plays a big part in career choices and direction.

Talking of leadership opportunities, we need someone to fill the metaphorical size 11s of David Oliver, who demits as clinical vice president in July. If you are not sure you are quite up to filling those shoes we are also looking for four new councillors. Both roles are open for nominations until 22 March. The RCP is a really interesting place to be at the moment and lots of people are looking to us for our opinion. There's no place like it.

If you follow me on Twitter (I confess it is not my most prolific output) you will notice that I call myself a gardener. This might be overstating it (although I was particularly proud of my parsnips this season) but I enjoyed catching up with the RCP garden fellow Henry Oakeley recently. If you haven't had the chance to do a tour around the RCP Medicinal Garden you must next time you are in Regent's Park. Henry and the team have created a world-class and unique collection which is both fun and educational to tour. They are a credit to the RCP and I'm looking forward to the spring proper when the garden flourishes and all their hard work comes to fruition.

I will be attending the Internal Medicine Meeting of the American College of Physicians in Philadelphia this April and am keen to meet any members and fellows of the RCP who are attending the conference, or who live nearby. I will be hosting a small members and fellows meeting at the Circ Bar at the Philadelphia Marriott Downtown from 12–2pm on Friday 12 April. Please contact global@rcplondon.ac.uk if you are interested in joining me or would like some more information, and I look forward to seeing you there.

I know that many of you will have been having a sneaky peek at jobs on our jobs board even if you're not really thinking of moving. For those of you who are seriously looking, do sign up to our new Medicine Jobs bulletin, which will automatically keep you informed about opportunities.

I've managed to avoid talking about assisted dying for eleven paragraphs but this has rather dominated my life in the past few weeks. The survey is now finished and we are quality assuring the data to release this around 21 March after we have discussed it at Council.

You may have seen in the media that we have had a legal challenge which, amongst other things, is seeking to prevent us publishing the survey results. We are in the hands of the lawyers on this one but I must confess to being a bit perplexed why some people would not want the survey results known. I will email all members with the results as soon as we can and before we go public.

April 2019

Never ending story

Every time I sit down to write these bulletins I think surely Brexit will be decided by now. But 29 March has been and gone, the politicians continue to disagree and Brexit becomes more and more like a famous puppy-associated toilet paper – soft and very long. I met up with my old room-mate from university days last weekend. He is a software engineer in Silicon Valley so it was interesting to hear a non-medical, non-UK view. It wasn't any different from most people's views this side of the pond though: 'What a complete mess'.

The drugs don't work

I had the pleasure of sitting in front of the Health and Social Care Select Committee a couple of weeks ago to take questions about cannabis-based products for medicinal use (CBPMs). There has been a large amount of press coverage about this topic, especially around the use in children with intractable epilepsy. Thankfully I was sitting next to Finbar O'Callaghan, the president of the British Paediatric Neurology Association who handled most of the questions on that topic. I was there to talk about the RCP guidance on the use of CBPMs for pain. In short, we don't recommend their use as although there is some evidence for efficacy, you have to treat 24 people to get a 30% reduction in pain in one person. Put another way, the effect is a reduction of pain on a 100mm scale of 3mm. Furthermore, you only have to treat six people to cause harm.

Many others, though, think we should be using far more CBPMs. I was rather staggered, though, that their understanding of how unlicensed and new medicines are prescribed in hospitals was rather rudimentary. Those championing CBPMs have stated that we just need to prescribe them in hospitals and they can be dispensed. No one has talked about the cost of these drugs (up to £25,000 per annum) so the committee seemed surprised when I told them that most hospital drugs and therapeutics committees have not got this sort of

money to spend and the decision as to whether to allow their use would be quick, blunt and negative. Even the otherwise excellent review in the *BMJ* last week failed to focus on funding as the main barrier to prescription.

Those pushing hardest for CBPMs don't work in the NHS and there are many companies wanting to sell these products that are not used to producing medicines, so maybe I shouldn't be surprised no one knows how hospital prescription systems work. The profits to be made from CBPMs are massive, so we also need to look out for conflicts of interest. For the record, I have no stakes in any company either selling or not selling CBPMs.

Whistle down the wind

Whistleblowing is one of those difficult topics many people try to ignore. By their nature, both whistleblowers and the issues they are trying to draw attention to make colleagues and managers feel uncomfortable. Two separate events in the past month have allowed me to reflect on the issue of raising concerns.

The first one was at the Royal Society of Medicine's 'Spotlight on whistleblowing'. I missed a sizeable chunk of the meeting as I was doing the CBPM thing described above but managed to hear a couple of great talks, including one by Peter Wilmshurst. Peter is speaking at our conference in Manchester at the end of April (a shameless plug but please come along!) on research fraud. I would strongly recommend the session, although you will need to bring some bandages to keep your jaw from dropping to the floor. Another talk will focus on the barriers to whistleblowing and how we might change NHS culture to facilitate this. Progress has been made since the 'Freedom to speak up guardians' were introduced but many problems remain.

The following day it was made clear to me that the RCP still has a quite a distance to go in this regard. I met up with two female trainees who had felt marginalised and ignored at a committee meeting. Thankfully someone picked up on this and contacted me. This is not what I want us to be about – inclusivity should be an essential part of the RCP ethic. I met with them to see what we can do to improve matters. They told me they were very used to being ignored in the NHS and were surprised that anybody had either noticed or wanted to do something about it. They had lots of great ideas about how we can develop our inclusivity work and are now helping to lead on it.

It's not all doom and gloom

Whenever I'm having a bad day at the RCP – be it due to errant politicians who don't understand genomics, mass emails from lobby groups, or doctors bringing the profession into disrepute – I need a pick-me-up. The best one available is to attend an MRCP ceremony. The positivity, potential and proud parents that fill the building on those evenings are truly inspiring. I know the future of medicine is in good hands and thank you to all those in purple gowns who give me hope.

May 2019

We all stand together

This month, I thought it would be great to include the photo of the various members from different countries who attended our annual conference, Medicine 2019, in Manchester 2 weeks ago. You may just be able to spot me in the back row. I would also like to send my greetings and best wishes to everyone observing Ramadan this month.

The conference was a great success, the biggest ever and with an exciting buzz. There were many highlights from my perspective. The wide diversity of delegates both from the point of view of professional life (trainees, PAs, consultants) and country of origin (just look at that photo) and that the conference could attract this broad range of physicians was one. The extensive choice of talks and sessions was also impressive and I was particularly struck by the advances being pushed by our trainees. The clinical entrepreneurs who pitched in a Dragon's Den style in the last session of the conference were inspiring. Medicine 2019 was also an opportunity for many to step away from the 'hamster wheel' of NHS pressures and reflect on the good things in medicine and meet old friends. If you didn't come, don't worry, you can register for next year already with a 50% discount (until 31 May) and read write-ups of some of the main sessions.

It was a bit of a coup getting all of the senior NHS leaders, including Matt Hancock, Dido Harding, Steve Powis and David Behan to talk in the afternoon plenary. This was almost unheard of and shows that we physicians are a critical audience for them. This can be taken in two ways and there was certainly a 'feisty' response to the secretary of state's speech, which will live long in the memory. From all the talks that afternoon, though, the themes of improving the NHS as a working environment and equality of opportunity came through strongly and I sense we are at a tipping point.

In my opening keynote talk I stressed the disaster that is a loss of 25% of staff from the NHS between entering medical school and either becoming a consultant or a GP. This is an unacceptable rate of attrition and relates to the working environment of the NHS as much as anything else. I talked about the damaging effect this has on us, something that has been called 'moral injury' in the USA, and the need to move away from blaming individuals as having a lack of resilience and put the onus on improving the NHS as a place of work. Those high up in the NHS get this and know it is something that

needs to be fixed. Getting trusts to do something about it is the next hurdle.

The only certainties in life

One of the hot topics at the conference both in speaker questions and over coffee was the impact of the current taxation of pension contributions. I know that some think this is a First World problem but I have seen so many colleagues stop doing additional activity or even retiring early that it cannot be ignored. It has the potential to deplete the consultant workforce by 10%. The thought of a reasonable pension helped keep many of us going through the dark days of training. Trainees will be watching all of this with as much interest as consultants.

Historically, the RCP has not lobbied on terms and conditions, given that this is the BMA's role. However, the impact on the workforce and thus the quality of patient care and safety cannot be left unsaid so I have used every opportunity I have had with politicians to share my concerns. Again, they get it and I sense that a solution may be coming soon. If it doesn't the damage will be long-lasting.

Apart from taxes, of course, the only other certainty is death. Next week is 'Dying Matters' week and I will be giving a talk in Derby on the RCP's *Talking about dying* report. Society needs to open up about this taboo topic and if you didn't see the report when it came out at the end of last year it is well worth a read. The barriers to talking about death are many but not insurmountable and the benefits of early conversations on quality of life are significant. It is good to talk.

One of the barriers is the variability of access to specialised palliative medicine services in the UK. I was delighted to have the chance to catch up with Baroness Finlay this week to discuss the Access to Palliative Care Bill which she is leading on and is currently going through parliament. I hope this Bill makes it to become an Act, but it does depend a bit on how long the current government lasts.

Stroke of good fortune

While I am worried about early retirements due to punitive taxes, not all physicians retire early. However, almost all do retire eventually. One of medicine's big characters is retiring in June and I cannot let this pass without some comment. Professor Tony Rudd has been one of the main drivers of the dramatic improvements in the care of patients with stroke over the past 3 decades. He has worn many hats in this journey either as national clinical director for stroke or as lead for the Sentinel Stroke National Audit Programme (SSNAP, formerly hosted by the RCP and now by King's College London).

SSNAP is a pioneering audit that has dramatically improved the care of patients with stroke over the past 20 years. From its early beginnings collecting data about the acute phase of stroke care in hospitals, it is now the only national stroke register in the world to collect longitudinal data on the processes and outcomes of stroke care up to 6 months post stroke. Under Tony's leadership, the audit became a beacon for quality improvement in stroke care, including using the results for research, journal publications, and health economics. It has been our good fortune to have Tony driving these changes and he will be missed.

It's not all doom and gloom

You will be pleased to know that I don't get much time to watch telly these days but one of the programmes I do watch is 'Line of Duty'. The writer, Jed Mercurio, used to be a doctor but even though he's no longer on the NHS front line his script writing is keeping the morale of many going.

While the plot of the latest series has been a little far-fetched at times I suspect that many of us wish that we had the ability to vent our frustrations in the style of Mercurio's Detective Inspector Kate Fleming. When faced with an over-officious fellow DI her put-down was both withering and made my family laugh out loud. Some of the language is not repeatable in this column but it is worth finding on the internet if you have had a difficult day with difficult colleagues.

June 2019

Power to the people

This week has seen the publishing of the interim NHS People Plan as well as the announcement that a potential solution to the NHS pensions crisis has been reached. I am torn. On the one hand, I really welcome both as they are a clear sign that the issues with our workforce shortages have been recognised. On the other, I have significant concerns.

The strong commitments in the plan to improving the NHS working environment, supporting the nursing workforce, developing the physician associate grade, more medical students and growth of the Medical Training Initiative all have to be welcomed as they have been a central part of RCP policy for a while. I have met with the leaders of both NHS England and NHS Improvement and have no doubt that their intentions regarding these commitments are genuine, as well as their desire to improve working lives in the NHS.

The problem, though, comes with the funding and the size of change. In a time of political uncertainty (had you noticed?) I worry that the political powers in charge of the money won't invest in the NHS workforce to the level needed. The scale of investment needed is huge and, for me, even 1,500 more medical students won't be enough looking 15–20 years into the future.

The pensions solution may be as good as can be achieved with a distracted Treasury. It is said that a negotiation has been successful when both sides are not happy but I suspect that this 'solution' is too little too late. If (and it is a big if) the BMA agrees, the biggest challenge will be implementing it quickly before we haemorrhage any more consultants or their clinical commitments. It will be up to NHS Pensions to respond to enquiries and action them. I worry that they do not have the capacity to do so. I visit hospitals around the country most weeks at the moment and at every one I have heard about consultants retiring early or dropping their PA commitment. The pensions tourniquet needs applying quickly.

We're all in this together

Consultant programmed activities are not the only PAs that have featured in the news in the past couple of weeks. Physician associates have been the feature of debates at the BMA junior doctor conference and several 'motions' have been passed by the BMA which, while I understand the concerns behind them, seem to me to be a very backward step. The idea that trainees and PAs are in competition with each other or are interchangeable with respect to clinical responsibility suggests there needs to be improved understanding by many as to who PAs are and how they work.

Like many doctors in the NHS I haven't yet worked in a clinical setting with PAs (there are just over 1,200 practising currently in the UK). However, I have met many trainees and consultants who have and have been told in no uncertain terms of the fantastic value PAs bring to both service and training. Knowing there have been concerns I have been asking trainees how they would feel to have the PAs working in their hospitals taken away. 'It would be a disaster' is the common response. 'They have improved our training and made our working lives easier'.

I'm hoping that the Faculty of PAs and the BMA can work together to improve understanding and allay the fears of trainees. Educational opportunities are one of the four cornerstones to trainee happiness (the others being workload, strong teams and flexibility – all of which PAs will help with). There are enough educational opportunities for all provided they are planned and thought about.

While I'm thinking about PAs we shouldn't forget the other important type of PA, consultant secretaries. My trust PA is the person who keeps my head above the clinical water. They are a much-neglected group of professionals. They take the brunt of patient ire, ensure that the phone is answered when ours are turned off and will do the leg work in chasing a referral or result when the rest of the hospital seems incapable. However, I worry that the consultant PA is endangered. Digital dictation, financial pressures and a

misunderstanding of their critical role mean that their number are dwindling. We must resist this.

ME and the coroner

When I was a medical student I wanted to do forensic pathology, inspired by afternoons watching Quincy, ME. Indeed, I spent my student elective doing forensics in Miami, at the time the city with the highest murder rate in the world. I worked with the Dade County Medical Examiner of the time, Joe Davis, and had my heart set on becoming a medical examiner myself. David Rubenstein, MD showed me the error of my ways and I've been a physician ever since I was his houseman. However, it now looks like my dreams are coming true and you can be both a physician and a medical examiner.

The medical examiner programme is currently being established in the UK as a single point of advice around hospital deaths and eventually all deaths. MEs will be the step before the coroner gets involved and will speed up certification, prevent unnecessary inquests and also highlight cases which might otherwise have gone unnoticed.

Our sister college, the RCPath, has been leading on the ME programme under the skilful direction of their former president, Suzy Lishman. The programme is being rolled out nationally after a successful pilot, and MEs will be supported by ME officers. Listening to the highs and lows of the pilot it was slightly depressing that an ongoing problem when trying to organise matters after a death is the illegibility of doctor's names and contact details in the notes!

It also seems that funding (a theme today) is another challenge. Around 80% of people are cremated which attracts a fee that can be used towards funding the ME service (there is no other funding identified yet) and if a flat fee is introduced for all deaths we could have a fair and equitable service for all deaths. However, some see this as a 'tombstone tax' and think it unfair, as currently no fee is payable if you are not cremated. Death and taxes, never a good combination.

If you want to know more about the ME programme the RCPath has some excellent resources.

It's not all doom and gloom

At times my job has its perks. Not only do I get to work with some brilliant people (just see the candidates for clinical vice president and councillors below), I also get to meet the famous.

I was at Number 10 (Downing Street, as if there were another) a couple of weeks ago talking through health policy with Mrs May's team. I paused for a selfie outside the iconic door (for the website rather than personal use, obviously) and noticed a furry presence to my side. Larry, the Number 10 cat, was in residence and seeing a photo opportunity I tried to get him to face the camera. Sadly, he was having none of it – apparently he is very suspicious of visiting presidents. What is it about those at Number 10 not being for turning?

July 2019

Summer hit with a vengeance in the UK at the weekend and there has been a lot to enjoy and a few things to get hot under the collar about.

I was looking at the acts playing Glastonbury this year and feeling very old as I didn't recognise many of them. To remind me of my younger days I have gone for a 'music cream tea' theme to this month's bulletin.

Start!

We are only a month from the start of new rotations and in particular the first year of the new Internal Medicine Training (IMT) programme. Local and regional education leads have been working enormously hard to get everyone ready for this and the first thing to say is thank you to all of them, from college tutors and regional advisers to heads of school and deans. A lot of this work goes under the radar and deserves our gratitude.

I am both excited and a tad anxious about IMT. At meetings I've been calling it a 'once-in-a-generation' opportunity to improve internal medicine training and facilitate increased exposure to a range of specialties as well as smooth the transition into the medical registrar grade. IMT will increase exposure to intensive care, geriatric medicine and outpatient services. I did worry that trainees might delay joining the new programme to see how it works but that doesn't seem to have been the case. One hundred per cent of IMT places have been filled for August, which is brilliant news.

As an educational supervisor I've been trying to get my head around the new framework and how educational supervisor meetings will be different. It is clear that the first meeting with the trainee is the most crucial and we will need to spend a bit more time than previously to ensure work and educational schedules are sorted and that the new trainees (and supervisors!) are clear about the timetable for the year. I've been using the *Rough guide to IMT* produced by the JRCPTB which has been very helpful, as well as the slide resource they've prepared.

Most of the questions I've been getting about IMT as I go around the country have been about the transition between the old system and the new system as well as the transition between stage 1 and stage 2. This has also taken up much discussion between those leading the programme and I think it is safe to say that nothing is yet fixed in stone and that arrangements will be as flexible as possible and no trainee will be disadvantaged. Having said that, getting into higher specialty training will remain as competitive as before, and rightly so.

The modern world

Some of you will know I have a bit of an interest in digital health. I was chuffed to be asked to chair the new Medicines and Healthcare products Regulatory Agency (MHRA) advisory group on AI, software and apps. We recently had our first meeting. There were lots of experts around the table (I don't count myself as one) and we discussed some fascinating issues. I have long worried about the necessary patient safety controls with new software and technologies but we do seem to be making positive progress in that direction. Regulation will be much stricter from next year.

When considering if a piece of software (including apps and AI) needs to be regulated, there is a seemingly simple question to be answered. Is the software a medical device? It is a medical device if it has a 'medical purpose' which can sometimes be a bit confusing. For example, the Glasgow Coma Score (GCS) is a concept, not a medical device. However, an app running on your phone that calculates GCS from the data you input is a reification of the concept and is a medical device. (Reification is a word I must use more – it means to make an abstract concept something concrete – literally to 'make a thing').

The line between wellbeing and medical purpose is a little grey (if an app tells someone they need to exercise more is it being medical?) but the MHRA has published some useful guidance. One of the first jobs of the advisory committee is to update that guidance so I would welcome any feedback.

I was also delighted that we have appointed a new lead for digital health. Wajid Hussein is a cardiologist from London and will have responsibility for taking forward the RCP's digital agenda. Welcome Wajid.

The Eton Rifles

I was saddened but not surprised to see that the recent Care Quality Commission (CQC) survey of hospital care reported a drop in patient satisfaction of around 2% in all parameters. We all feel the pressure is getting worse year by year and it looks like the patients can see this now. Even Simon Stevens has now talked about the need for more beds.

However, in order to create more beds we need more nurses and a strong economy to support the NHS. Looking at the pronouncements from our two candidates for prime minister I am not filled with optimism. Both are lurching towards a no-deal scenario and want to be shot of the EU. This may be the bitterest pill. I'll stop 'The Jam' references now and move on to 'Cream' and tea.

Crossroads

On a positive note there has been lots of new blood coming into the leadership team at the RCP over recent weeks. Sarah Clarke will replace David Oliver when he steps down as clinical vice president later this month. Sarah has been on RCP Council so has left a vacancy along with four other councillors who have demitted after sterling service. The five fellows who have been elected to replace them are Ruth Law, Jenny Vaughan, Tom Solomon, Rob George and Kaushik Chaudhuri.

We have also appointed three new censors in Jyoti Baharani, Rudolf Bilous and Rasha Mukhtar. Most RCP members and fellows would struggle to describe what a censor does. In early days of the College they decided who could be a fellow but more recently have been about supporting the educational work of the RCP. This is led by the senior censor who is the vice president for education and training (Emma Vaux).

As well as Wajid (mentioned above), we have welcomed a new lead for audit and accreditation in Jane Youde who will take over from Ian Woolhouse. Jane is a geriatrician from Derby (I didn't have anything to do with her appointment) and also happens to be my sister-in-law (I really didn't have anything to do with her appointment). We also have a new independent lay chair for our board of trustees in David Croisdale-Appleby. David's CV is eye-wateringly impressive and his experience will be a real asset to the RCP.

And finally, welcome to Adam de Belder and Jonathan Bennett as new deputy medical directors for the RCP's Invited Service Reviews.

As you can see there is a huge wealth of talent and skill in the class of '19. Thank you to all of those demitting office and welcome to everyone joining us.

Strange Brew

The RCP position on assisted dying (we are neutral just in case you hadn't heard) continues to get talked about in various forums and press reports as the RCGP and BMA now plan to survey their memberships. The content of these reports and discussions remains a rather strange mixture of truth and untruths about our survey and even my personal position. The topic is being debated in parliament this week and we have produced a simple summary of the facts on our position and legal challenges.

For the record, I have never thought that doing the survey was a 'big mistake' and there is no ongoing High Court action. You can't believe everything you read on Twitter.

Talking of Twitter, at the RCP update in Hinxton last week Adrian Jennings, the regional adviser, asked how many in the audience used Twitter regularly. Of the 200 or so people there, the answer was 13% (using keypads). My interpretation of this is that we need to use lots of different types of media to communicate with the membership. I'm afraid that means you will continue to get monthly emails from me.

Lastly, NHS England and NHS Improvement have just launched a new strategy on patient safety. The strategy aims to be the 'golden thread' running through healthcare and sets out what the NHS will do to continuously improve patient safety.

September 2019

You may not have noticed, but I spared you a President's bulletin in August. I hope this didn't spoil your summer too much and that your email inbox hasn't piled up too much with other stuff in its absence. Since the last bulletin we have acquired a new prime minister, new cabinet and a new vocabulary. Who knew prorogue was a real word? It seems the UK does not have as strong a constitution as we thought and (rightly) is struggling to stomach the idea of a no-deal Brexit. Twenty-four hours seems a very long time in politics, so who knows what will have happened by the time you read this. At the time of writing the prime minister had called for a snap general election but the 'rebels' have yet to oblige.

Having written to Mrs May in March, when she was still PM, about our concerns regarding no deal, I was delighted that so many other colleges and organisations were happy to sign our letter to Mr Johnson asking for more thought about the implications of a no deal on the NHS. Our best laid plans for how the letter would be sent were slightly derailed when it was leaked, but our warnings about the oncoming flu season have been well-received by many in the NHS.

I learned many things while preparing for appearances on news items to discuss the vaccine issue. The manufacture of flu vaccine has been delayed this year as WHO's publication of which strains to include in the vaccine was held back by a couple of weeks. The four strains for 2019–20 sound like a round-the-world trip, including Colorado, Kansas, Brisbane and Phuket. It does bring home the point that flu travels more easily (and cheaply) than any of us, and we should watch what happens in other countries.

Much has been made about the Australian flu season being 'worse than usual'. Looking at the data, while deaths this year were up compared to most years, they didn't reach 2017 levels – the worst season for many years. Importantly, though, the 2018–19 season peaked 6 weeks earlier. This has important implications for us, as the window for vaccination is smaller, and thus any challenges to the supply chain will have a greater impact. I plan to be first in the queue when it becomes available, which will please my trust's infection control team, if not my deltoid.

In July I attended my first NHS Assembly meeting. The Assembly has been set up to help steer the NHS Long Term Plan and is a great group of people from all parts of the service and the public. The last meeting was focused on the Interim NHS People Plan, carers, climate change and equality and diversity – quite a broad range of big topics. I was impressed by the level of discussion in the room and in particular the clear acceptance that the NHS needs to put the health of its staff first, as without them it will never be able to look after the health of everyone else.

I also learned a lot about carers. I had some understanding beforehand but was blown away by some of the stats. It is estimated there may be up to 7.4 million carers in the UK at the moment, with about 6,000 people becoming carers each day. The number of NHS staff juggling lives as carers is also massive – around 250,000 (one in five). Over 70,000 of these will give up their NHS work as a result. The total cost of this unpaid care was last estimated in 2015 at £108 billion, not too dissimilar to the NHS budget. We should all be grateful for the work they do.

Earlier this week I had the chance to do my first ribbon cutting during my time as PRCP (I've been in post almost a year – can you believe it?). I was proud to open 'Regent's Perk', the new café in our London building, which is open to members and fellows when you are visiting. The café is open for coffee, tea, snacks and lunch, so drop in if you get the chance. It has a very modern and relaxed feel and I can recommend the cappuccino.

I've got a busy few months before Christmas, travelling around the UK and beyond. I'm particularly excited about visiting Zambia later this week to attend a meeting of the East, Central and Southern Africa College of Physicians and see all the work they are doing around training physicians in those countries. I'll be back in the UK next week and will be in Belfast. If you are a Northern Irish physician, I hope you can make the update so I can hear about the issues important to you (and not just Brexit).

October 2019

The whirlwind that is British politics continues to rage and wreak damage. Since my last bulletin all three main political parties have held their annual conferences, the recess that wasn't a recess has been ended and spider brooches are the latest must-have accessory. Supreme Court decisions aside it is obvious that all parties are readying themselves for a general election and health is high on the agenda for all and social care for some.

Among the 'vote-winning' policies that have caught the eye are free social care for over 65s, 5,000 training places per year for GPs (both Labour) and £40bn for 'new' hospitals (Conservatives). All three of these have a workforce element that bears thinking about. I was at the Labour Party conference in a wet and windy Brighton and it felt that the policies were a sideshow to the party politics. A clear commitment to social care was great to hear though, and the fact that it is receiving such attention very welcome. However, the social care workforce is estimated at being 110,000 short of what is needed and is heavily reliant on staff from the EU and beyond.

The potential of an increase in GP training places is tantalising. Primary care needs a bigger workforce and while I'm all for this I'm a little unsure where the additional capacity is going to come from. Around 7,400 training places are available each year, of which 3,250 are currently for general practice. To create the additional 1,750 we either need more medical students (which will take at least 7 years to become relevant), more immigration or a reduction in the number of training places by 40% from the rest of the medical workforce in acute hospitals, mental health trusts, hospices and elsewhere.

Investment in hospital building would be more than welcome and for many reasons. Most hospital buildings are in disrepair (some literally falling apart) and more bed capacity is desperately needed. Estate upkeep has suffered in recent years due to 'captorev' (a new word I learned in Brighton) spending where trusts have had to use monies intended for capital projects to support staffing costs. Therein lies the rub. Unless there is a revenue plan to support the workforce we may end up with shiny new buildings but no one to work in them.

I didn't have the chance to raise this with the Conservative health team as I could not make it to their conference. I was faced with a choice between going to the Wessex regional update in Basingstoke or 'Borisfest' in Manchester. It wasn't a hard choice. The talks were much more inspiring and interesting in North Hampshire.

I have been writing to the politicians though, which has been getting a bit of press coverage. The letter we sent to the prime minister over concerns around a no-deal Brexit and the lack of obvious inclusion of health and social care got a lot of coverage on the BBC and in the written press. The letter was leaked before we sent it – an occupational hazard with multiple signatories from other organisations – but had the desired impact. Being on breakfast telly is an interesting thing. You get lots of texts and comments from people saying they saw you as they got out of the shower that morning and that it is good to see the RCP having a public voice. Your family, though, can be relied on to bring you back to earth. 'You're looking a bit older these days'. Thanks Dad.

The treasurer has been busy writing as well and his annual letter sent to you all a couple of weeks ago has created a few responses, particularly around how quickly the RCP should divest from all fossil fuels. The responses have spanned a wide range of opinions from demanding immediate divestment even if that means the RCP goes bust, to saying we should continue as we are and not be swayed by short-term fixes that are 'unproven'.

I've been clear on my position in a *Commentary* article in August which, like all such complicated issues, will not please either extreme. I am committed to us continuing to divest from fossil fuels (we have been doing so over the past few years) but at a pace that doesn't destabilise our cash flow critically. Our investment advisers will be presenting our next options at a meeting later this month. Given all the positive things we do in the areas of air pollution and sustainability I am keen that we have a clear plan on this issue as soon as we can, so we can prioritise focus on the positive things the RCP does. Did you know, for example, that all the electricity we use at the RCP is renewable (80% wind, 10% solar and 10% hydro)?

Speaking of positive things, last week we launched an equality and diversity review to ensure that everyone involved with the RCP has access to the same opportunities and the same fair treatment. The work, recently presented to RCP Council, will be led by equality and diversity expert Ben Summerskill supported by RCP staff. It will take face-to-face evidence from a diverse group of fellows, members and staff as well as the members. You can have your say by completing the survey.

Another opportunity to contribute to our work is to become a peer reviewer. Could you help us ensure the quality of our journals by contributing your expertise to *Clinical Medicine* and *Future Healthcare Journal*? It would involve reviewing a maximum of two articles per calendar year, and only in your self-reported areas of expertise. It would be great if you could help.

I'm always conscious that as president of the RCP I follow in the shadow of giants. On 1 October it was the 300th anniversary of the election of Sir Hans Sloane as PRCP. His legacy is huge (just look in the British Museum) and his travels around the globe brought much benefit to both Britain and many of the countries he visited. The Hans Sloane fellow was established in 1986 to oversee the RCP's international work and we are now on to our ninth fellow, Professor Ali Jawad. Our global reach has continued to increase year on year since 1986, which I hope Sir Hans would be happy with.

I get many emails asking me to send out details of consultations on various issues. One that dropped into my inbox this month was around the Medical Licensing Assessment (MLA). In case you were not aware, from 2023 all medical schools will need to be using this assessment to allow their graduates to work in the NHS. Furthermore, the MLA will replace other assessments to ensure doctors coming from overseas have the knowledge, skills and attitudes to work in the UK. It is a big deal so please have a look at the 'road map' and respond if you have concerns.

Despite all the political shenanigans of the moment, the NHS continues to evolve itself under the direction of Sir Simon Stevens. The Five Year Forward View and NHS Long Term Plan have been about improving integrated care, although the flurry of three-letter acronyms such as STP, ACO, ICS and PCN is a little bewildering. Now that things are maturing we have come up with a simple guide to integrated care which we hope you will find useful.

November 2019

Welcome to the November bulletin. It has been a very busy month since I last wrote, with lots of things happening. The RCP is causing a few headlines of late and I was delighted to see us referred to as 'the most influential medical body' in the *Sunday Times* last weekend. The papers, though, only tend to report the 'bad news stories' so I will try and mix in some good news in this bulletin so the 'undertones' are not all bad.

'It's going to happen' – a general election that is

Each bulletin of late has included something about UK politics. The current plan is that we will have an election on 12 December and while this may be seen as a good thing by some, it is hard to envisage a clear majority for any one party. We've produced our own manifesto for the next government, focusing on patient safety, workforce and investment, do have a read if you have time. A 'hung parliament' will not be good for the NHS as decision making will be paralysed and much of the legislation we have been pushing for will get delayed further (such as the regulation of physician associates).

We are seeing, though, more detail of what the parties will be pushing for. The most recent thing that rather took my breath away was John McDonnell's promise to have a 32-hour working week for all in 10 years' time without any option to opt out of the working time regulations (what the European Working Time Directive became when it was written into British law). Both of these will represent challenges. By my estimate we will then immediately need 30–40% more doctors to have the same number of person-hours (is there a 'magic doctor tree' I've missed?). Does it mean we will need 30–40% more MPs as well? …

'Wednesday week' – flu vaccination

Have you had your flu vaccination yet? I had mine a week and a bit ago but didn't get my picture taken to post on social media so that may mean it didn't happen at all. Joking aside, my take on flu vaccination has changed over the years and it seems that others' views have too. I used to be an occasional vaccinee based on the belief that the vaccine was ineffective and even if I had flu, I and my patients would be fine. Opportunity was also a problem as I could only get time to go to the flu clinic between my own clinics and would then be faced with a long queue.

I now understand much more about asymptomatic carriage and the effect of flu on those more susceptible (ie many of my inpatients and immunosuppressed outpatients). The flu vaccine is also more effective than I thought. However, the problem of opportunity remains an issue. I've visited several trusts in the past few months with high rates of staff vaccination (95% or more). They send the flu vaccination team to the clinical areas making it easier to have the vaccine.

Mandatory flu vaccination is now being talked about by some high up in health policy. I think this would be a really bad thing to do and would have a negative effect on staff engagement on this as well as other matters. If some trusts can achieve more than 95% coverage it shows it can be done with a bit of effort.

'Jimmy Jimmy' – RCP bye-laws

I suspect that few, indeed any, of the readers of this bulletin have read the bye-laws and regulations of the RCP. They have been with us since the RCP was founded and have been added to and modified at fairly regular intervals when necessary over the years – for example, a major review in the '90s enabled some of the RCP modernisation recommended by Professor James. Two years ago, when I was registrar, a few of us suggested a further re-write of the RCP bye-laws to bring them up to speed with the way the RCP is running these days and make them a bit more accessible.

Given the large number of bye-laws (almost 200) this has been no small task but we are approaching the final draft version to put before the fellowship (who will be consulted and must approve any change). While I worried that this was going to be a rather dry and turgid process it has been surprisingly fun, mostly due to the people involved. We have tried to ensure that we have kept some of the historical golden nuggets while losing out-of-date language and directives. We have also endeavoured to reduce the word count significantly.

The final version has to be approved by the fellowship and this will be done at the annual general meeting (AGM) in July. That in itself will be a break with recent tradition. The AGM has been combined with the College Day celebrations on the Monday after Palm Sunday since the year 2000. The date of the presidential election is set by law on that day (and getting it changed would be no small task as it would require an Act of Parliament) and will continue to be then. However, RCP Council have agreed to move the AGM to later in the year for two reasons. Not only is Monday afternoon a bad time to get most NHS clinicians to the RCP building, but having the meeting so early in the year also means the RCP accounts are rarely ready for approval in a final form. This is a problem as that is one of the main functions of the AGM, so this change will overcome it.

'Teenage kicks' – what's in a name

As a gastroenterologist I look after a lot of patients with inflammatory bowel disease, and like many long-term conditions that can start in childhood there is a 'transition' period between paediatric services and adult services. Many 'adult' clinicians struggle with this and the RCP are working with the Young Adults and Adolescents Steering Group (YAASG) to improve training and awareness of the challenges patients and clinicians have understanding each other. Focused clinics for this age group work well.

At the most recent YAASG meeting it became clear that the terminology of 'transition clinics' may be a bit of a problem. A couple of the group reported that they had had patients not attending as they thought the 'transition' title referred to gender transitioning.

'You've got my number' – climate change

Following my recent *Commentary* article and last month's bulletin we are making progress on agreeing a trajectory with regards to our investment portfolio and divesting from fossil fuels. Our Investment Advisory Panel has come up with a plan which needs to be agreed by the Board of Trustees. It will cost us more as divesting will mean the fund management costs double and the returns fall. We will be looking to encourage renewable energy development through the changes and ensure that they minimise the impact on cash flow.

At the end of October I cycled from the RCP to London City Hall (near Tower Bridge) to promote the issues with air pollution in the capital. The London Mayor's office has made great strides in improving air pollution through the use of an ultra low emission zone (ULEZ) and this is a model that other cities could follow. I'm fairly clear, though, that if we want people to use cars less we need to make other forms of transport easy to access and safe. The cycle highways in London are a great example of that. Richard Smith, former BMJ editor and now chair of the UK Health Alliance for Climate Change, cycled with me and did some filming to highlight the issues. Once the film is finished we'll put it on the RCP website.

I also note that E.ON are using the evidence from the RCP and RCPCH report *Every breath we take* to promote renewable energy. Such unsolicited mentions are a double-edged sword, but once again highlight how influential the RCP can be.

December 2019

As we enter December and all that this month brings I suspect that many reading this bulletin are dreading the onslaught – be it of relatives, patients in ED or politicians. I've done a lot of writing on all of these (bar in-laws) in the past couple of weeks for the December edition of *Commentary* focusing on social care, winter pressures, pensions and digital health. I will therefore try to avoid repeating myself and keep this bulletin relatively short.

Scrubbing up well

I've said many times that I am very suspicious about social media and the frenzies it creates. The fuss over the wearing of hospital scrubs and stethoscopes by a group of (presumably) doctors on the front row at a political campaigning meeting was one such frenzy recently. The comments included conversations about infection control, wearing hospital uniforms outside of the hospital and the politicisation of the medical profession.

I was intrigued by how we view ourselves based on what we wear. The mere fact that the doctors there felt that wearing scrubs and a stethoscope best summarised their identity to the public (and a similar garb is worn by health correspondents who are ex-doctors in the Sunday papers) suggests that we have an image problem. The issues that this creates can be divisive.

I was at a trust recently where this division was noticeable. It has to be said that the trust, which had been really struggling 5 years ago, has turned itself around through focusing on culture and leadership and as a whole is a great place to work. I immediately noticed, though, on walking around that the FY1 doctors were wearing scrubs of a different colour to everyone else. When I asked those doctors if they felt devalued by this (I accept this is a leading question m'lud) they agreed strongly. Rather than enhancing the team, they felt marginalised and that patients saw them as lesser doctors than their colleagues.

I'm all for a way to identify what grades different doctors are, but this can be done with coloured lanyards. Provided clinicians identify themselves to patients by their name and job title (and that goes for all parts of the multidisciplinary team) then everyone, staff, patients and carers know who everyone is without creating deep professional divisions.

Word of mouth

I'm involved with a case at the moment where mouth care has been highlighted as a potential risk factor for hospital-acquired pneumonia (HAP). As is often the way, as luck would have it I had the opportunity to hear the latest on this area at a trust visit last week.

HAP is a big issue for our ageing and increasingly frail inpatient population. Around 1.5 % of inpatients get HAP and when it HAPpens (sorry) it increases length of stay by 12 days on average. HAP risk increases with age, no surprise, and the colonisation of the mouth and pharynx by respiratory pathogens. These pathogens are then aspirated into the respiratory tract. Thus, while there have been no clear studies demonstrating an association of levels of mouth hygiene with incidence of HAP it makes sense that we should keep mouth care high on our list of things to think about on the ward round.

Stocking fillers

I'm often asked what medical books I would recommend. Indeed, I am asked to review a book every month to write something supportive for the cover. The books I receive are mixed. It is not surprising that many are highly personal and result from experiences of the best or worst of our health services. Some are well written, some are not. By that I mean easy to read for a busy doctor and make their arguments in an accessible and evidence-based way.

Last week (because I heard the author give a fantastic talk) I was reminded of the best one I've ever had the privilege to read. I'm quite happy to give it a shameless plug if you are struggling to think of a gift for a colleague or medical student relative. Kathryn Mannix's *With the end in mind* remains an outstanding book on death and dying and I continue to believe it should be essential reading for all doctors in training.

Silver standards

Last month we celebrated the 25th anniversary of the creation of the Joint Advisory Group on GI Endoscopy or JAG as it is better known. Initially set up to standardise endoscopy training, it now also oversees accreditation of endoscopy services and screening endoscopists. Anybody who works in endoscopy knows JAG well and their standards are the watchword in endoscopy excellence. Since 2009 it has certified nearly 2,000 trainees in endoscopy and 264 endoscopy units. It has become so well established that it has become a verb: have you been 'jagged' recently?

New deputies in town

When I was registrar I came to understand that the workload has grown considerably since the days of the late David Pyke. We hatched a plan to recreate the deputy registrar role at the RCP, which I'm delighted to say has come to fruition. Better still, we have now appointed two deputies to job-share the role – Alastair Gilmore and Sonia Panchal. Both stalwarts of the New Consultants Committee, they bring a new perspective to the Membership Department and will support Donal, the current registrar, in his role. Welcome to them both.

In confidence

I couldn't help but laugh recently when I heard a presentation by a cardiothoracic surgeon from a tertiary centre dealing with lung cancer patients. Fully aware of both the strengths and weaknesses of his character he said: 'I'm often wrong but never in doubt'. On reflection this sums things up well. We need our surgical colleagues to have surety of knife and at the same time the humility to admit when things go differently to plan.

Keen not to be replaced by a melting block of ice I'll be hosting a 'Facebook live' to talk through the main issues I've raised in this bulletin and December's *Commentary* and answer any questions members might have. Please feel free to join the discussion on 18 December at 6.30pm.

2020

January 2020

Welcome to the new decade and all the very best for 2020. The social media feeds and papers have been full of what we have gained in the past decade (Instagram, iPads and Ed Sheeran, for example). I've been trying to think what the big gains in NHS hospital medicine have been that would surprise a 2010 version of me. Immunotherapies, including T-cell therapies for cancer, regular use of DOACs for most anticoagulation, electronic patient records, and thrombectomy for stroke spring to mind for me but I am interested to hear what others think.

New Year's resolutions

When I wrote the December bulletin we were about to have an election here in the UK. The result was not completely unexpected, although I suspect the size of the majority was a surprise to some. From the RCP's perspective we are pleased that there is a strong government that can now focus on the NHS and in particular the challenges of pressures on the front door and most importantly the workforce.

Mr Johnson has resolved to 'get Brexit done' and we need to do our best to ensure that this happens with the least disruption to the NHS both in the short term and the long term. I took some flak from some party activists on both sides pre-election for questioning the ability for us to magic up an additional 1,250 GP training places or create 6,000 more GPs. As I repeatedly say, we need our primary care services to be thriving. However, the sums for those figures just don't add up.

My resolves are 'to get medical student numbers doubled' and 'get physician associate regulation' and 'get the pensions sorted'. Not as catchy as Boris' but equally important.

In the longer term, we are developing a 4-year strategic plan, for 2021–24, on behalf of our trustee board, and we want everyone who has a stake in the future of the RCP to help us. Over the next few weeks, you will have the opportunity to tell us what you think our vision, mission and strategic aims should be. Keep an eye out for the consultation which will be sent out soon.

Who dares wins

Now the UK election and holiday season are over we are seeing a rush of reports from bodies that haven't been able to publish in the past couple of months. Two have caught my eye.

The first is the GMC report on specialty and associate specialist (SAS) and locally employed (LE) doctors. These two groups of doctors have similar needs as well as unique ones. The report highlights the difficulties in getting recognition for the work they do and in particular the training received. Getting a certificate of eligibility for specialist registration (CESR) remains a challenge which would defeat some of the hardiest souls from the other well-known SAS.

The GMC identified 48,000 doctors not in training or on the specialist or GP registers. 6,400 responded, around 25% of all SAS doctors and 10% of LE doctors. 20% of those responding said they did not get the opportunity to participate in training 'to advance their career'. Over 40% had difficulty accessing CPD opportunities in the past year.

To me this says that we are not valuing these groups of doctors enough and given that high-quality training and CPD are an important part of feeling valued as an NHS doctor this is something that needs sorting.

The other report was from the Academy of Medical Sciences, which some readers may not have heard of, but is the main body championing the medical academic and research agenda in the UK. Medical research is vital to the UK as shown by the fascinating stat that for every £1 invested in medical research, 25p is generated for the economy every year thereafter. The National Institute for Health Research (NIHR) clinical research network is estimated to have generated £8billion in 2016–18 alone.

The Academy report focuses on the engagement of the NHS as a whole with research and the need to value research, ensure our doctors are equipped

to engage with it and that they are given the time to do so. The report echoes the RCP's 'Research for all' agenda and is really welcome. We need more NHS CEOs to dare to create an environment for NHS clinicians to take part in research. Everyone wins if they do.

Also, look out for our new member survey on involvement in clinical research. We know that many clinicians face barriers, such as time and funding, so your response to the survey will help us determine what steps we should take to enable more of us to participate effectively in research.

Association football

New year often gets people exercising more and this is a good thing. Although cycling is now my main aerobic exercise, I spent many a happy hour on the hockey pitch in my youth and as many hours as a dad watching my kids play various pitch-based sports. I was therefore a little alarmed when a fellow contacted me about concerns regarding the 'rubber crumb' risks of 3G sports pitches.

I have probably just lost a few of you here so some explanation is needed. Synthetic sports pitches (often called 'astroturf' in my youth) are like phones in that they come in various generations. Most include multiple strands of synthetic green grass with other constituents to help prevent wear both to the pitch and to the players. 2G are sand-based and have an impressive grazing effect if you decide to fall over on them. 3G include a cushioning layer of recycled rubber crumb, which is loose and thus easily recognised by those tasked with washing sports kit after the match. 4G, 5G and 6G pitches do not contain rubber crumb.

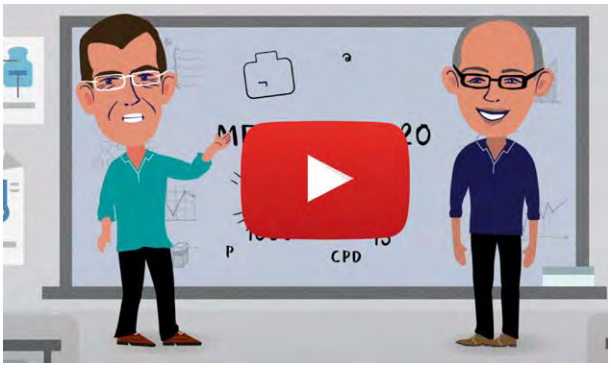
Recycled rubber, as you might expect, is not a simple compound and potentially toxic – there is a reason tyres are not allowed in landfill. 20–40,000 tyres are needed for each pitch and there are at least 50 recognised carcinogens in rubber crumb. The particles are of varying sizes and many can be extremely small and easily aerosolised. Concerns have been around for a while and rubber crumb pitches are banned in the Netherlands. Case series of young sportspeople in the USA show a worrying level of malignancy including three cases of lung cancer in people under the age of 30.

Having said all of this, the evidence is still circumstantial and by association. Encouraging our children and indeed our adult selves to exercise is essential and all exercise carries risks (says the person currently recovering from two 'sports injuries'). However, we have to ensure we are not exposing anybody to a significant cancer risk and I will be watching this issue with interest.

Cartoon characters

Many of the readers of this column will know I am known as Bod by friends and most people who work with me. This has been the case since I was a young child (for reasons that are not as interesting as you might think). 'Bod' was also a cartoon character in the 1970s based on a series of children's books. 'Bod' stories were a little bizarre but supposedly reflected the Taoist beliefs of the authors. I have, unsurprisingly, acquired various 'Bod' cartoon memorabilia as gifts over the year although these have not influenced my philosophical leanings.

'Bod' the cartoon is about to be joined by this Bod as a cartoon as we start to build up our engagement for Medicine 2020, our annual conference. Cheng-Hock, the RCP academic vice president has also been 'cartoonised' and both of us await with some trepidation how our new personas will be used. We are, though, really excited about Medicine 2020, which is looking like it will be our biggest-ever conference.



February 2020

2020 is now in full throttle and the world of health seems as busy as ever. There are a few issues taking up my time at the moment but coronavirus predominates, so I thought it might be helpful to summarise where we are.

Coronavirus

Two months ago, most of us in medicine had a rough idea what coronaviruses were but had no idea that they would feature in our lives and conversations so much in 2020. There is already a lot of very useful information available on the NHS, Public Health England and Foreign and Commonwealth Office websites, so I will not reiterate that. We have arranged a streamed teaching session on the current outbreak for next Wednesday evening which will update us, cover some of the more detailed epidemiology and virology, and explore how these pathogens cross between species (I now know what a civet cat is). You can attend in person by registering now.

Some observations on the outbreak from my perspective:

The UK is well prepared for it and we are in safe hands leadership-wise. We are lucky that Chris Whitty is our chief medical officer, such outbreaks being his bread and butter. His calm and measured tone in the media and full understanding of potential scenarios are just what we need. We are also lucky to have Keith Willett at the helm from the NHS perspective, fresh from his role as NHS lead for no-deal Brexit. Steady hands both.

This coronavirus seems a dangerous foe, but not as 'deadly' as MERS or SARS. Figures seem to vary a little, but the current estimate of case fatality rate (or CFR; the correct measure in an outbreak like this) is 2.5%. This compares with 7% for SARS, 35% for MERS, 70% for Ebola and 0.1% for most seasonal flu. Spanish flu was similar, but the two viruses are different in their mode of transmission and we don't really know the exact 'infectiousness' of the new coronavirus yet.

As an aside, Spanish flu was so named as only the Spanish media was open after World War I and thus freely reporting infection in their royal family. It was rife throughout Europe and America and probably started in France or Germany, but censors prevented it from being talked about much in the media. Fake news was alive and well back then.

I have been saddened by the stories of stigmatisation of Chinese people in the UK since the outbreak and suspect this will worsen if the outbreak becomes a pandemic. Such situations bring out the best and worst in humans. Ignorance and racism go hand in hand. If true, an anecdote of someone attending ED because they had been for a Chinese takeaway and wanted to be tested is a microcosm of this. We currently have no evidence that this infection can be spread by asymptomatic individuals (the purported case in Germany doesn't fit with any other cases and is under scrutiny).

In another aside, I spent most of a Sunday afternoon a couple of weeks ago removing food boluses from two patients whose oesophaguses had got blocked by Chinese takeaway food. Not the most pleasant part of my job and it made me want to go around Derby putting notices up on all fast-food establishments to tell people that just because the food is fast, you don't have to eat it quickly and forget to chew.

The NHS is fortunate to have units where proven cases are being / will be cared for. 'High consequence infectious diseases' (HCID) units are rather scary environments, but I had the honour of visiting the one in Newcastle just over a year ago. I was impressed by their teamwork and preparedness for whatever nature might throw at them. All the HCID units are well prepared for what the outbreak might bring us, and experiences from Ebola and monkeypox in recent years have shown this.

As always in such outbreaks, there are moments of black humour. I was struck by the name of the company that provided the coaches for the repatriations from China to Arrowe Park (well done to all there for their hard work, by the way). As four coaches went past with 'Horseman' blazoned on their tailgates, I wondered about the person who had booked the firm as the world was worrying about an apocalypse.

In conclusion on this topic, we remain at an unknown stage of the outbreak. We all hope that the measures taken by the Chinese government so far have been enough to keep the outbreak from becoming a pandemic, with only 'spillover' cases in other countries. Time will tell, and I know that our experience with flu has prepared the NHS for either eventuality.

New wellbeing resource

Burnout, work-related stress, mental illness and suicide are increasingly recognised within the physician workforce. Doctors are not good at seeking help; often denying there is a problem, not recognising there is a problem, being fearful of any stigma, having anxieties and guilt about burdening others with our own difficulties or even possibly losing our job.

When I was elected president of the RCP, wellbeing was one of my key priorities and I am delighted that the RCP's work in this area is coming to fruition. Today we launch our new mental health and wellbeing resource, led by our vice president for education and training Emma Vaux. I've written more about this in my February *Commentary* leading article, but please visit the website to explore the resource and send us your thoughts. We're also emailing you a survey on wellbeing today – it only takes 5 minutes to complete, so please respond! We need as much data as possible to demonstrate the effects of the increasing pressure we know you are under.

RCP strategy

We have been working on a strategy for the next 4 years and hopefully you have received an email asking for your comments. If not, visit the RCP website for more details. I've been looking at the 2,000+ responses we've had so far and it seems that most are in agreement with the broad aims and directions. I have been struck, though, by the answers to the question 'If the RCP could only do one thing, what should it be?'. These answers show the diversity of views held by our members and fellows, and indeed what people feel most passionately about. Suffice it to say there is no clear single thing that you all feel we should be doing. However, there are a few strong themes emerging, which means making our future plans will be a simpler task.

March 2020

If you can keep your head when all about you are losing theirs … let's start with what we're all talking about.

COVID-19

Things have moved on a bit since my bulletin last month – the nomenclature for starters – and are changing on a daily basis (even as I write this I accept that I might have to edit it tomorrow). As a result of the ever-evolving situation we have decided to **postpone our annual conference Medicine 2020** to 7–8 January 2021, to ensure that NHS staff are available to meet the increased demand on services. While this is disappointing for all of us, we are responding to the bigger picture of protecting clinicians and the public from contracting COVID-19 and to prevent the further spread of the virus. We hope to see you all in January.

I have attended numerous meetings, telephone conferences and read innumerable webpages and emails on COVID-19. Here are my observations:

The information on the government websites is clear and easy to use. For the latest advice for healthcare professionals visit the NHS website. For the global epidemiological data you can't do much better than the Johns Hopkins dashboard. For a list of current category 1 countries and regions (self-isolate if you have been there in the past 14 days, even if asymptomatic) and category 2 countries (self-isolate if symptoms develop) see the advice from Public Health England.

The media are helping to stoke public anxiety nicely. I was struck by the comment by someone trying to coordinate things that history will damn them whatever – if it becomes a large pandemic in the UK (why didn't you do more?) or if they prevent this (why did you make so much fuss about this and spend so much money?).

The window for successful containment is narrowing but not yet fully closed (there is a gale force wind trying to push it shut). The work done by local Public Health England teams in contact tracing and testing is absolutely astounding. If the pandemic is prevented within the UK it will be due to their (thankless) efforts. I am saddened that the media have not highlighted their role. As I said in my last bulletin we have a great chief medical officer in charge of things at the moment.

This is a serious disease for some with mild symptoms for most, and, while parallels with flu and SARS are useful to a degree, we must be careful not to overplay or underplay those comparisons. It is useful to highlight to the public that flu kills 10,000 people most years (and this may improve vaccination rates next year). It is even more useful to get both children and adults more aware of the importance of hand washing and 'cough etiquette'. However, we must tackle COVID-19 on its own merits.

Talking of coughing, I am now noticing just how many people don't cover their mouths when they cough. On my train journeys this week I estimate that about 70% of people don't bother. If it could, I'm sure the virus would laugh at the ways humans help it spread.

The appearance of multiple experts in the media is fascinating, some seeing it as their opportunity for 15 minutes of fame. If that frees up the time for others to crack on and solve the problem it is a good thing. If it stokes public fear it is not. Some have been excellent, though, and I was impressed by Tom Solomon (a member of RCP Council), talking recently on BBC Breakfast. It is good to see an RCP Council member talking sense (I can hear them all saying 'we always do, president').

If the pandemic becomes established, the impact on the NHS will be large. Some have reflected on the 2009–10 flu, which had a big impact on us all. Who knows if this will be like that but the retrospectoscope shows us that the impact on NHS staff was significant, due both to the large numbers of very sick people as well as the background worry about getting infected themselves. We will need to support each other like never before if the situation deteriorates as much as some people fear. Trainees (as always) will bear the brunt of looking after patients on wards and seniors will have increasing anxiety depending on their 'seniority'. We will all be stressed but we can all do our bit to support those around us.

Increasingly, we will see NHS staff being identified as having COVID-19. We need to ensure such people are not vilified if they pass on the infection. However, it also is beholden on us all to not take risks if we know we may have had a relevant contact and develop symptoms.

It is also important that we all understand what the 'pandemic plan' is for the organisations at which we work. If it isn't clear from your hospital website or trust protocols this is worth feeding back to your medical director and ensuring all are aware of what needs to be done. To paraphrase – poor planning predicts poor performance (in a) pandemic.

The impact on the RCP of a major UK outbreak will be significant. We have 400 staff over many sites and need to ensure we look after all of them. We have already cancelled a couple of sittings of PACES internationally and produced guidance for all candidates sitting PACES in the UK or abroad. Thank you to all the staff regionally, nationally and globally for the work they are putting in to keeping business as usual.

Alex Lake has written a helpful update on COVID-19 for the next edition of *Clinical Medicine*. Modern publication processes allow us to get this out very quickly. It will be interesting to see how it stands the test of time. As regular readers will know I'm a bit of a social media sceptic. Some of the stuff out there on COVID-19 is mad, bad or sad. However, I have been directed to a diamond in the rough on Twitter. @OutbreakJake has some really useful information and links to helpful videos (although I'd follow him for his handle alone).

Finally, we need to keep our normal lives going as far as possible. The planet will continue to spin and patients will still come our way with diseases other than COVID-19. It is not wrong to have a sense of humour and take time with our families. Indeed, it may be vital.

Medical schools expansion

The RCP work on medical schools expansion continues and I had intended most of this bulletin to be an update on how things are going. Given all the above, though, I'll be brief. Following on from our 2018 call for a doubling of the number of medical school places we have been working closely with economists and stakeholders to get all the data together to create a business case type 'green paper' for government. This group includes medical students, HEE, GMC, the other big colleges, the Medical Schools Council, the UK Foundation Programme and others.

I have been struck by the consensus we are achieving and also the clarity of data we have to strengthen the case. There seem to be three main 'big problems' we have to solve: the geographical maldistribution of medical staff; the lack of doctors with skills in managing people with multiple health conditions; and the lack of training capacity (we will need to ensure we can teach and train any new medical students).

I was reassured that these three problems, although 'wicked' in modern parlance, are not impossible to solve when I visited the new medical school in Lincoln a couple of weeks ago. The building isn't finished yet (they are borrowing space from the science faculties) but the multidisciplinary teaching I observed and the complete rejuvenation of the Lincoln campus since I was last there showed what a positive impact investing in training can have on the local community. More like this please.

Invest in all parts of the system

Today we wrote a letter to the chancellor, signed by 29 other specialist medical societies and faculties, calling for the government to use this budget to invest in public health and social care. We urged the government to recognise that the NHS does not operate in isolation – it is part of a wider health and care ecosystem, and unless we invest in all parts of the system, plans for truly integrated care will never be realised.

Unconscious bias …

On my visit to Lincoln I was mildly amused by the unconscious bias exhibited by some of those we met. I love Donal, our registrar. He has much more gravitas (it's a hair dye) than I do and when we walk into a room of people who don't know us, people often assume he is PRCP. While this creates a moment of embarrassed amusement (it doesn't bother me at all) it has made me think much more about the preconceptions we all carry with us like a millstone.

16 March 2020

Given the speed of how things are changing at the moment I plan to send you a weekly update. There is a danger of information overload at this time but there is much to say. I will try and keep things simple and relevant.

A single source of truth

At times like this there are many 'experts' out there willing to say what should be/have been done. I am fully supportive of the approach taken by the chief medical officer (CMO) and chief scientific officer (CSO). It is evidence-based, pragmatic and cool-headed at a time when this is needed more than ever. They are holding the map and compass as we reach various forks in the road. Some may want to take a different fork (even if they haven't looked at the map). I'm sticking with Prof Whitty and Sir Patrick.

As I said last week, the guidance on the Public Health England, Department of Health and Social Care, and NHS England websites are the best single source of guidance on COVID-19 issues. They are updated regularly (often daily) so it is always best to link to that guidance rather than relying on either word of mouth or a social media article.

For individual conditions, many of the specialist societies are working with the NHS to provide guidance, eg providing palliative care for patients in the setting of COVID-19. Such guidance will be available centrally (via the NHSE website) over the coming couple of weeks. Obviously not all conditions can be covered on the NHS COVID-19 pages, and I know that the specialist societies are working on condition-specific guidance. We are establishing a page on the RCP website to signpost to this specialty-specific information.

If there is an issue in your specialty that you are worried about, please let us know and we will link you to the relevant people.

If you have any questions or concerns about COVID-19, I will be hosting a live Q&A on our Facebook page this Thursday 19 March at 6.30pm.

NHS issues

I hear from physicians around the UK that there is considerable variability as to the actions and planning of different trusts regarding elective activity, leave, management of particular conditions and co-ordination of services. I have been on-call this weekend and my hospital is closed to elective activity in medicine and has heavily restricted visiting. These are difficult days and there is unease among staff as patients come in with suspected COVID-19 both in terms of what to do and what the implications are for them.

Plans will need to be tailored to local circumstance but there are clear lines of command established across the NHS now that we have a 'Level 4' national emergency. If you want to know what guidance your trust is getting it is available on the NHS and MHRA Central Alerting System website. It makes for useful reading.

The key message for the NHS is that we have moved to a pandemic flu approach. TV images have shown us wandering around in hazmat-style suits. This perhaps sends the wrong impression and we need to redress that (hence the photo of me on the ward before seeing a possible COVID-19 patient on Saturday).

It is best to think of patients in different groups:

Suspected cases coming into hospital (eg community-acquired pneumonia). These need apron, gloves and fluid repellent mask with or without a visor as personal protective equipment (PPE).

Suspected cases needing aerosol generating procedures (AGPs) (eg bronchoscopy or ventilation – access the full list). These need a higher level of PPE, ie full facemask to FFP3 specification, gown and gloves. Vigilance is needed once again.

Known cases are as for suspected cases and depend on the procedures being performed.

If you are wearing this standard PPE and the patient is subsequently proven to have COVID-19 you don't need to worry but should be vigilant for any symptoms of COVID-19 in yourself and self-isolate for 7 days if you get them.

All of the above will need testing for COVID-19 so it is worth saying a few things about testing.

Who we test has changed. Previously we have been focussing on testing all suspected cases and contacts. Now we will now move to testing based on the current case definition. Lots of people have asked me about testing of staff. From my understanding, the test would need to be very sensitive in the context of staff to ensure we didn't have large numbers of false negatives and re-introduce infectious staff back into hospitals. For the moment 'self-isolate' for 7 days seems the safest policy until this is established and testing is widely available.

How we test may also change as near-patient tests are developed and serology becomes available. Many in PHE and elsewhere are working on such tests. They will need to be assessed before widespread use. We must learn from the USA where a test was introduced that was inaccurate and led to many missed cases.

Training issues

The RCP is there to support our members and help provide the best medical training in the world. At a time like this clear messaging is needed to allow trainees to understand what is likely to happen. It isn't always easy to do this when the situation is changing rapidly and we need to co-ordinate with our sister colleges and across four healthcare/education systems, but what follows is where we are at as of today.

Exams

I've been contacted by trainees rightly worried about what is going to happen with exams. Some are desperate for them to go ahead as they have been revising for months. Others think it would be nonsensical to deliver them. Most other colleges are cancelling exams for the next few months but in slightly different ways. Many trainees will not be able to attend due to restrictions on study leave imposed by employers.

Those in the MRCP office and in the colleges' PACES and assessment teams have been working hard at looking at possible solutions, including smaller venues. Ultimately this has proven impossible to resolve though and we have therefore taken the extremely difficult decision to cancel all MRCP(UK) examinations in the UK and internationally from today until September 2020.

For full details please visit the MRCP website.

ARCPs and progression through training

Many are worried about what cancelling their exams will mean for progression. Staff in the JRCPTB have been talking to all parts of the system in the whole UK on this and have managed to get an agreement for trainees that should allow relative stress-free progression.

For those trainees who may be worried about not getting through their annual review of competence progression (ARCP) as they haven't been able to complete all the necessary assessments, new guidance has been published today by the JRCPTB. However, before the onslaught of COVID-19 cases really hits us, trainees should check their ePortfolios and make contact with their educational supervisor to ensure things are in as good a shape as possible for that ARCP, whatever shape it may take.

The nature of service demand may mean that trainees may not be working in the next job as planned. Local heads of school are working hard to look at what needs to happen to support service

and training at this time, and will try to find ways to ensure trainees are not disadvantaged.

Recruitment into ST3 is a particularly thorny problem as it seems very unlikely the traditional way of recruiting will be possible this year as both interviewers and interviewees are needed on the front line. Necessity is the mother of invention and, again, a four-nation approach is being worked on to tackle this.

Hopefully we should have a better idea of what this will look like in the next week or so. Again, it is important for trainees to contact their educational supervisor as soon as possible as the supervisor's report may be important in the decision-making processes.

CPD

Although the worry about getting CPD credits may seem like a relatively minor issue, I have had emails about it from some concerned consultants. We are working on a solution to this and will hopefully confirm that in next week's bulletin.

Dad's army

Another concern that has been raised is about retired physicians returning to the NHS front line to help out. This is fraught with all sorts of issues and there will need to be a BMA-agreed plan.

My take on it is that it should be voluntary, not direct patient-facing and perhaps best utilised when we try and get the 'training engine' started up again in the later part of the year. We will need assessors and examiners by the bucketload. I also think that recently retired consultants will make great mentors for those on the front line. The psychological impact of COVID-19 cannot be underestimated and a supportive ear/voice may be just what is needed.

Tough decisions

Tough decisions will be part of the business of managing the pandemic. I have been very grateful to the RCP's Committee on Ethical Issues in Medicine, chaired by Alexis Paton, over the past couple of weeks. It has provided some very helpful guidance for our thinking, which we will share in the next week or so.

If you are faced with a difficult decision, you are not alone. Ask a colleague you trust. If you are a trainee, ask your clinical supervisor or your educational supervisor.

And finally...

We are in this for the long haul. It is a marathon not a sprint and over-reaction will lead to early fatigue of the service and consequent problems. The number of admissions will increase considerably over the next couple of months and the impact on us all will be huge, but like a Roman testudo we need to stick together to be most effective.

There are a few key moments coming up. One will be a COVID-19 bill to allow short term changes in legislation to facilitate getting through the crisis. Another will be the move to social distancing for our vulnerable populations. This will be hard for the older people in our society. If you have an older neighbour, please keep an eye out for them.

Please also look after each other and yourself. We are no use to anyone if we don't.

23 March 2020

The events of the past week have continued to rapidly reshape society in the UK and across the world. There are so many things I could talk about but I will try and focus on the ones that seem to have struck a chord with physicians. View last Thursday's update and Q&A session on Facebook live.

I should also say that the RCP comms team have created an easy to use RCP COVID-19 resource to bring everything together.

'Shielding' our most vulnerable patients

You will have seen the announcement from the prime minister last night that we are advising around 1.5 million of the most vulnerable patients to self-isolate. If you look at the list of types of patient, many of them are under the care of physicians. People who have undergone an organ transplant, had active cancer treatment, have a rare disease or severe respiratory disease will be contacted directly by the NHS.

Patients who are immunocompromised make up a large vulnerable group. They are difficult to identify centrally so it will be up to us to ensure they know what to do. Our registrar Donal O'Donoghue has been working with all the specialty societies to ensure we adopt a consistent approach to immunocompromised patients.

If you look after patients who are immunocompromised, please look at the information on your society's websites and work with your hospital to ensure the advice is clearly visible on the hospital website's main page. Sir Simon Stevens has written to all CEOs so they should know that they need to help signpost patients.

I also know that specialist nurses caring for immunosuppressed patients have already been overwhelmed by calls since the outbreak began and this next step will create more work still. Some are being reallocated to acute wards. Please lobby for

them to remain in their specialist role for a further week or two to support these patients and hopefully prevent them from contracting COVID-19.

Palliative care

The Association for Palliative Medicine has come up with some very helpful guidance on how to manage the dying patient in the era of COVID-19. Some may not want to be 'shielded' like other at-risk groups.

Personal protective equipment (PPE)

The guidance for what PPE people should be wearing remains as I described in last week's bulletin. There have been concerns that Public Health England (PHE) guidance differs from World Health Organization guidance, but I have been reassured by many infectious diseases and virology experts I trust that the evidence base for the PHE recommendation is sound.

The supply line for PPE seems much less sound with multiple reports of trusts either running out or offering bizarre instructions about re-use. The NHS hierarchy are aware of this and the supply chain had been redesigned and restructured to improve flow. However, the issue is not resolved yet and we need to have all hospitals following the same rules. Donal and I wrote to Matt Hancock about this yesterday to reiterate the point.

I note that some have used my photo from last week to show a difference between PPE in the UK and PPE in China and this has been circulated around interventional cardiology circles. For the record, I am not an interventional cardiologist and the photo pictured me as I was about to see a patient with possible COVID-19. You do not need to wear a full hooded gown and goggles in the setting I was in, but you do need to wear FFP3 mask, gown etc if you are doing an interventional aerosol generating procedure, such as those carried out by interventional cardiologists.

In this context, the issue has been raised about other clothing which is exposed when wearing an apron. This is a good point and the advice about infection control remains the same. Scrubs are fine (and many of my colleagues have invested in some) but all clothing that you have worn in hospital should be changed out of either before you travel home or immediately on getting home. It should then be washed as soon as possible.

The 14-day rule

I spent most of last Tuesday trying to get the 14-day rule overturned for healthcare workers. In my own team we saw a decimation (actually a triple decimation if we apply the Roman terminology correctly) when it came into force. Coughs and snotty noses are common in children at this time of year, so it is no surprise there were healthcare worker households having to self-isolate once the rule came in. For physicians this has the greatest impact at the registrar and consultant grades.

The rationale for the rule is that evidence from China shows the family unit is a potent source of spread of the infection and that isolating families if one member has symptoms was effective. This is very different from the idea of 'shielding' our vulnerable patients as I've outlined above. The logic of the 14-day rule is sound, so I changed my stance but know that the impact at the moment on teams is huge. It is why testing for the virus in healthcare workers and their household contacts is absolutely critical. The sooner we can get people back to work the better.

Having decided on a plan as a country, though, we should stick to it. I know that some hospitals are saying that the rule doesn't apply and staff should come to work. This is not true and we want to know if there are any hospitals flouting the rules so we can feed this back to NHS leaders. We have created a way for members to feed back this information.

Lastly on this issue, I know that many of those self-isolating because of the rule are frustrated and want to come back to work. It is important we as colleagues let them know that we know that it isn't an 'easy option' for them. Trying to access hospital IT remotely, looking after young children in an enclosed space 24/7 and knowing you can't do the job you love is not 'easy'.

A United Kingdom?

At this moment in history we need to all work together. I know that the CMOs from each of the four nations meet almost daily to compare notes and drive forward an overall strategy for tackling the outbreak. The unique make up of each nation means that their governments will have a take on the exact detail of how to work with their public health and NHS service. However, this is not divide and rule. We will try and tailor our messages as needed – I know the Wales office is already on the case. Importantly, the presidents of the three physician colleges in the UK are committed to working together to try and promote collaboration.

Clinical features

As we all become more familiar with the disease, its typical features are becoming clearer. Professor Ali Jawad, our vice president (global) has pulled together a useful set of slides (log-in required) summarising the features and a short summary of some of the agents that are being touted as potential solutions.

In addition, there are some other clinical issues that are being debated. We know that the virus binds to ACE2 receptors and there is a fear that those on ACE inhibitors/ARBs have worse disease. This currently doesn't seem to be being borne out, so the current recommendation is to continue people on those drugs.

Sudden anosmia has also been reported by our ENT colleagues as an early sign so is worth asking about. Lymphopenia is a common feature and should also raise suspicion.

We are also understanding more and more about the benefits (or not) of different types of ventilatory support. As we have more patients needing such support this is important. The survival of patients once they are ventilated though, is very much the wrong side of 50%. Some of this may be related to the comorbidities of the patients, such as those in Washington State and Northern Italy.

We need to understand which patients are most likely to benefit from ventilation so we are not offering a futile treatment.

Testing

I note from the PHE guidance on testing that there are a bewildering number of tests becoming available and PHE are busy trying to validate them. The current test we are using in the NHS is an RT-PCR for the RdRp gene. It has a sensitivity of around 88–90%, which can be maximised if the swab is pushed right to the back of the pharynx – this is no time to be tentative. As it is not 100% sensitive keep an open mind with patients who have the typical clinical features of COVID-19.

I understand the development of a serological test is making good progress and this will be very useful once available. It is rare among blood tests that having a positive test will be seen to be a good thing.

If the press are to be believed some doctors are using the new unvalidated commercial tests to boost their private income. If true, I am ashamed that some of my profession have acted this way and if you become aware of any of our members or fellows behaving in such a 'profiteering' way, please let me know.

And finally ...

The COVID-19 crisis will be a definitive moment in world history and be remembered by us all. What will also be remembered is how we behave with each other. I am particularly grateful to our own Patient and Carer Network who have produced a statement in support of healthcare professionals, underlining the importance of safeguarding the health and wellbeing of all clinicians and healthcare workers in addition to maintaining patient safety.

In the Facebook live Q&A session I was asked what senior doctors should be doing. My response: leading by example, looking out for those in their team and ensuring people get the chance to have some rest. Consultants – our trainees will need us to advocate for them and we will need to support each other like never before.

United we stand, divided we fall.

30 March 2020

The COVID-19 pandemic continues to change our lives – I hope that this bulletin finds you well and keeping your head above water. COVID-19 has hit my trust (Derby and Burton) like a train and the death of a consultant colleague has been a shattering reminder of the situation we are all in. The outbreak is having a huge effect on those on the frontline and it will get worse. We can only get through this if we support each other.

As things are moving so rapidly, I have tried to stress where advice in this bulletin supersedes previous advice. There is much to say so I'll crack on.

Personal protective equipment (PPE)

The past week has seen much public and private discussion about the lack of and type of PPE. The supply chain has been a significant issue and I think it is with some relief that we now have a dedicated PPE supply chain for the NHS and social care, in part facilitated by our military colleagues. The information that many of you have submitted to us about shortages has been very helpful in making the argument for this. Please continue to feedback to us so we can ensure that things improve. As I have said repeatedly this week, PPE remains the biggest concern of most on the frontline.

Public Health England (PHE) is working on updated guidance for secondary care to try to ensure that there is one set of rules for all secondary care in the NHS. It seems likely that the standards for what is needed will not change from my previous two bulletins, but there should be more clarity around aerosol generating procedures (AGPs) as well as the guidance being 'place-based' rather than 'procedure-based'. Furthermore, we have (sadly) moved from a world where COVID-19 patients are rare to there being widespread community carriage.

Trying to define an aerosol generating procedure (AGP) has been a big challenge, with individual colleges and societies all coming up with their own guidance. Some of this guidance is unarguable but some is based on rather dubious evidence.

Two bodies have been helpful in trying to ensure consistent, evidence-based and pragmatic guidance. The first of these is NERVTAG (New and Emerging Respiratory Virus Threats Advisory Group), which includes many experts in the transmission of viruses like the current coronavirus. The second is the HSE (Health and Safety Executive) – as much as to provide an external perspective on the issues. I know there will still be some who argue with whatever PHE produces but it is imperative we all follow the same set of rules to ensure that the precious resource that is PPE is not used inappropriately and that all our staff have the protection they need.

Community and primary care PPE guidance is also set to follow shortly.

Critical care escalation

The issue of who gets escalated to critical care has been one topic that has exercised many minds over the past couple of weeks. Multiple bits of advice are being prepared or have been published and it is a little challenging to get them all to fit to a coherent picture. I think, though, we are now beginning to approach consensus.

The RCP Committee for Ethical Issues in Medicine (CEIM) under the superb chairing of Alexis Paton produced an ethical framework almost 2 weeks ago, but we have held that back to allow the government's Moral and Ethical Advisory Group (MEAG) to produce theirs so there can be one ethical framework for the healthcare system across all four nations. Alexis has been inputting into the MEAG work and thus we were looking to support their framework when it comes out. I had hoped it would be out last week but no release date is imminent (I have found this more than frustrating). Given we need a framework out there as soon as possible we are working with other colleges and organisations to co-badge guidance based on our framework, which we plan to launch tomorrow.

One of the most contentious parts of escalation is the use of decision-making tools to assess patients who may need ventilation. A week ago, NICE published a guideline commissioned by the NHSE&I

clinical reference group for critical care. That guideline is supported by a set of resources including an algorithm to help identify those who would benefit from ventilation and some background data on the outcomes from ventilation in different patient groups. The RCP helped facilitate the development of these resources in conjunction with members of the Faculty of Intensive Care Medicine, the Intensive Care Society, the British Geriatrics Society and the Royal College of Emergency Medicine. Joined-up thinking and working is vital in such decision making.

The algorithm looks quite arbitrary at first glance but a few things need to be remembered at this point. Firstly, the task of prioritising limited resources is not new to the NHS (take transplant waiting lists as an example) and ensuring the systems are fair and equitable across the whole system needs national not local approaches.

Secondly, the teams looking after sick patients with COVID-19 are working under extreme pressure at the moment and we need to make difficult decision making as simple as possible for them to minimise additional stress.

Thirdly, the algorithm does not replace clinical common sense. All of us are very used to weighing up clinical situations and making a judgement call on the best treatment for an individual patient. In outpatients we often have the advantages of knowing the patients well and having time for discussions and careful shared decision making. With COVID-19 we may not have such time or knowledge, but we still have our clinical acumen. The art of medicine is what we do as physicians. This also makes the point that we need to look at advanced care planning as soon as possible on admission and ideally before admission.

Lastly, the clinical frailty score is not applicable in all patients. The algorithm states this but it bears repeating. The score does not apply in younger people, those with stable long-term disabilities, learning disabilities, autism or cerebral palsy. If someone needs a stick to walk because of a birth injury it doesn't make them frail. We must also be wary of not widening health inequality in this area. Our unconscious biases can play a strong part in decision making when we are tired and stressed. Again, common sense and care is needed.

We are going to see very large numbers of patients needing intubation and care on ITU over the next few weeks so the sooner all the resources above are available the better.

NIV/CPAP

Ideally, though, we should prevent patients from needing intubation if we can. Non-invasive ventilation (NIV) holds much promise with experience of continuous positive airway pressure (CPAP) in Italy demonstrating a significant reduction in the need for intubation and ITU-based ventilation. NHSE&I have produced a very helpful set of guidance on this which the RCP fully supports. These recommendations are the current RCP position on NIV, superseding any previous guidance.

CPAP should be used for hypoxaemic respiratory failure and BiPAP (bilevel positive airway pressure) for hypercapnic acute on chronic respiratory failure. NIV in this setting can be used to avoid intubation, to facilitate extubation and as a ceiling of treatment for some patients.

Treatments for COVID-19

The race to find treatments for COVID-19 goes on apace. We have sent out some mixed messages about our thoughts on hydroxychloroquine – to be clear we do not think it should be used outside of a trial setting as the updated advice on our website underlines.

There are three active trials in the UK which should be supported if possible. The RECOVERY Trial includes randomisation to multiple different treatment arms, including hydroxychloroquine, low dose steroids, interferon 1-beta and lopinavir-ritonavir. The ISARIC trial is an observational study into which many units are feeding data. The last trial is an extension of the REMAP-CAP trials, which are looking at prolonged macrolide therapy, steroids, lopinavir-ritonavir and immune-modulating therapy.

Testing

You will have heard that testing of healthcare workers is up and running. This is good news, although I suspect it will take a while to get up to the speed and coverage that we would all like. Reagent supply is a key problem (a lesson for after the COVID-19 crisis: ensure we don't rely too heavily on monopoly suppliers in the NHS).

Jo Martin, the RCPath president, has shared some very helpful tips when taking swabs for COVID-19 to maximise their usefulness. The common practice now is to take a single throat-nose swab due to shortages of supply. It can seem a bit unpleasant and can sting. A negative test may occur if the patient has lower respiratory tract disease (this was seen in MERS and SARS) so you should maintain a high level of suspicion in such patients and consider aspirated sputum or bronchiolar lavage as a sample source; these have a higher yield. If someone has flu-like symptoms and has a negative test though, this does not exclude COVID-19. Some publications suggest that CT results are more reliable.

There is no evidence that you should repeat swabs to see if an individual is no longer shedding virus and there is no benefit of duplicate swabs within 48 hours for those with symptoms, the above caveats considered.

New NHS Steroid Emergency Card

In the same vein, we have also worked closely with the Society for Endocrinology and NHSE to develop the approved NHS Steroid Emergency Card, to be carried by patients at risk of adrenal crisis, particularly when presenting in the emergency department or to acute medicine teams, undergoing surgery, or invasive procedures. The card can be downloaded free from our website.

Medical Training Initiative

It seems our environment is a little less hostile for our international colleagues at the moment. The Home Office has issued reassuring guidance for our colleagues who are in the UK on a visa, with extension to 31 May, but individuals must contact the Coronavirus Immigration Team. People may be able to switch to a long-term UK visa and can apply online for this.

For those on Tier 2 and 5 visas who may need to be working from home, it seems that work directly related to the pandemic will be viewed positively.

I know there are some international doctors working in the UK at the moment who are unable to get home due to travel restrictions. If you have any colleagues in this predicament, please support them. The same is true for some UK doctors trapped overseas. Some of our trainees were trapped in a remote part of Peru last week but they are thankfully now on their way home, thanks partly due to the help of our associate director for Americas David Martin, and the Irish Consulate.

Social distancing, self-isolation and shielding

The past week has also seen a massive shift in public behaviour. As a nation we have always enjoyed a good queue and this discipline is serving us well. It seems that most of the public have listened to the advice and are staying at home and ensuring they keep their distance when they venture out.

I worry about the 'shielded' patients of ours that we have (rightly) told to cocoon themselves away for 12 weeks. By their nature, some of them are quite heavy users of NHS resources in normal times but the services we are able to provide for them are now heavily curtailed. For those who have to come into hospital it must be very scary for them and we will need to be aware of that. These patients (many of whom are uncomplaining) will need prompt escalation when they run into problems.

I'm also aware that we are focusing much of our attention on the challenges of managing COVID-19 patients but we must remember that not all the diseases that afflict us are swayed by social distancing. Not all breathlessness is due to COVID-19 – heart failure, pulmonary embolism and exacerbations of COPD remain our bread and butter.

The medical specialties have produced and helped gather together some great resources for 'shielded' patients and we have linked to these on the RCP website. Many of the disease- or organ-specific charities have also come up with useful guidance for patients. The British Heart Foundation is a good example. Both RCP journals will be prioritising the rapid peer review and online publication of short reports that share innovative practice, helping teams and trusts meet the demands placed on them by the pandemic. Do submit to *Clinical Medicine* (for clinical content or content targeted at the physician on the front line) or *Future Healthcare Journal* (for more systems-focused content).

The shielded populations do not formally include frail patients with multiple health conditions such as those looked after by geriatric medicine and primary care. We must get the message out that they too must be very careful around social distancing and shielding is sensible at the current time, especially as not all members of the public are obeying the rules.

For those who cannot leave the house and are not Olympic athletes, I have been forwarded some useful home exercises to help maintain muscle strength by a rheumatology colleague. They may be helpful for your patients or your older relatives.

There is no doubt that once the danger of COVID-19 is past there will be a very long tail of excess morbidity and mortality in people with pre-existing health conditions. How big this tail will be remains to be seen but the debate about the effectiveness of social distancing on the impact of COVID-19 can only be truly settled once this tail has finished.

Settlement of legal dispute on assisted dying

This bulletin focuses on COVID-19 but I need to take this opportunity to update you on another matter. A year ago, we published the results of a survey of UK fellows and members, which led to the RCP adopting a neutral position over whether there should be any change in the law on assisted dying.

Neutrality was defined as neither supporting nor opposing a change in the law, to try to represent the breadth of views within our membership. Regrettably, this position has been interpreted by some as suggesting that the RCP is either indifferent to legal change or is supportive of a change in the law.

So that there can be no doubt, the RCP has agreed to clarify that it does not support a change in the law to permit assisted dying at the present time.

As some of you will know, our position has been the subject of legal challenge and I am very pleased to say that by agreeing to issue this clarification – the full text of which you can read on our website – the threat of further legal action is removed. Now more than ever, that's very good news.

Welcoming our new statement, the claimants, Drs David Randall, Kathryn Myers, Dermot Kearney and Adrian Treloar, said: 'We are pleased that the RCP Council have reflected on ways in which the neutral position on assisted dying adopted by the RCP last year has been misrepresented by some outside the College to imply an indifference to the issues raised, or support for a change in the law. We, as individuals, have profound concerns about the safety and impact on society of any change in the law in this regard. We therefore endorse the statement that makes it clear that the RCP does not support such legislation.'

A word of thanks

The RCP family includes many different professionals and I just wanted to say thank you to all in that family, be they doctors, physician associates, ACPs, healthcare scientists, medical students and many others. Without everyone pulling together we would not have made the progress we have so far and will not make the progress we still need to make.

And finally …

The news that Boris Johnson, Matt Hancock and our own Chris Whitty have proven or probable COVID-19 is no great surprise given the way the virus has gripped London and I wish them all a speedy recovery. I feel for Chris in particular – it must be bad enough when Dominic Cummings has your telephone number on speed dial, let alone when you have COVID-19 as well.

Stay safe everyone and remember to support each other as much as you can.

6 April 2020

The COVID-19 pandemic continues to crank up and we are all adapting to our new world. It has been an eventful week and although many issues are getting sorted, new issues keep presenting themselves – it feels like we are playing pandemic whack-a-mole. Let's go through those moles.

Personal protective equipment (PPE)

Public Health England published its updated guidance on Thursday. This was later than expected due to the large amount of feedback that had been given to the initial version. Hats off to PHE to listening to this and taking on board lots of the concerns that were raised. I found the table for secondary care and graphic particularly helpful.

The only outstanding issue as I write is the difference between PHE and the Resuscitation Council (UK) on whether resus is an aerosol generating procedure. The RCUK guidance is clear and helpful and I support it.

There are still concerns about people getting the PPE they need. Our survey last week (see below) showed that only 78% of people are getting the PPE they need at the moment. However, the supply chain is improving and the survey confirms that people have noticed this over the past week. There is still a long way to go and PPE remains both our and, to his credit, the CMO's biggest concern.

Sickness absence

I try to keep my spats with politicians behind closed doors but one door was left slightly ajar over the past week.

Last Monday I was on the BBC Breakfast show with Chaand Nagpaul from the BMA. Chaand's broadband connection wasn't working as well as mine (Derby 1 London 0) so I ended up doing most of the talking. I was asked about staff sickness and I said that 1 in 4 doctors were off work at the moment, many due to self-isolation. This wasn't remarked on at the time but the rest of the media quickly picked it up.

The figure was based on feedback we have had from members and hospitals around the country over the past couple of weeks. Quite reasonably, we were challenged to provide some data, so we undertook a survey last Tuesday/Wednesday. Over 2,500 of you responded – thank you. The results showed that 30% of you were off work in central London and 18.3% in the rest of England (RoE). For the preceding weeks it was 30.4% and 25.8% respectively.

Before we went public with this yesterday, Matt Hancock was asked on live TV if our data were correct. He said they were 'wrong' and that 5.7% of doctors are off sick. I've written to him to see if he can explain this figure and sent him our data (do you think I'll get the same back?).

To be fair, we are quoting different figures (and I'm happy to be clear on that) – our data are for people 'off work'. Looking at this group, 40% are off as they have suspected or confirmed COVID-19 (33% and 7% respectively), 23% as they are self-isolating with household contacts and 15% because they are self-isolating in the 'vulnerable' or 'shielded' groups.

I suppose the 5.7% figure may include all hospital doctors rather than just physicians as in our survey. Our data are not 'wrong' but then it may be that the 5.7% figure for sickness absence of all doctors is not too far off the mark either. However, given that much of the hospital care of COVID-19 patients is being provided by those who responded to our survey, our data are more than relevant and to dismiss them as wrong does nothing for morale. Any absence makes the job we are doing tougher, and it is only going to get tougher over the next few weeks.

The geographical differences will also be masked by using a figure for all doctors in the NHS. The 30% figure in central London, where COVID-19 has hit first, should be a sobering wake-up call.

Testing

The survey also asked about testing. 31% of respondents were able to get testing for themselves if they have symptoms and 12% if it is a member of their household. Rather than bamboozle you with more figures, if you need more detail it can be found on our website. In short, testing for healthcare workers remains a big problem.

Last Thursday (he had a busy week) Mr Hancock promised 100,000 tests a day by the end of this month. This is a 'brave decision' minister, but I'm not sure we need that many and it is more important that the tests that we have access to are accurate and relevant. A serology test will not be of use if someone has symptoms.

I know the lack of tests is not the fault of the NHS – there is a global shortage of swabs and reagents. But we need to be honest about what can be achieved. Wikipedia is not perfect, but its tabular representation of tests performed each day on its UK coronavirus pandemic page is a useful way to track the progress towards 100k.

Ethics

On Wednesday we published our ethical guidance for frontline staff, which I mentioned last week. Most of the other colleges and faculties have come on board to support it, including our ED, intensivist and GP colleagues.

The vexed question of escalation to ITU is covered in this guidance but practical tools can be found in the NICE guideline, including a web tool we helped to design with Faculty of Intensive Care Medicine colleagues and others. I have discussed some of the issues with senior lawyers this week and as always it is documentation that remains key. Documenting what information you had available to you, the discussions that took place and who was involved in those discussions is critical.

Some hospitals have established 'clinical decision groups' that are available 24/7 to support such decision-making. This strikes me as a great idea and their experience so far is that it has been of great help to the physicians making those decisions.

Sadly, we will see many patients die from COVID-19 on our wards. Once again, I would commend the Association for Palliative Medicine guidance on the management of such patients, which has been updated this week.

Smoking

I've been involved in some conversations this week on the role of smoking in COVID-19 lung disease. Smoking seems to have been an important risk factor for mortality in the Chinese cohort. Smoking may increase ACE2 expression and obviously causes local damage and impairs local immunity in the lung. This association, though, doesn't seem to be as convincing for European patients but more data are awaited.

Sanjay Agrawal has written a useful piece on this for this month's *Commentary magazine*. It makes common sense that now is as good a time as any for people to stop smoking.

ACE2 receptors have even been appearing in the mainstream media when explaining how the virus gets into cells. It remains the case though, that there is no good evidence for stopping ACEIs or ARBs even in smokers.

The hidden iceberg of non-COVID mortality

Talking about smoking brings me onto the biggest mole of the week. There has been increasing evidence this week of substantial drops in the presentation of emergency conditions, including STEMIs and TIAs. Other specialties have seen this with a drop of 70% in retinal detachment operations. This is becoming a great concern for us, the CMOs, NHSE&I and not least, patients.

Together with other colleges we are rapidly compiling data to help understand the size of the problem. Thank you to all those in the specialties helping with this work.

As I talked about last week there will be a lot of morbidity and mortality from this outbreak. I think there are several groups of patients:

- Those with COVID-19 able to get optimal care.
- Those with COVID-19 unable to get optimal care due to limited resource at the pandemic peak.
- Those with non-COVID diseases unable to get optimal care due to service reconfiguration during the pandemic.
- Those with non-COVID diseases who do not seek help due to fear of contracting COVID-19.
- Those who develop non-COVID diseases due to social distancing (especially mental health).
- Those who develop non-COVID diseases that would have been prevented by public health measures suspended during the pandemic.
- Those who develop non-COVID diseases as a result of the economic impact of the pandemic.

The true impact of COVID-19 won't be seen until all of these have declared themselves. Coding of diseases and causes of death need to be as accurate as possible to understand this. I worry we will need to add COVID-19 to the list of causes of health inequality in years to come.

One area of concern is in those patient groups with increased risk due to their underlying conditions. Dialysis patients are a good example. There are around 20,000 patients on haemodialysis in the UK at the moment and in the past 2 weeks 926 have contracted COVID-19 with a mortality of 15%.

Lastly on this topic I noted the alert from the intensivists and Royal College of Anaesthetists about drug shortages. Drug supply may become an increasing issue for all of us and we will be working with the NHS to spot these impending problems and manage them. Getting ready for a no-deal Brexit (remember that? It hasn't gone away) means we already have good mechanisms in place around drug shortages.

NEWS2 additional guidance

This week we have published a short document to provide support for implementation of NEWS2. NHSE has also recognised the importance of using NEWS2 in a new guideline on managing the patient with a cough and temperature during the coronavirus epidemic.

This is a global problem

I know that my bulletins have tended to be very UK/NHS-focused and that COVID-19 is not unique to this set of islands. The pandemic is at different stages across the globe and we are keen for our international members to share their experiences and the challenges/solutions they find. Please email them to global@rcplondon.ac.uk

Now is a time for global collaboration and although (as with smoking) COVID-19 and its treatments will have a local theme there is much to learn from each other.

I wrote about changes to the UK visa system last week but things have developed further this week. All doctors with a visa that is due to expire before 1 October will now automatically be granted a 1-year extension, free of charge, should they wish to use it. This extension will also apply to their family members. The Certificate of Sponsorship will also be replaced by a letter from employers. This is all great news.

A death in the family

This week saw the first death from COVID-19 of a practising fellow of the RCP. Dr Alfa Sa'adu was a highly respected consultant in Watford and his death at 68 was a tragic loss to medicine. Some of those who examined with him or worked with him have been sharing their reflections of the man – his being here has left the world a better place. Rest in peace.

And finally …

On that note I think I just need to finish. All being well, I'm a doing Facebook live COVID-19 Q&A at 6pm on Wednesday and will have further updates for you then.

Please look after yourself and those around you.

14 April 2020

After 3 weeks of national lockdown in the UK there are some hints of good news but still lots of concerns. I can't cover all the issues, but as always will try to cover the crucial ones and a few that have raised my eyebrows in interest, amusement or ire.

Personal protective equipment

PPE remains issue number one. Mr Hancock revealed the latest national plan on Friday (the first briefing I've managed to watch live). It is clear he knows it is a problem – all the professions have been shouting this at him for weeks – and there is much to commend in the plan. Actions, though, speak louder than plans and while we are getting fewer reports of problems in supply, as I said last week, we all want a situation where all healthcare workers have access to the PPE they need.

The survey we did 2 weeks ago showed 22% of physicians could not get the PPE they needed. We will repeat our survey this time next week to see if this has changed. The reporting system we established almost 4 weeks ago has been successful in highlighting trusts where there have been problems and the NHS has acted on this feedback with generally positive results. I worry that the reduction in reports may be due to 'report fatigue' so please continue to tell us when you have problems.

Over the past couple of weeks I have been reminded that as well as having the right kit available, PPE only works if it is put on and taken off correctly to prevent spread. Donning and doffing is a complex but critical process. The Public Health England guides on this are helpful but as was so well pointed out by one of the RCP regional consultant reps on a call this week (thanks Charlotte), the best way to ensure you get it right is by having a PPE partner to watch you. You can then return the favour. Good technique is crucial and I've needed to practise.

We know that mask shortages are a problem particularly for FFP2/3 masks. These masks work by electrostatic charges within the mask pulling particles out of the air going through. Those charges last a long time so in some countries (including the USA) it is normal practice to decontaminate and re-use masks provided they are not 'soiled'. This is something we've not been doing in the UK but after prompting by one fellow (thanks Asif), I've been talking to PHE about this.

The PPE issue is also being helped by those outside the NHS. Derby has a rich history of engineering and I cycle past the main Rolls Royce factory on my way to work. While traffic is now much quieter around the site it sounds like the engineers are keeping themselves busy 'doing their bit'. One Rolls Royce worker walked into the GP surgery where my wife works on Friday and handed over a box of face shields they had manufactured for local medical teams. It made Good Friday a very good one.

A double-edged sword

My comments to a member of the press over a week ago about welcoming the recent PHE guidance caused upset last Thursday. I had explained to him that previously there were multiple guidelines in place and this had meant that by following these guidelines some were using PPE more often than was needed based on the evidence. The said reporter tried to get me to say that I thought people were wasting PPE on purpose. I wouldn't. An expert in his trade he still created the headline he wanted by getting others to comment as though I had said this.

I stand by my actual comments that the new PHE guidance is helpful and removes confusion. I am very frustrated that the reporter used the story to sow division among healthcare workers, especially given I specifically pointed out to him that PPE was not just an important issue for hospital doctors but also for nurses, GPs, allied health professionals and those in social care. That didn't make the story though (I wonder why?).

The relationship between the professions of medicine and the fourth estate is always a tricky one. Most times the press are helpful – the same outlet that misrepresented me was helpful in raising the 22% figure mentioned above – however, sometimes they most definitely are not.

Oxygen supply and renal support

Following last week's alert on oxygen supply I've been learning more about the engineering constraints of NHS oxygen supply. Our oxygen is supplied in the main by BOC and getting it to hospitals is not the problem, it is getting it from hospital stores to the patients. If there is excess demand the liquid oxygen in the vacuum insulated evaporator (VIE) (see last week's Facebook Live) leaks out and causes damage. Not good and not a quick fix.

CPAP apparently needs high flow-rates – sometimes up to 40–80 L/min. Thus we need to plan the number of patients we can support through CPAP carefully so that demand does not exceed supply. I'm keenly awaiting the results from the CPAP trials in London.

Renal support may also be an issue supply-wise. Large numbers of critically ill patients are in need of renal support and we have a limited number of the continuous veno-venous haemofiltration (CVVHF) machines most usually used in critical care. Experience is suggesting that CVVHF in COVID-19 patients can fail due to clots in the machine making this an increased challenge. I know that people are addressing this issue in NHSE and among the ITU and renal communities.

The medical bush telegraph

The above comments remind me that the global and national medical bush telegraphs are alive and working well. Physicians are sharing their experience and this combined experience is taking our knowledge about COVID-19 forward in leaps and bounds.

Initial advice for sick patients was to 'run them a little dry'. Experience has now taught us that this is probably not true and acute kidney injury (AKI) is common in this pyrexial, unwell and rapidly respirating population. 'Run the urea in the normal range' is the new mantra and precise guidance is soon to follow. Fluid overload can also be problematic in these patients. Fluid balance, as always, is a fine art if not an exact science in these patients.

We also know that COVID-19 patients can deteriorate rapidly and have been learning how best to spot this. NEWS2 can identify deteriorating patients and should be used in these patients. However, any increase in oxygen requirements should trigger a review by a competent clinical decision maker and an increase to hourly obs if not already indicated by NEWS2.

Sharing information is part of what we do as physicians. As we start to begin to think about what next for COVID-19 I enjoyed reading the Faculty of Pharmaceutical Medicine's latest blogs on the topics of treatment and vaccination. The latter is especially interesting and explores the challenges of developing a vaccine for the virus. My understanding of immunology has always been a bit basic (if it hadn't been for the pictures in Roitt I'm not sure I would have passed that bit of finals) and I am relieved that those developing vaccines do not have such immune deficiencies.

Talking of treatments, I make no apology for repeating the call for us all to enter patients into the current trials going on. Please can we all support recruitment into these trials.

The final example of the bush telegraph that has changed the way I think about managing patients was the work done by the British Thoracic Society on minimising exposure of staff to the virus. Called SPACES, it is a framework for how we conduct our patient contacts. A simple but brilliant idea.

Trend setting

Regular readers of my bulletins or those who have seen me speak know that I love a good graph. I was therefore rapt by those that are now being presented by the government on the number of cases and bed occupancy.

The former has always struck me as a slightly dodgy metric given that the number of positives is only as accurate as the sample population and how many tests you have available. Although grim viewing, the graph of deaths allows more of an inter-nation comparison than the cases graph. We do need to get a better understanding of care home deaths though.

The best metric we have is the NHS COVID-19 bed occupancy and ITU COVID-19 occupancy (available each day on the @10DowningStreet Twitter feed following the daily coronavirus briefing) – as these show the population phenotype of the virus far better. The fact that ITU occupancy has flattened out in London and some other parts of the country is encouraging. Once that starts to fall, we will be making progress. If it increases it suggests that social distancing is not working and we are in trouble.

The worst metric being used globally is one we can't see, that inside Mr Trump's head. Words fail me.

Training issues

As we battle on through the peak of the pandemic we mustn't forget our trainees and their needs, both pastoral and with regard to training.

I was staggered to hear that in Scotland some trainees were being asked to live in their hospitals if on attachment a distance away from home and not return home between periods of shifts. Aside from the huge negative effects this will have on their psyche, the logic doesn't quite make sense: it is OK for trainees to go home if they are within 10 miles of home, but not if it is 50 miles. I was not aware that the virus is transmitted from the inside of a car and that this increases per mile of transport. This looks like a single nation issue (the RCP doesn't get involved in Scottish training issues) and there are no plans for similar diktats in the other nations. If there are, I will respond robustly.

Given the April rotation was cancelled for almost all, concerns are reasonably being raised about what is going to happen in August. We are all expecting that people will rotate as planned but much depends on the metrics described above. It is vital our trainees are able to progress and we will do all we can to facilitate this. We are thinking how we can support rotating trainees both through new forms of induction, providing increased educational support and mentoring (the returning retired workforce may be especially valuable in this regard).

If you are a supervisor, please take the time this week to talk to your trainees and find out how they are doing and what concerns them. Our Trainees Committee are providing lots of regularly updated information which should be helpful.

Being non-conformist

I know some people don't warm to me (but most of them probably don't read this far down the bulletin). For those who have, you'll be pleased to know it is official – my face doesn't fit. Despite repeated attempts over the past weeks with different masks, I was unable to pass fit-testing successfully. Being told by the third year medical students doing the tests that I cannot do endoscopy was an odd bit of role-reversal. Initially gutted, I went on the hunt for a hood and was planning a midnight raid on orthopaedic theatres. This morning, though, a new model of mask became available in the trust and thankfully I passed the test.

It has made me realise, though, the impact of what we say to people when we stop them doing the thing, such as driving, that they have been doing for decades and is very much a part of them. I can now do on-calls again (although it is safer for patients all round if I'm not let loose in ITU) but for anyone else side-lined in this crisis I have new-found empathy.

And finally...

I wanted to take the opportunity to say thank you to those in acute medicine and respiratory medicine who are doing much of the 'heavy lifting' in response to COVID-19 at the moment. Yes, all medical specialties are stepping up and doing their bit, but it is hitting our acute medicine and respiratory colleagues the hardest. Thank you to them and their teams (especially the nurses) for all they are doing.

Stay safe and look after each other.

20 April 2020

We have now entered the next period of lockdown here in the UK and there is a perceptible shift in the situation. I will come on to that, but must first tackle the 'COVID-19 usual suspects' which have not gone away.

Personal protective equipment

The PPE journey feels like one step forward and two steps back at the moment. Our Trainees Committee met virtually last Wednesday and the noises around PPE were that things were 'okay' in many places, with problems in some hospitals and departments. Shortages of gowns and face shields seemed to be the commonest issue, but it didn't feel like a crisis.

Late on Friday evening (don't start me on the timing) new government advice was released on considerations for acute PPE shortages that makes for grim reading. Timing aside, the fact that this advice has been produced shows how awful the shortage of PPE situation actually is. We have known that the whole world has been living day-to-day in terms of gown supplies for the past 2 weeks but who'd have thought we would be considering going back to wearing white coats? The advice itself is not unreasonable given the Hobson's choice nature of the situation we find ourselves in, and the principles have come from the WHO.

The advice was requested by NHS trusts so as to understand what the options are if a hospital runs out of gowns or other PPE. The NHS has been let down by many suppliers (like last weekend) around the world and everyone is drinking at the same water fountain – don't believe those 'middle men' on the internet who promise they have a special supply in China – they don't. Sadly, the advice is therefore needed but the honesty of our political leaders in acknowledging how bad things are is sorely lacking. No one can pretend these are not the darkest days the NHS has seen.

If you find yourself in the impossible situation of needing to deliver patient care with insufficient PPE and are conflicted about your own safety, we will back you, whatever you decide to do.

The BMA has produced a simple, practical and helpful step-by-step guide on what to do in such situations.

The positive side of me says hopefully we will never need this advice. As I said last week, we are repeating our survey on sickness, testing and PPE on Wednesday and your input will allow us to see what progress, if any, has been made over 3 weeks. We will ask a couple more questions around PPE and release the results as soon as we can.

Resus guidelines

There has been much toing and froing between Public Health England and the Resuscitation Council over the past 2 weeks regarding the PPE people should wear for CPR. They have agreed to disagree. Therefore, while we (RCP) support the PHE guidance on PPE in every other setting, we continue to stand by the RCUK guidance on the wearing of PPE for chest compressions. Level 3 PPE needs to be donned before commencing CPR in a healthcare setting.

Tracheostomies

One area where effective PPE is needed is in the care of patients with tracheostomies, especially in neuro-rehabilitation units. The care of tracheostomies is an aerosol generating procedure (AGP), as anyone who has had to do this will attest, and those clinical areas should be treated like an ITU setting. The PHE guidance on AGPs makes this clear, yet some trusts have been slow to implement this and the stories from such units around the country this week are really worrying as PPE has been prioritised to other areas.

To help make the situation clearer, Lynne Turner-Stokes and colleagues have been working on an update of our guidelines for the management of patients with prolonged disorders of consciousness (PDOC) with specific guidance for the current pandemic. The update should be ready for release later this week.

The neuro-rehab community was also hit this week with the news that Dr Peter Tun had died from COVID-19. I knew Peter – he was a force for good in the championing of SAS doctors in the RCP for many years. He was a lovely man and will be missed by everyone who was lucky enough to work with him.

Infection control (and some Greek and Latin)

As this pandemic has developed in the UK it has become apparent there are three groups of spread. The first is community spread, which seems to be settling with the lockdown measures in place. The second is in care homes, where the enclosed nature of the environment and the vulnerability of the patients create a deadly combination. The last is nosocomial spread in hospitals.

Nosocomial (from two Greek words: 'nosos' means disease and 'komeion' to take care of) spread of COVID-19 is a challenge to understand due to the long incubation period of the virus, the prevalence currently in the community and a lack of adequate tests, either serological or viral RNA. Estimates of the burden of nosocomial-acquired cases is around 15% but it feels higher to most of us working in the NHS at the moment. This spread has three problems associated with it – the impact on the health of the workforce, the exposure of patients with COVID-19 and the ability to restart normal services (I'll come on to that later).

Controlling nosocomial spread needs close attention to infection control. Adequate PPE is obviously critical, but as I said last week so is the correct donning and doffing (the buddy system remains a good idea). Spread via fomites is also important. The Latin singular form 'fomes' means 'tinder' (as in 'tinderbox' for fires, rather than the app). Thus, door handles are fomites, as are computer keypads. Cleaning such surfaces is important in controlling spread but handwashing regularly is the other key defence against spread via fomites.

I never thought I would be trying to offer advice on infection control given my performance in e-learning self-assessments over the past few years,

but understanding the above has changed my relationship with the handbasin and soap to a much closer one.

It's okay not to be okay

The emotional toll on us all at the moment is substantial and therefore it is worth remembering the resources there to support us. We have signposted many relevant ones in our wellbeing resource but there are a couple of new ones that are worth mentioning.

I was emailed by the Samaritans this week and it reminded me that they are helping provide the NHS mental health hotline to support healthcare workers during the COVID-19 pandemic. They remain an easy-to-remember source of support if you or your team need them.

I was also sent the British Psychological Society's (BPS) guidance on the psychological needs of healthcare staff this week. This is a short and helpful document. It talks about differing needs at different parts of the response to the pandemic and I would recommend reading it if you get the chance. As well as stating 'it's okay to not be okay' I was relieved to see the statement that those in leadership roles don't 'need to have all the solutions all the time'.

Punctuated equilibrium

The BPS document chimes well with other documents I have been seeing this week about the next steps as we plan to move beyond the plateau phase of the pandemic and start to get back to 'normal' business in the NHS. It is obvious to all, though, that 'normal' will not be the same after COVID-19 and so I have started to think of this as a likely 'punctuated equilibrium' for the NHS.

Punctuated equilibrium is a theory of evolution to explain the observation of the fossil record which shows large-scale change occurring in short periods of time after long periods of equilibrium. This will happen in the NHS and that is probably for the better. We must build on the progress we have made over the past couple of months in areas such as digital communication, workforce support, information sharing, rapid decision making and team-working (to name but a few). As we come out of this we must not slip back into the bad old ways. In my hospital we have started listing the new things we are doing that we don't want to change – it is an insightful exercise.

The first step in the recovery phase will be to ensure emergency services are working and that the public knows this. Fear of catching COVID-19, overburdening the NHS or poor communication on our part must all be overcome. The late presentations we are seeing for STEMI suggest there is a long way to go.

The next step is re-establishing our urgent services, including diagnostics. This will be a challenge as many staff (trainees, nursing, technicians, admin staff etc) who have been redeployed elsewhere will need some time off and may have become de-skilled.

Finally, we need to re-establish routine services. We have been looking to transform outpatient services for a while now and this is just the opportunity that is needed. Our patients are now used to us having phone contact with them and for many this beats spending hours on public transport to get to the hospital. I also suspect that it will be a while before any of us use public transport without looking suspiciously at the coughing person opposite us.

The thought processes as to how we get these three sets of services up and running again have started in earnest. The backlog is getting bigger by the day and the sooner we can start, the better. We must also not forget how our patients will feel, scared both by the delays they have had and the potential of getting COVID-19 if they have avoided it so far.

New service challenges

One of the blocks to getting things going again will be having to accept that COVID-19 will be around for a long time and we will have to run two sets of services side by side in many hospitals. If we can't do this efficiently and safely patients will be reluctant to engage and staff safety will be a challenge.

We should also expect to see new diseases. Those who survive an ITU stay will have a long road to full recovery and rehabilitation services will be busy. It seems likely that lung damage and renal damage may be permanent in some patients and that the hypercoagulable state that COVID-19 creates may be leading to strokes. Neurological problems seem to be raising their head as well. The physical legacy of the pandemic will be as big as the psychological one.

Ramadan

Ramadan starts this week and if you have colleagues observing this time of reflection and devotion please support them as they fast through the daylight hours. It will be a challenging Ramadan for other reasons as well. The numbers are showing that severe COVID-19 disproportionately affects BAME healthcare workers and their families. While the reasons for this are unclear it is a big concern for our colleagues and friends from a BAME background.

Weekly shout-out

Last week I said a public thank you to respiratory physicians and acute medics and I plan to take the opportunity to do this for different parts of the RCP family each week. This week I would like to say a massive thank you to palliative care and rehabilitation medicine teams. Both have had to face extraordinary pressures over the past few weeks.

And finally...

What would you do if you were in Mr Hancock's position? That is the essay question for this year's Doctors for the NHS trainee prize. I suspect non trainees would also have an opinion or two on this. Answers on a postcard only please.

The feedback I'm getting is that most people are happy to get these frequent updates so I will continue to produce them on a weekly basis for the moment.

Best wishes and stay safe.

27 April 2020

I have spent a fair bit of time this week getting involved in work on the 'restart' of NHS services. We also conducted our latest 3-weekly survey tracking the impact of COVID-19 on the workforce. I will use the latter to help explain the progress in the former.

Incidental changes

I was struck (well dumbfounded, actually) when I heard the COVID-19 crisis referred to as 'this incident' by two different senior NHS folk in meetings this week. I'm all for a structured and well-coordinated approach but it feels a little more than an incident to me. I'll stick to pandemic as my preferred term.

There is no doubt we are past the peak of the first wave of the pandemic in the UK. I've been careful to use the term 'wave' as it seems highly likely that we will have further waves over the next year or two. Given the increased traffic on the roads and the groups of people I saw gathering as I cycled home from the hospital on Friday evening, the next wave may be quite soon.

Talking to consultants throughout the country it sounds like many places are seeing an upturn in the non-COVID acute take. This weekend has been the busiest in this regard for a while. We must remember though, that there are many who are still up to their FFP3 masks in COVID-19 work, particularly on the respiratory wards and in intensive care settings. There is considerable geographical variation and I would commend the HSJ chart published this week showing population-adjusted rolling mortality by STP (the HSJ is currently offering free subscription to these pages).

Trying to understand the patterns for different STPs will be the making of many a research thesis for years to come, but my first impression is that rurality and population density must be important. The latter has been cited as one explanation for the enigma that is the German mortality rate.

It looks like we will have endemic SARS-CoV-2 infection for the foreseeable future, and together with workforce issues, these form the main challenges for the NHS 'restart'. Managing hot and cold (or red and green if you prefer) services will need close attention to those two recurrent themes of my bulletins: PPE and testing.

PPE

The results of our second survey of members and fellows published today showed the proportion of physicians who could get the PPE they needed had fallen from 78% to 73%. Goggles, visors and long-sleeved gowns are the main items in short supply.

The detailed results of the survey can be found on our website and have been covered today in the *Independent*, *Times* and Mail Online.

This worsening of supply is a truly terrible state of affairs and while I, together with other college presidents, have welcomed the appointment of Lord Deighton as the 'PPE tsar', there is a chasm between what is needed and what is available. He will have a difficult job to regain the confidence of the healthcare professions.

If we don't have the right PPE it will be impossible to keep staff safe and the infection under control in hospitals. If we can't manage the latter, any thoughts of starting elective activity and seeing our most vulnerable patients are but a dream.

I have also had a couple of reports of gowns being opened and found to be less than sterile. If this happens to you please let us know via our PPE reporting tool. Importantly, please include the batch number and the country of origin.

Testing

We will need rapid access to testing for both patients and staff to keep the infection under control in healthcare settings. The survey showed some positive news on testing, with 96% being able to access tests for their patients and 91% for themselves if symptomatic (up from 32%).

However, we still do not have testing that is sensitive and will allow us to rapidly identify which patients should be grouped into which part of the service going forward. We will need to create a testing protocol for patients coming for procedures that applies across all specialties and healthcare providers. Work has started on this but the lack of a decent test is rather hampering things. The problems keyworkers have had getting testing over the weekend and the delays to getting results suggest we have a long way to go. The 'testing tsar' John Newton also has a tough job on his hands.

One thorny problem is that of asymptomatic carriage. We know that a proportion of health staff without symptoms have the virus detectable on swabs. As yet we don't know if this is pre-symptomatic or asymptomatic disease, and if asymptomatic carriage, if it leads to infection. Large staff testing programmes are underway in healthcare settings to look at this.

All the right people but not necessarily in the right order

The mobilisation of different parts of the workforce has been one of the successes of the NHS response to the pandemic. This expanded workforce needs to be redistributed for the next phase and this gives rise to a few issues.

Our survey showed that around a third (29%) of physicians are currently not working in their usual clinical areas. Moving these valuable people back to their home turf will need thought and care. Everyone will need some time to recover and we need to be sure that the demands of the first wave have reduced enough to free them up.

The response of retired physicians to return to practice has been amazing, with many only too willing to help out. There are two specific problems though.

Firstly, some trusts are saying 'thanks, but no thanks' as they feel they have enough staff already. This is so short-sighted and I, Simon Stevens and the GMC (an unusual triumvirate) are all applying pressure on trusts to ensure we don't let this precious resource slip through our fingers like sand. We will need them.

Secondly, these folk are on a temporary register which will cease to exist once the 'emergency' (so much better than 'incident') is over. We will need people for a while longer to help support trainees and non-COVID outpatient work. Many of those who retired did so because they were beaten into submission by the endless bureaucracy of the previous systems. We are therefore working with the GMC to ensure that if we can convince returnees to come back onto the normal register this is as quick and easy as possible.

Trainees

Trainees and those in non-training grades have been a massive part of our response to COVID-19. I could not agree more with Jeeves, the previous chair of the BMA Junior Doctors Committee, in his assessment that COVID-19 has put paid to any thoughts of a 'snowflake generation'.

Trainees are keen to get back to normal training life as soon as possible. The two minor barriers are the August rotation and the annual review of competence progression (ARCP) process. HEE tells me we will have clarity for all trainees about the August rotation in the second week of May and I'm awaiting similar commitments for the other nations.

Rotation will, of course, require trainees to have an appropriate 'outcome' at ARCP. Guidance on how COVID-19 will be taken into consideration has just been produced by COPMeD. This has created a new 'outcome 10' and the decision tree is, at best, rather complex. In short, moving into an area to provide COVID-19 care will not be an impediment to progression.

The ARCP will need some minimum pieces of information though. The educational supervisor's report will be critical, as will two multiple consultant reports and patient feedback within the past 2 years.

Many of those who came back to the NHS from clinical academic posts will also need to get back to research as soon as possible. One positive thing that COVID-19 has demonstrated to the UK public is that medical science is an essential part of the NHS and UK plc. Hopefully it will act as a springboard for clinical academia.

My final thought about trainees this week is the big role our chief registrars have had in some hospitals during the pandemic. I had a letter from one MD at a trust outlining how critical the chief registrar had been in organising their trust's response and what an amazing job she had done. Thank you to her and the other chief registrars for all the contributions you are making and for making me proud to be part of the RCP.

Shout-out for SAS doctors and LEDs

One thing that stood out to me from our survey this week was that although sickness rates for consultants have halved in the past 3 weeks to less than 8%, they remain high for SAS doctors and LEDs at 23% and 15%. This is a worry as we are very dependent on these doctors in medicine. Many are from a BAME background (see below).

As we move forward, this is an opportunity to revisit and finally get sorted some of the issues for these groups, including the CESR process and recognition of experience outside of training rotations.

In the meantime, a big thank you to all our SAS doctors and LEDs for everything that you are doing.

Understanding why COVID-19 affects BAME doctors

It is staggering that more than 94% of the doctors who have died from COVID-19 are from a BAME background and are male. The reasons for this are complex and unknown. Some of these doctors were beyond retirement age, but not all. Many had pre-existing health conditions.

However, most were working in frontline specialties and last week I called for an individual risk assessment for healthcare workers in such areas in light of this alarming problem. This will be as important for the 'restart' as it is at the moment.

A risk factor being put forward by some as an explanation is vitamin D deficiency. This is a plausible hypothesis although I remain unconvinced it is the whole story. There is a summary of the rationale behind this line of thinking on The Physiological Society's Q&A forum, including reference to an article by Jon Rhodes and colleagues noting the mortality from COVID-19 related to latitude.

The NHS has recently advised people to take 400 IU of vitamin D daily due to the lack of exposure to sunlight caused by the lockdown. This may be insufficient for some and a few fellows have exhorted me to call for a national programme of high dose vitamin D3 supplements especially for healthcare workers from BAME backgrounds.

I have therefore asked our advisory group on nutrition weight and health to come up with a position statement on this as soon as is practical.

Crowd control and the 'clinically extremely vulnerable'

Just before the pandemic hit I was spending a fair bit of time working on the clinical assessment standards, or in layperson's terms the 4-hour, 2-week and 18-week standards. One of the main problems in urgent and emergency care was the crowding seen in emergency departments. The thought of this in a world where COVID-19 is endemic is truly frightening and we will need to think hard about how we prevent crowding in all the waiting areas of our hospitals.

The group of patients I worry about most in such settings are those we have classified as 'clinically extremely vulnerable' (a rather clumsy phrase). These are the patients we have 'shielded'. Identifying those patients was no mean feat and a big thank you must go out to the medical specialties and to Donal, the RCP registrar, for coordinating things. Now we know who they are we will need come up with safe ways to assess, treat and care for them to minimise exposure to COVID-19 cases. This will be even more challenging than the identification process, but once again Donal has put his hand up to be the RCP lead.

In addition, the medical specialties and Donal have been busy creating a plan for prioritisation of services for the 'restart' with NHSE. This will hopefully be published later this week.

And finally...

I received emails this week from a couple of fellows who have been hospitalised recently.

The first had COVID-19 and has put his reflections into written form. In some ways it is a story of the best and worst in how the NHS can look after a member of staff. We will find a way to share those reflections as it is a compelling story of our current time. What struck me most, though, was the impact COVID-19 has on the family and friends around our patients. We forget sometimes how worried our loved ones are when we are ill.

The other email was from a colleague hospitalised while in New Zealand a long way from home. Both emails have reminded me that these words are being read by many people in many far-flung places and supporting each other is more important now than ever.

So, to all members of the RCP family, whether you are a mile down the road or 12,000 miles away, keep in touch and stay safe.

4 May 2020

I have been working in the hospital over the weekend so have not had much time to write this. It may therefore be a bit shorter than usual (some of you may be relieved by this). It has been an interesting week and progress is slow but sure with some bits of good news.

The RCP COVID-19 Appeal

Firstly, I'm delighted to be able to announce that the RCP has today launched a charitable appeal in support of our own and wider efforts to address COVID-19.

The appeal will focus on four areas:

- support for physicians and their colleagues in the next phases and aftermath of the pandemic
- preparedness for future pandemics ensuring we establish improved systems
- inequalities and COVID-19's impact on particular groups of the population, including BAME
- research, in particular on the social impact and healthcare response.

I hope that you will join me in donating to the appeal.

PPE

The PPE results from our survey 11 days ago have created a few ripples this week. The observation that PPE provision had worsened in the 3 weeks since our first survey caused some noise in the middle pages of the papers when it came out on Monday. Twenty-four hours later it was front-page news and 48 hours later I was being quoted in PMQs (although it was First Minister's Questions – references begin at 11.27) by the leader of the opposition. Bad news travels fast.

However, the point has been made and it is such a crucial issue for us all. We will repeat the survey in another 10 days. I really hope that things will be better. Until then we will let the data speak for themselves.

There has been much debate about masks recently. While there is a significant shortage of IIR masks at present (and there are solutions in place for that, thank goodness) it is the widespread use of masks in the community that has created most debate. Lots of strong opinions are being expressed and it has become rather politicised.

My take, as I explained in my Facebook Q&A last Tuesday, is that the debate has two sides and the evidence base is weak for both. There was a fascinating viewpoint in *JAMA* on the relative benefits of face shields and masks in the community. It makes the important observation about the nature of COVID-19 spread being droplet and fomites rather than airborne, such as occurs with measles. Measles has an R0 value of 10–18 and while there are a few reasons for this, the article does make you stop and think.

If we do end up recommending masks for everyone, we mustn't forget it is the hands that act as the modus operandi for viral spread in people not coughing or sneezing and is as important in those who are. Washing hands and cleaning surfaces remain our best defence against such spread, particularly in hospitals. The best analogy I have heard about how to do the former properly is to wash them as though you have just chopped up a jalapeño pepper and need to put a contact lens in.

The last thing to say about masks is that the impact on people with hearing loss (about 11 million in the UK) who rely on non-verbal communication and/or lip-reading should not be forgotten.

Transparent masks that don't fog up are technically challenging to produce. Hoods with respirators are a more obvious solution and have been used with positive feedback from both wearers and patients in some hospitals. Advocates are pushing for hoods to be considered on a wider scale as we prepare for the next wave of infection and I certainly think this should be looked at.

Testing, ramping and grating

Over the past week I have heard the how testing, 'normal' NHS business and primary care activity are all being 'ramped up'. This phrase, like COVID-19, has become endemic in the PM's daily briefings and if I'm honest I am finding its ubiquitous use a bit grating. Ramp apparently comes from the French 'rampe' for slope and was first used in the 14th century to refer to vines climbing upwards. If they can find a new phrase I'd drink a glass of vine juice to that. Now, back to testing.

Meeting the 100k target set a few weeks ago has been seen as a pyrrhic victory with the ends justifying the means. The change in testing 'case definition' to include tests sent out in the post before being received has raised a few eyebrows, but on the face of it the increase in testing capacity is to be welcomed. Also, the relative numbers of 'tests done' and people tested hasn't changed much over the past 2 weeks as shown in the graph below (reproduced from the Department of Health and Social Care daily report).

The news last Sunday that all emergency inpatients were to be tested if admission was expected was also welcomed. Many places, though, have struggled to meet this goal with shortages of reagents still a problem. That some staff have had to drive many miles to be tested themselves has also rather dampened down the enthusiasm about the 'ramped up' (sorry) processes and the wonder of 100k being passed. Looking at the graph this is one peak I hope hasn't been passed.

Over the past week various commercial companies have launched immunoassay antibody tests. Most of those who know about such things have been enthusiastic about this development and expect roll out over the next few weeks. We still don't understand what protection having antibodies provides but at least hopefully soon many of us will know if we have been infected or not.

If you work for the NHS and need a test as you h ave symptoms, please download this useful summary of options.

Restart, reboot, reset, restore (delete as appropriate for your preferred term)

The letter sent to the wider NHS last Wednesday about the next phase of the pandemic shows that we are definitely 'past the peak'. As I have said before, this going to be a hard, long and difficult phase for us all.

Many have said (me included) that we mustn't just 'restart' services but use the opportunity to 'reset' health and care services to a new way of working. Indeed, this week I have received innumerable emails from management consultancies offering help, so we know we are not short of ideas about what we could do. Managing this thirst for transformation is going to be much harder than any of us would like. I was sent a thought piece on this from Manchester University, which I would recommend reading. The NHS Confederation have also produced some material on what they call the NHS reset.

Talking to ITU folk and respiratory physicians this week has made it clear to me that our capacity to cope with a further wave of infection is very limited. As we stand down these services we must ensure that we can quickly stand them back up again. The staff will need time to recover as well.

A global and bigger workforce

Necessity is the mother of invention.

I would hope that no one in the UK can be in any doubt about how reliant we are on our internationally trained workforce in the NHS. We (the RCP) have been lobbying on many issues for colleagues working on visas, including around the health surcharge. We will be launching a specific campaign around these issues in the next week.

We have also been working hard on the case for expansion of medical schools. This work was steaming along nicely when COVID-19 struck but there is now a realisation that we do in fact need more healthcare staff in the future and that we need to ensure we train as many as possible. We

should hopefully bring the medical school work to completion over the next few weeks and I will share more as soon as I can.

Shielding and high-risk groups

The creation of a list of 1.8 million people as a 'clinically extremely vulnerable' group who need 'shielding' from COVID-19 was both a mammoth task and one that all involved should be proud of. Risk, though, is not a binary thing. As our understanding of what makes people more vulnerable to the effects of COVID-19 improves, we may need to be a bit more flexible about who needs shielding and who does not. This will be especially true as the rest of the population comes out of lockdown and being shielded may be seen by some of the shielded as a curse rather than a blessing.

Such risk needs to take into account the susceptibility of an individual to infection and the severity of disease that results. Some of this will be defined by obvious parameters such as age, comorbidities, medications, ethnicity and sex. The risk will also depend on the exposure risk in the community (will we have a local COVID-19 level as we do for pollen, pollution and UV exposure?), occupation and means of commuting. Lastly, each of us has our own perception of what we will accept when it comes to risk. As we refine 'shielding' it will need to be as personalised and thought about as any shared decision we make about a treatment in clinic or on the ward.

The role of ethnicity remains something that many are rightly worried about. There are several pieces of work going on in both PHE and NHSE looking at this. Occupational medicine has a large role to play for us as physicians and the letter from Simon Stevens formally tasked trusts with risk assessing staff. Anne de Bono, president of our Faculty of Occupational Medicine, is working hard on this with colleagues, including the Society of Occupational Medicine. This is going to be a massive amount of work for an understaffed part of our workforce.

This week's shout out therefore goes to them. Thank you to all our occupational physicians.

The medical press

Throughout the pandemic medical journals have been at the forefront of disseminating information and research. Most journals have adopted much faster review processes to get papers into the public domain, which is even more impressive given the increase in submissions they have seen.

Our 'stable' of journals, under the leadership of Anton Emmanuel, are no different. Through a fast-track process, the RCP journals *ClinMed* and *FHJ* have published several peer-reviewed COVID-19 rapid reports in a dedicated collection of articles. Our journals are easily accessible – if you want to read or submit anything please visit the RCP journals website.

No journal can have any articles unless people give up their free time to review them. Thanks to all those reviewers out there, especially at such a busy time.

RCP traditions and elections

The RCP can never be accused of lacking history and some of our traditions have been around since before the plagues of the 17th century. College Day, normally a celebration of the best of these traditions with the annual election of senior officers, including the president (that's me!) had to be cancelled this year. The elections took place virtually for the first time ever at an extraordinary meeting of Council and we have had to postpone the AGM until the autumn. We hope that the AGM will be a chance to have a face-to-face celebration but only time will tell.

Before lockdown we held a fellowship nomination round and this is due to complete on 11 May. In the old days a paper list of nominated fellows approved by Council would be distributed on green paper – the so-called 'green list'. This allowed fellows to know who was being elected to the fellowship and raise any concerns if needed. The green list still exists but it too is virtual these days and can be found on the MyRCP part of the website. If you are a fellow, please log into your MyRCP account and follow the fellowship and green list prompts.

And finally…

Social media has been buzzing this week with dermatological manifestations of COVID-19, including 'COVID toe'. A pernio-like appearance on the dorsal aspect of toes is apparently common in young people with COVID-19 and may be due to microthrombotic episodes or vasculitis of the skin. It is apparently a late feature of infection and PCR swab testing is almost always negative.

Therefore, the abnormal appearance of one of my toes over the past 5 weeks may not be due to me wearing clogs with my scrubs day in and out. It must be because I'm so young.

Stay safe everyone.

11 May 2020

It has been a busy week in some respects. We now know the UK's plan for coming out of lockdown, have had early results from the research into the risk factors for deaths from COVID-19, and many Nightingale hospitals have been mothballed. In other respects it has been 'same old, same old'.

Lockdown alert

It is fair to say that the detail of the UK government's plan for coming out of lockdown announced last night has caused consternation. The new mantra of 'stay alert, control the virus, save lives' has not landed well except to act as a template for a proliferation of comical or political three-phrase alternatives on social media.

Clear simple messaging is needed about who can return to work, what facilities can open and what 'going to the park' means. The fact that the Scottish and Welsh governments have taken a different line shows a political fracturing of the 'United' Kingdom and does not bode well for us as a set of islands.

While we can all understand that no one knows what will happen as the rules are relaxed, most people working in the NHS are worried about a second wave. The pictures of large street parties on VE day (or 'virus escalation' day as it is known in my house) show that we have a long way to go to get the change in behaviours we will need as a society to tackle this highly infectious disease.

PPE, testing and modelling

There isn't much new in the world of PPE – we lurch from day to day. On Saturday the MHRA put out an alert warning us not to use 'Tiger Eye' goggles. One much-lauded shipment turned out not to be Turkish delight and we continue to receive stories of problems. The photo last week on Twitter of the BTS chair Jon Bennett in a shredded plastic gown and his plea 'protect me', said it all.

Even though the demand for PPE for dealing with known COVID-19 cases continues to fall, it will be needed more and more as we understand the risks in health and care home settings. PPE supply will be a major rate-limiting step to getting services back online.

Testing hasn't yet got back up to the giddy peak that was '100k'. The piloting of the tracking app in the Isle of Wight has revealed a new tool at our disposal to manage the spread of the virus. I hope this will work but have doubts about how it will sit with the public and how we mitigate the complexities for health and care workers who have multiple interactions with contacts day in and out. Rapid testing will be needed to help solve this conundrum.

Whatever, the number of cases in the community still needs to fall further if any form of contact tracing is going to be possible. The easing of the lockdown is unlikely to improve this and we will continue to need modelling to give us some guidance on the direction of travel. The resignation of 'Professor Lockdown', Neil Ferguson, was a depressing moment in many ways.

Infectious disease modelling is a team game though, and thankfully there are many others with experience and knowledge in the field. John Edmunds is one such expert and having heard him speak at an RCP meeting a couple of months ago, I know that he will be able to give sage advice to SAGE.

Risk of death from COVID-19

Two papers have been released in pre-peer reviewed formats this week looking at the risk factors for death from COVID-19. Peer review is an important process that allows the subtleties of research methodology that may pass many of us by to be scrutinised. However, the headlines from these studies and the thirst for knowledge on this topic make for a compelling 'needs must' argument.

One of these is by Ben Goldacre's group, which used the 'OpenSAFELY' platform to assess 17 million NHS records and worked collaboratively with NHSE. They assessed 5,683 deaths and confirmed what we already knew about some risk factors, have refuted some beliefs and clarified the relative risks around ethnicity and obesity. The figure from the paper is well worth looking at.

Age and being male are confirmed as critical risk factors as well as obesity and diabetes. Smoking and hypertension do not seem to increase risk of death (and should be discounted from any escalation tools). Deprivation, unsurprisingly, is a strong risk factor as is ethnicity. People from black or Asian groups have a higher risk, and although some of this risk is reduced when deprivation is considered it remains highly significant.

We still don't know how much occupational and community exposure impact on these risks. Many of us physicians suspect that being in a frontline specialty with dubious PPE will be important. Furthermore, population density where you live and work seems to be important from observational data.

As I mentioned last week, I hope that soon this increasing wealth of knowledge will allow tools to estimate a personalised risk score.

Training issues

As COVID-19 wards empty and thoughts turn to the restart the issues affecting our trainees are becoming much clearer. Our Trainees Committee has been working hard with other trainee groups to minimise the impact of these issues, but there are some significant complexities. A summary of the state of play will be produced by the committee in the next couple of days but in short, the issues are as follows.

Many trainees have been working in 'emergency rotas' which are neither compliant with their contract nor sustainable. Shifting trainees into 'normal' rostering needs to happen ASAP as well as ensuring people get adequate time to rest and recuperate from the past 2 months.

We also need to get our clinical academic trainees back into research and look for ways to extend their time in research to ensure they do not lose out. Cheng-Hock Toh, RCP academic vice president,

summarised the main asks in his letter to the various stakeholders that went out last week.

The ARCP process is getting underway. As an educational supervisor, part of me welcomes simpler processes (I do much prefer the new IMT ePortfolio) but for trainees it is a big worry that they may not get a fair hearing. We have a responsibility as supervisors to ensure we support them as much as possible through the next couple of months.

Recruitment is probably causing the most angst. The use of a scoring system from the application form across the board for the medical specialties that didn't complete recruitment before COVID-19 hit has resulted in some unintended consequences. For those who don't get a post in round 1 we are looking at potential options, none of which is perfect.

There are a few trainees who are on visas and without a formal training place will not be able to extend their visa. Everyone loses if this happens and although the numbers are small, we need all the doctors we can get. We also need to help those international doctors who are on the MTI scheme but are 'trapped' overseas having travelled during the pandemic, to get back to the UK.

A busy news week coming up

On the matter of international doctors we are continuing to put lots of pressure on the government around the issues for all overseas doctors working in the NHS. This has included doing some public polling of how international doctors are perceived. We will publish this later this week – there are some very clear (and some surprising) messages.

Later this week we will also send out the third of our 3-weekly COVID-19 surveys. Given the impact of the two previous surveys I know the results are eagerly awaited by politicians, the press and policy makers. The surveys have opened doors in a way none of us here expected. I've always believed that knowledge leads to power and no more so than in a time of uncertainty.

The old problems haven't gone away – in fact they've got worse

The pandemic has distracted many people from the big health issues that were vexing us all 'BC'. COVID-19 has also shone an even brighter light on a few of those issues and our policy work is warming up to re-tackle these thorny problems.

The first of these is health inequalities. Earlier in the year we launched the Health Inequalities Alliance to bring all the medical colleges and faculties together to form a unifying strategy. COVID-19 has put the problems of health inequality to the front of house with a postcode lottery of survival (see Goldacre's study mentioned above). The economic impact of the pandemic will increase these inequalities further still and the time is right for the profession to lead loudly and strongly.

Second is the workforce or rather the lack of it. The Nightingale hospitals were a great idea and thank goodness we haven't had to use them. Only 51 patients used the 2,900 bed London Nightingale (and I'm slightly perplexed as to why one has opened in Sunderland this week). However, one main reason for not using them more has been lack of staff, both nursing and medical. The lack of staff and beds per population is now clear for all to see. We are therefore getting ready to produce our blueprint for doubling the number of medical school places.

Third is the wellbeing of the workforce, especially trainees. I have been staggered by the response from our retired members to return to the workforce to support COVID-19. They will be instrumental in supporting others, young and old, as the psychological impacts of the past 2 months come home to roost.

Last is climate change. While it is reassuring to see China get back to industrial activity (more PPE please President Xi Jinping) the fact that air pollution in some parts of China is worse this week than a year ago is a cause for concern. It is good that air travel will be much reduced for years to come and the increase in cycling that is expected in London and other cities will change our relationship

with active travel hopefully forever. However, climate change (or global warming if you prefer) needs global solutions and will kill far more people than COVID-19 ever can.

The sun always shines on TV

Last Thursday saw the launch of the RCP Player. I am only too aware that our website isn't our finest product and its difficulties handling video content have been part of that. The RCP Player has solved this problem and we've started with lots of COVID-related content. We will be building on this over the next few months so if there is something you want us to feature please let the team know on RCPplayer@rcplondon.ac.uk.

Talking of televisual offerings, there will be a special two-episode edition of 'Hospital' on BBC2 today (Monday) and tomorrow filmed at the Royal Free London featuring RCP members and fellows. I've not seen it yet and hope they focus on the non-ITU settings a bit. It seems to have passed people by that most patients hospitalised with COVID-19 never got to ITU and have been cared for by physicians, including many for whom acute medicine is not a natural first home.

Thank you to all those from specialties such as dermatology, rheumatology and neurology (as well as many others) who have taken on the responsibilities of running COVID-19 cohort wards. You have proven that the skills we all developed as medical registrars stay with us for life and physicians don't run away from a crisis. Thank you.

And finally...

We have had more than our fair share of tragic moments in the past 2 months and it is right we pause every so often to reflect on the heavy toll COVID-19 has taken on patients, colleagues, friends and loved ones. I would heartily like to thank those of you who have kindly donated to our new COVID-19 fundraising campaign and we recognise you at the foot of this bulletin.

However, we should also not shy away from celebrating the best bits of medicine. Thus, over the next few weeks we will be announcing the winners of the annual RCP Excellence in Patient Care Awards via our various channels using #EPCA2020. It is the fifth year of EPCA and the achievements of the winners are well worth shouting about. Medicine remains brilliant no matter what comes our way.

18 May 2020

It's been a busy week (aren't they all at the moment?) with lots of things happening, including meetings with various politicians and the results of our third 3-weekly COVID-19 survey. I will try to weave in my insights from both of these throughout this week's bulletin.

We are the world – a new deal for international staff

Like the RCP, the NHS is a global family and we all know the massive contribution that international doctors make to both organisations. 28% of doctors working in the UK and 13% of all NHS workers are international staff. The propensity for COVID-19 to lead to increased risk of death in staff from a BAME background has drawn public attention to their dedication to the NHS in a tragic and graphic way.

The challenges facing international healthcare staff are many, not least the punitive financial penalties of visas and the Immigration Health Surcharge. The IHS currently costs £400 per year per family member to allow them to use the NHS. The perverse logic of charging people to use the service they themselves are needed to provide does the UK no credit. That there are plans to increase the IHS to £624 later this year makes this worse.

A couple of weeks ago we did a poll with YouGov to gauge the views of British public on how we should respond to the contributions of international staff in the NHS and social care following COVID-19. YouGov used a panel of 1,679 people from all parts of the geographical, demographic and political spectrum so the results are a reasonable representation of the country's mood (and more representative than those who answer the folk with clipboards on the high street). The results are striking and make me proud of the British public.

59% agreed that all NHS staff, their spouses and dependents, should be exempt from the IHS. 59% also agreed that all NHS staff who have worked during the pandemic, their spouses and dependents should have indefinite leave to remain. The figures for social care staff were 51% and 55% respectively. Given these results we have made these two calls to government together with a call to extend the new 'NHS visa' to social care staff as part of a 'new deal' for international staff. We are asking other colleges and bodies to join us on this.

We must continue to increase our domestic supply of doctors and nurses (I am relentless in my call for the doubling of medical school places) but we must also demonstrate our gratitude to those from across the world without whom we could not have managed the COVID-19 pandemic so far.

Livin' on a prayer – where are we on PPE, testing and sickness?

PPE supply remains too tight and while there is a movement in the right direction, last week's survey of RCP members showed 16.5% of us could not access PPE in line with PHE guidance over the past 2 weeks. This is still an awful position to be in. It may explain why 48% of us feel concerned or very concerned about our health at the moment. As I understand it, deals are being struck each week with British manufacturers to secure long-term supply for the years to come.

I've been reading a few papers on testing-related issues this week in both the popular and academic presses (it helps me get to sleep). Testing has been front-page news as the Roche antibody test got PHE approval. There will be multiple antibody tests available for us to use, plentiful analysers and hopefully adequate reagent supply to allow the PM to reach his 200k 'tests' by the end of May. It looks like the main limit to testing capacity will be access to phlebotomy and understanding who should be tested.

Frontline staff in the NHS and care sector will probably be first. Once we understand the relevance of a positive antibody test we may be able to stratify patients as to risk of contracting or spreading COVID-19. There remains the possibility that you can be re-infected even if you have antibodies and the humble ferret is a promising model to help understand this.

The PCR swab tests continue to be our main tool in understanding who has COVID-19. Modelling by a Chinese group reported in *Nature Medicine* has suggested that the virus may be transmitted up to 2.3 days before symptoms, is usually finished by 7 days after symptoms commence but may carry on until day 21. A report from my alma mater, Addenbrooke's Hospital, that 0.5–1% of staff have asymptomatic infection, also shows that meticulous attention to infection control and prevention (IPC) will be needed to control nosocomial spread.

Our survey showed that testing rates have improved again but that delays in getting results are the main problem. 5% of us can't access testing if we need it for ourselves, 17.5% for our household members and 4% for our patients. Only 53% got the result within 2 days and 14% have had to wait 4 days or more.

And we need those tests. 7.3% of physicians working in clinical settings have had confirmed COVID-19 and 14.1% have had suspected infection. That we haven't been able to test that latter group is wrong on many levels.

Working on it – plans for training

When the COVID-19 lockdown hit it did so at a critical time for those who had just taken PACES or were due to take PACES. For the former group we have been unable to scan scoring sheets so have had to delay publication of the results. This has rightly caused much angst for those affected. Now we can get back into the RCP buildings and have created a safe working environment for staff in the Federation offices, scanning has started as of today. It will take a week or so to finish the process (there are over 10,000 sets of scores to scan) but we hope to have results verified and published within the next 2 weeks.

For those who were unable to take their exams, we are planning written papers for early autumn and are developing imaginative solutions to how clinical exams can be delivered in a COVID world. In the UK there is some pressure to consider abandoning clinical exams. This should be a last resort. The exam exists to maintain high clinical standards and patient safety. Such a critical assessment must be fair for all those taking the exam and there is a reason the MRCP(UK) is viewed as the best clinical exam in the world. It works.

We have had confirmation that all trainees in foundation and core posts will rotate as planned in August. ST3 recruitment is underway and the fill rate for round one was 100%. For those finishing CMT who were not able to get a post we have been working with the trainee committees of all three physician colleges to produce a proposed solution, which we will send to the SEBs (Statutory Education Bodies).

A good summary of the issues as trainees see them is given by Michael Fitzpatrick, Matthew Roycroft and Gareth Hynes from our Trainees Committee, and published on our website.

Think for a minute – SAGE advice

Last week I was contacted by the chair of the 'Independent SAGE' with their review and suggestions to government. The report is well worth reading and I found it a useful counterpoint to some of the lines taken at the moment. Being non-governmental means they can say things and criticise policy publicly. It is good to debate the important issues and consider both sides.

I disagree with a few of the recommendations, but they are honest about where there was significant disagreement in the group – for example on the use of face coverings in public. I did learn lots of useful stuff from reading the report, though, and some of the references are worth looking at too.

I do have some concerns about the make up of the group which is very London-based. This often happens in self-appointed groups although to be fair the 'official SAGE' suffers from the same

geographical bias. It makes one wonder how someone gets invited onto such groups. There must still be some people who have useful insight to contribute on the issues tackled by the SAGE folk. However, setting up an 'independent independent SAGE' group may be a step too far.

Cigarettes and alcohol – risks related to COVID-19

My comments on the OpenSAFELY study last week resulted in some emails. The observation by Goldacre's group that smoking was not a risk factor for death was challenged as being potentially due to 'collider bias' – a term I've not heard of before. If you recall, the study showed the risk for death in current smokers was 1.25 if adjusted for age and sex and 0.88 in the fully adjusted estimate.

A paper using multivariable logistic regression (which I have heard of and think I understand) in the *NEJM* showed smokers were more likely to die than non-smokers (8.9 % v 5.3 %). Data from the symptom tracker app also suggest smokers are more likely to report COVID-19 symptoms.

Collider bias is another term for ascertainment bias, selection bias, sampling bias and it is likely that COVID-19 is more susceptible to such bias due to the problems of testing. A useful paper on collider bias in COVID-19 has been published, but it does need you to concentrate! When it comes to smoking, I think the bottom line is that we still don't know and that smoking is bad for you for many other reasons. Goldacre's group, to their credit say this in their paper.

Not much is known about the risks of contracting COVID-19 yet, although it seems likely that being a healthcare worker or care worker is a risk. Data from our survey on risk factors in those who have had confirmed COVID-19 compared with those who haven't had suspected or proven COVID-19 show no increase in risk by sex, ethnicity or BMI. We are working with the data to look at workplace-based factors and will share that later this week.

There have been several pieces of work going on around risk assessment for healthcare workers and tools to support this are due out imminently (I'm particularly interested in the one being designed by the Society of Occupational Medicine). Our Trainees Committee this week heard how some of these risk assessments are being done for trainees. This is a complex area and if asked to do this by your hospital it is worth understanding the principles and practice. The RCP will be producing guidance, but in the meantime do look at the resources from the Faculty of Occupational Medicine and NHS Employers.

COVID-19 Appeal

Thank you to all of those who have so generously donated in the first 2 weeks of the RCP's charitable appeal for our own and wider efforts to address COVID-19. The funds raised are already being used to develop e-learning resources for medical students who have graduated early to help the NHS and for consultants who have been reassigned from their usual medical specialties. The appeal is ongoing and I would like to encourage you to join me in making a donation.

Thank you

This week's shout-out goes to all of the specialist societies and their teams. Over the past few weeks they have been working phenomenally hard to come up with plans for how the restart will work for their specialty and their patients. This has been a massive task, but it has allowed us to help shape things and demonstrated that clinical leadership is the future of the NHS.

It's all about you – RCP elections

Voting is open from today until midday on Wednesday 17 June for the elections to the crucial roles of senior censor and vice president for education and training and RCP councillors.

All of us at the RCP are grateful to the candidates for being willing to stand for election. Fellows can show that by using their vote. Even if you don't know the candidates personally please use their statements to form a view of who you want to represent you and us. I can't do my job without a great team behind me so I'm relying on you all to choose wisely!

For these elections voting will be online only. Fellows will be contacted by email, where the RCP holds one, and by post if we don't, to direct you to the online election platform. If you're chatting to colleagues who don't receive this bulletin, please encourage them to provide us with an email address through MyRCP.

And finally...

Cycling to work is not without its risks but allows me some headspace time and an endorphin rush. I've noticed over the past week that traffic has increased substantially as people come out of the lockdown. However, some people seem to have left common sense at home and are wearing facemasks in their car as they drive on their own to wherever they may be going.

I'm all for us sticking to the rules but think this might be taking the government advice about enclosed spaces too far.

26 May 2020

With all the Cummings and goings of the weekend the UK medical profession is feeling as angry as it has been at any time of the pandemic. This has been a definitive week politically in many ways, but the hard work put in by the health and social care professions, key workers and the members of the public who have stuck to the rules is paying off. Our COVID-19 wards are emptying (good) and the beaches filling up (less good). We have undoubtedly moved into the next phase of the pandemic.

Never tear us apart – working together to change policy

Last week I wrote about the findings from our YouGov poll of public opinion around international staff working in the NHS and social care and our call for a 'new deal' for them. This included a removal of the Immigration Health Surcharge. On Thursday the government did just that.

While I am in no doubt that the poll and our 'behind the scenes' lobbying of politicians from all parts of the House helped get to this point, this has been a long battle. Many groups have been involved, our friends in BAPIO in particular.

I have learned two things from this. Firstly, that understanding and communicating public opinion is a useful tool in convincing politicians about an issue (otherwise we always risk being seen as 'whingeing doctors'). Secondly, that if at first you don't succeed keep trying and coalition is effective at keeping momentum going.

Of course, we have still to get the other parts of our new deal agreed – indefinite leave to remain and the NHS visa for social care. Having said that, things have got off to a good start.

Protection – not out of the woods yet

PPE has slipped out of the headlines and progress is slowly being made with respect to supply. However, understanding how best to use PPE moving forward remains a significant issue. The confidence in 'PPE policy' has been knocked during this pandemic with uncertainties about the evidence taking second place to the availability. The data emerging around healthcare worker infections will help us understand what we need to wear where.

I've been told that the UK uses 10% of all the medical PPE manufactured in the world. This doesn't sound sustainable to me from an environmental perspective so the sooner we can understand what PPE can be decontaminated and reused safely the better.

Testing has been in the news with the promise of antibody testing for us all from next week being greeted with enthusiasm and a bit of scepticism. The tracking app trialled in the Isle of Wight has had good pick up and it was fascinating listening to one of its architects at our teach-in last Monday evening. All of that teach-in was about testing – I learned much and would recommend it to all. An hour well spent. Our next teach-in on Monday 1 June is on drug trials and treatment so do join us.

The app may also help us understand the 2m rule a bit more. Not all countries use 2m as the social distance de jour, and the WHO recommends 'at least 1m'. I'm told the app will be able to assess time of and proximity to contacts and I think all of us would be relieved if the distance was reduced a little.

I haven't met anybody yet who isn't keen to know their antibody status. Once we have all been tested some of us will be relieved, some anxious and some frustrated. It is important we do not wear our antibody status like a badge or else we risk stigmatisation of those who have no evidence of infection. Until we know the risk of secondary infection we should also not drop our guard.

I'll be there for you – supporting each other

The part of the latest RCP member survey that got most press coverage last week was the finding that 48% of physicians and 76% of those from BAME backgrounds are concerned or very concerned about their health. This suggests we need to ensure we are looking after each other and in particular our trainees.

People often confuse peer support and mentoring. Peer support is a valuable tool at our disposal to improve psychological wellbeing but does need organisation and even training to be most successful. Together with the RCPsych we have produced a simple guide to peer support and how it can be used during the COVID-19 pandemic. Having the pictorial guide in my mind when speaking to colleagues needing support has been helpful.

Mentoring is a critical process for supporting colleagues to learn and develop their potential. The relationship is more hierarchical with the mentor sharing their skills with the mentee. The support that mentors give, though, is often much more than developing one set of skills. We have all been busy recently but if you are a mentor and have not had a chance to catch up with your mentee in the past few weeks, now is a good time to see how they are doing.

As an aside I had an email last week about mentorship which included a potted history of the character of Mentor (I didn't do Classics at school). He was a friend of Odysseus and when the latter went off to the Trojan war was left to teach and look after Telemachus, Odysseus' son. Athena took the form of Mentor to give Telemachus help and advice in his efforts to find his father when he didn't return from the war. Maybe it should be called Athenaship?

U can't touch this – how do we do clinical exams in a COVID world?

I have been musing a lot this week about assessing and examining clinical skills in a world with COVID-19 and limited travel for medical students, physician associates and those doing the MRCP.

It seems unthinkable that for the foreseeable future we will be able to examine in hospitals while COVID-19 is endemic and movement of healthcare staff between sites creates a risk for all involved. Many of our stalwart patients who support us year after year in exams are shielding or have increased risks from COVID-19. We will need to assess skills in virtual consultations as this becomes a major form of patient interaction, and also how people perform when communication and examination is limited by PPE. Using PPE in this setting would be unethical at the moment but hopefully we can move to a position when there is more than enough PPE around to allow it.

The counterargument to this, as I mentioned last week, is that we know clinical examination and communication skills are the defining characteristics of effective doctors and physician associates, so whatever solutions we find we must ensure we test these skills. Simulation and virtual reality will have a place but are less accessible in poorer parts of the world.

We will work with all interested groups over the next few weeks to solve this conundrum. It seems unlikely that clinical exams will look the same ever again.

Forever in blue jeans – harnessing the potential of genomics

Regular readers will know I have an interest in genomics (I stress I have an interest rather than am an expert). This interest has been further sparked recently by the work of COG-UK looking at COVID-19 genomics. The patterns of different SARS-CoV-2 variants from this group have not only informed SAGE but have shown that the UK pandemic came from multiple places especially within Italy. There doesn't seem to be any evidence yet that different strains have different disease courses but the hope that as it mutates it becomes less pathogenic remains.

The value of genomics for understanding nosocomial infection has been shown by a report from South Africa published on 15 May (thanks to Eric Topol for spotting this). The paper provides convincing evidence that fomites and healthcare workers were the predominant mode of spread in a large outbreak from a single initial case. Anyone who thinks fomites are not important should read it. Infection control is critical. As the RCP registrar Donal O'Donoghue put it last week 'we may not need Nightingale hospitals, but we need Nightingale principles'. Churchill could not have put it better.

I was sent a document by the PHG Foundation this week on AI and genomics. Reading such documents makes me realise the possibilities available to us as we move forward to solve many of the problems we have. There were a few interesting new things to me in this report. The amount of healthcare data we collect each year is huge. This is (rather precisely) estimated at 2,314 exabytes. Just in case you end up on 'Who wants to be a millionaire?', an exabyte is 1 billion GB. I have heard of Google DeepMind but not heard of Google DeepVariant. This is the AI that they are using to look at genetic variants and could be a useful tool in deciphering the genome.

And finally…

The registrar has been on fine form this week with his wordsmithing in RCP meetings. The Nightingale comment above was great. Best of all, though, was his mixing of metaphors when talking about the dangers of the division of NHS leadership teams for COVID-19 along military principles to create 'incident cells'. 'It may be necessary to break up the elephant into small pieces to eat it, but will we be able to put Humpty Dumpty back together again?' Eric Cantona, eat your heart out.

How we say things is important (it is part of the art of medicine). How we behave is as important. No matter how angry we may be right now we should not give up the ground we have all worked so hard to gain. Lockdown rules OK?

1 June 2020

In England today many primary schools reopened. Some have breathed a sigh of relief (teachers, if not their unions, have a new-found respect in many a parent's mind). Others are holding their breath to see what happens next, me included.

One step beyond – what happens next?

The past 3 months have been a steep learning curve for most of us as our learning about epidemiology, public health interventions (or non-pharmaceutical interventions – NPIs), virology, respiratory physiology and infection control have increased by a log order or two.

The public health aspects have been as important as anything and the fragility of keeping the public on board has been highlighted by the Cummings debacle. The next steps are critical and we must be careful how we tread as the lockdown is released. There are four likely scenarios from here on in. Firstly, things stay reasonably under control over the summer and we get hit with a second wave in the autumn/early winter. This seems the most probable and as we learn more about who has been infected from antibody testing (see later) the size of that second wave can be guesstimated.

Secondly, the infection remains reasonably under control, but we have localised outbreaks. These are likely to cluster around healthcare and social care institutions. The closure of Weston General Hospital to new patients last week was a sobering portent of things to come. The policy of testing and contact tracing has been shown to be a powerful tool internationally to identify and control such outbreaks. In the NHS Test and Trace we must trust.

Thirdly, the lockdown wheels fall off and we 'lose control of R0'. This will result in a new peak of infections for the second wave. To prevent this, clear and consistent public health messaging is needed. As some of our political leaders are struggling with that concept, it is up to us as a profession to provide leadership. Mixed messaging is not helpful.

Lastly, the summer of '20 results in the disappearance of circulating SARS-CoV-2 and the pandemic dies of natural causes. This may be a tad optimistic. Whatever happens we must do our best not to step too far too quickly.

Survivor – antibody testing

I've been asked by NHSE&I to reiterate the message that antibody testing is now available for all NHS frontline staff. This is great news, but I know that many trusts have capacity issues and are prioritising ED, ITU and respiratory staff. Our phlebotomy colleagues are critical to this so if you are lucky enough to get the trust email inviting you for a test, please say thank you to them. At the moment, they may be the only members of staff many of our patients are seeing face to face.

I also understand that there are surveillance studies going on for groups of staff who are known to be antibody positive to assess the risks of reinfection. We are all awaiting the results of those studies with interest, both personal and professional.

Golden years – focusing on older people in the restart

The restart of the NHS is slowly gaining momentum. Much work has been done looking at cancer waiting lists and the loss of elective activity in the NHS. The backlog for surgical and medical specialties is eye-watering, although likely activity moving forward is quantifiable and easily measured. This is a potential problem, though, as easy measurement may mean that the NHS focuses on this activity and not others. I'm as concerned about the future of urgent and emergency care especially in respect to acute medicine and geriatric medicine.

Our older patients have been hit especially hard by COVID-19 either directly through the infection itself or indirectly through the need for self-isolation. Age remains the biggest predictor of mortality from COVID-19 and all other risk factors, while important, are out-trumped by our number of years on the planet. The pattern of disease in older people has been very different both with respect to symptoms as well as mortality. Managing a patient with delirium and COVID-19 presents some challenges.

We will need to plan specifically as we release vulnerable older people from their self-isolation. Mental health issues, deconditioning and undermanaged health problems will all need addressing. Community health programmes will need to be developed and expanded.

The relationship between health and social care has been laid bare for all to see during the pandemic. Again, it is good that everyone can see how the system has been limping along over the years through under-funding and neglect and that it is time to develop an integrated system once and for all. My only worry is the mistrust that has been created between the sectors following early discharge of patients with COVID-19 from hospital and the disparity in PPE provision. We in the healthcare sector have much making up to do.

The British Geriatrics Society is at the forefront of leading on the work needed for older people, community health and the NHS-social care interface. Their online coronavirus and older people resource is a gold mine for those of us looking after older people on our wards, and includes guidance on delirium.

Reelin' in the years – estimating your COVID-age

I've talked about risk assessments in this bulletin before and remain worried that they are multiplying with a R0 of above 1. Most are hard for the public to get their heads around and need to be taken with a pinch of salt. If you are doing risk assessments it is well worth reading our webpage on the principles and practicalities of carrying them out effectively, which we have worked on with the Faculty of Occupational Medicine.

Their sister organisation, the Society of Occupational Medicine, has produced an elegant tool that allows people to estimate their COVID-age. It is not perfect, and we are working with them to ensure the tool uses all the information we are gaining about mortality from COVID-19 in different medical conditions.

The advantage of this tool is that you can explain to an individual in terms they understand (relative risk and absolute risk are hard concepts to convey). Telling a black 20-year-old footballer he has the same risk as a 26-year-old white footballer is much easier than saying his relative risk is 1.7–1.9. It has its disadvantages. We used this in our department to compare risk and in COVID years I'm the second oldest …

Promised you a miracle – more false dawns

I will be covering the challenges of uncertainty with treatments for COVID-19 in my leader for the June edition of *Commentary* but this week has seen another promising agent, remdesivir, founder on the rocks of reality. It hasn't sunk yet, but neither is it setting a transatlantic speed record.

Preliminary results from the trial by Beigel et al published last week in the *NEJM* showed that compared with placebo, remdesivir reduced time to recovery from 15 days to 11 days but not mortality. Importantly, it didn't seem to have an effect for those patients needing mechanical ventilation and longer follow-up of patients is still underway to understand what other benefits are to be realised. An editorial in the *NEJM* described the clinical effect as 'modest' and avoided the use of superlatives such as 'life-saving' or 'game-changer' as used in less well peer-reviewed media.

The promise, though, that antiviral drugs can influence the course of disease is tantalising. Remdesivir is a so-called ProTide, a pro-drug that gets metabolised to form a nucleoside analogue that interferes with viral replication. It may be that multiple drug combinations are more effective as they are for other viral global epidemics that continue to rage across our planet, such as HIV.

There is an RCP teach-in on drug trials and treatment in COVID-19 at 6.30pm this evening. In case you miss it, it will be available to watch on the RCP Player later in the week. The Player will also feature content in a new research section which is being produced in collaboration with NIHR.

Computer love – TELs and VELs

Three letter acronyms (TLAs you could say) are in abundance this week. TEL stands for technology enhanced learning and it covers a wealth of methods for improving training and teaching, obviously a significant interest area in recent times. HEE now have a TEL lead and are exploring how e-learning platforms can be used to support training in a world where face-to-face teaching will be minimised. They are introducing a learning hub for trainees and we will all need to use and understand this if we are or supervise trainees.

VELs are virtual learning environments such as Moodle. These environments support students by allowing them to access, organise and record their learning. They have gained much ground in university education and are likely to become more used in medical education. They are not a panacea, though, as the art of medicine is as much about human interactions and team working as it is knowledge and we must be wary not to become over-reliant on such tools. Medicine is an apprenticeship.

Read all about it – online-only content for Clinical Medicine

As part of the digital transformation and spurred by the need for rapid publishing of articles for COVID-19, the May edition of *Clinical Medicine* included online-only content for the first time. This is subject to the same peer-review process and is cited on PubMed in the same way as printed articles. This is a significant step towards a paper-free future. Not all of us are ready for that quite yet so we will continue to take it slowly but surely.

Changes – a new VP Global is coming

At the end of July, Professor Ali Jawad will demit as VP Global and Hans Sloane fellow. We are advertising for his replacement now. We will continue to call on Ali's expertise, but he will be missed as lead for our international work. He has been a great supporter of the RCP and the perfect ambassador for us as we have worked with

colleagues and politicians across the globe. Anyone who has had the pleasure of travelling or examining with him will attest to this. Thank you, Ali.

Super trouper – a champion of education exits the spotlight

Not everyone is leaving in such an expected way. I was staggered to hear on Friday that the president of the Royal College of Physicians of Edinburgh has resigned. Professor Andy Elder is one of the good guys, a passionate supporter of trainees, training, the MRCP and collaborative working. He is much-loved by colleagues and was a hugely popular choice when elected. The reasons for his resignation are as yet unclear, although I understand this was not due to illness. I hope this does not imply an underlying malaise in our sister College.

I would like to publicly acknowledge a massive gratitude to Andy for all that he has done over the years. It has been an honour to work alongside him. The world of UK and international medicine, assessment and training is a poorer place without him at the helm. Thank you, Andy.

And finally…

They say 7 days is a long time in politics and even though it is only 6 since I wrote the last bulletin there has been much to write about. I am conscious that we all get lots of emails so I'm going to take a weekend off from bulletin writing next week (don't worry I'm on duty at the hospital so will be causing mischief elsewhere). I may go down to fortnightly bulletins thereafter. I think it is about the right time to do that now but let me know if you think otherwise.

9 June 2020

An unequal society

I hadn't planned to send you a bulletin this week but in view of the events across the globe following the killing of George Floyd I felt I should. After our comments on social media last week we have put a formal statement on the RCP website. However, I thought I should also write to all members and fellows.

I am lucky to be a privileged middle-class white man. When my BAME colleagues and friends relate their all too frequent stories of abuse, be it verbal or behavioural, I am ashamed to be British. If you think I am overstating the situation just ask your colleagues. You will be shocked by what you hear.

COVID-19 has shown the problems in our society in sharp relief. Increased mortality in those from a BAME background and those from the most deprived parts of our society has been dramatically displayed on the front pages of our newspapers. We have made progress over the years but I would hope all could agree there is much further to go.

The protests we have witnessed over the past few days have in general been a demonstration of the public desire for change. I have worried about the potential for an escalation of infection and upset by the violence shown by a small minority of protestors. Most, though, have protested peacefully to show their desperation in the way things are and to call for change.

What can we as the RCP and as individual physicians do?

On one hand I am proud that I lead a diverse and modernising organisation. Of our eight senior officers, three are women, three are from a BAME background and two are white men. I fully accept that this diversity does not permeate the whole organisation and the report on equality, diversity and inclusion we commissioned at the end of the last year and due for publication after our meeting of Council in July will make this clear. We are committed to change.

The problems I have described around inequality in our society represent systemic racism and need to be addressed through a joined-up approach and a loud voice from the medical profession. When we first explored the creation of the Inequalities in Health Alliance at the beginning of the year, I was delighted that all our sister colleges were keen to be part of that Alliance. Having announced its formation just before lockdown we now have the time and opportunity to get the Alliance up and running, with clear asks of government.

The RCP will continue to support physicians of all backgrounds, nationalities and faiths. Lobbying on issues such as the immigration health surcharge is one way, but the personal and professional support we can provide is as important. We must continue to work with our brother and sister physicians across the globe. Working to improve access to medicine and improved healthcare and health for everybody remain core to our purpose.

As individuals we should question our own values and behaviours with people from different backgrounds and ethnicities. Conscious and unconscious bias are hard to overcome and require deliberate thought and action. Asking colleagues about their experiences, championing services for those most in need, learning more about other cultures or taking more time with those we find it most difficult to be with are all things we can do. None of these are easy but they are needed. Doing nothing is not an option.

There was a poster on the wall of one of my friend's rooms at medical school. It featured a judge with a simple message that bears paraphrasing: 'If you were accused of being a racist would there be enough evidence to get you acquitted?'

Throughout the pandemic we have solved problems by standing together and working together. Let's continue to do that to end racial inequality in our society.

15 June 2020

As you read this many of you will have spent your first day in a new NHS world of compulsory masks for all. This masked ball is not quite how I imagined it to be and I will discuss the implications of this new policy later. It is 2 weeks since my last COVID-19 bulletin and there is a bit to catch up on. Before that I need to reflect on last week's bulletin, which focused on racism, health and why we must all do more.

Ripples – an unequal society and racism

Understandably that bulletin created quite a postbag for me. I am grateful to you all for contacting me and there was a wide range of responses. The large number of responses means I am taking some time to respond (I try and answer all emails personally) and some were sent as a reply to this email bulletin address which I would not usually look at (the best email address to use is the. president@rcplondon.ac.uk).

The vast majority (80%) of responses thanked me and the RCP for taking a stand and that they had felt empowered by it, 15% said that we have not gone far enough and a few that we have overstated the problem. We are always keen to hear how we can do things better and what people think we should be doing.

But I stand by my comments that health inequality is a blight that we need to work together to sort and that we all have a part to play in reducing racism in our health systems. I say 'systems' as the problems we see in the UK are replicated across the globe and we will need to involve all our members across the globe. Sharing experiences will be vital to finding solutions.

Invisible touch – contact tracing

Contact tracing is now routine business in the UK. The NHS Test and Trace service is England's version and is causing consternation for a couple of reasons. First off is how successful it has been in its first week of operating. Having identified around 8,100 patients with positive PCR test results the system was able to contact just over 5,400 of these, identify around 31,000 close contacts (or six people for each case) and contact 85% of them. Some have criticised this as poor performance but I take a slightly different view.

Any national system will take time to embed and for the public to get used to how it works. That 85% of contacts have been contacted seems to me quite impressive, although we need to increase the number of cases contacted and the speed of initial testing. The number of close contacts per case is another worry as it is a measure of how the social distancing rules are being used across the country. I suppose there could be some very large households but six seems like a big average number to me.

The second big debate is the application of the 14-day rule for healthcare worker contacts. The possibility of complete NHS teams having to self-isolate has come to fruition in a couple of hospitals. Many of us have pushed for an alternative involving regular testing of such contacts to allow them to continue to work but there have been two compelling arguments against this and for the widespread application of the 14-day rule to us all. The shift from a mainly community-spread infection to one within health and social care settings means that workers in those settings are at least as likely to be vectors as members of the public. The poor sensitivity of the PCR test also limits the safety of a regular testing approach. It is hard to argue with either.

Of course, the 14-day rule does not apply if you are wearing PPE, which brings me on to masks.

Throwing it all away – masks for all in hospitals

On Friday a box appeared on my desk in Derby, a gift from my line manager (ooh, what could this be?). Fresh from Hunan Province in China (the irony was not lost on us all) this was my supply of masks for when all NHS staff in hospitals have to wear masks (from midnight this morning). Signs have also appeared all around the hospital stating that wearing masks will 'protect yourselves and others'.

I have lots of thoughts on this issue. Together with the RCN we lobbied for masks, aprons and gloves for all in hospitals before the lockdown began as a way to reduce infection of workers. So this new move is probably a good thing albeit 3 months late. It also demonstrates to patients that hospitals are taking nosocomial spread seriously, although whether this allays any of their fears remains to be seen. Surgical fluid-repellent masks are also considerably more effective than the face coverings most people are currently sporting in public (some as a fashion statement it seems) as a form of offence/defence.

My understanding of the evidence for mask usage in preventing asymptomatic spread is that there is none and so how effective this will be in that setting remains to be seen. The worries about its impact on communication, poorer behaviours around hand washing and other infection control measures and the impact on the environment when we throw them away also temper my enthusiasm. It will be interesting to see how many masks we will get through per day in the NHS but it is likely to be in the millions (as presumably we have to assume the mask is contaminated and will need to be changed every time it is touched to eat or drink).

Infection control and prevention remains a critical part of our ability to control nosocomial infection. Recent NHS guidance has clarified what our approach to this should be. For those with a short attention span – wash your hands, stay 2m apart, don't come to work if you feel unwell, and wash your hands again.

Turn it on again – returners to the NHS

One of the great positives of the pandemic has been the response of those who have left the NHS wanting to come back to help. If only the NHS had returned the favour. Of the 30,000 or so who came back onto the register only around 1,500 have been employed, and most of these in staffing NHS 111 services. Trusts have said to many 'thanks for your offer but we're alright'.

Some of this is understandable. At the early stage of the crisis most elective services were stood down and there was a surplus of consultant hands and feet (which trusts were already employing) so they felt no need for additional staff. However, this will not be the case moving forward. The backlog is so large, the need to keep non-COVID services going in a second wave more obvious and the other additional workforce dwindling that we will need these willing volunteers desperately for the winter.

The increase in hospital medical workforce was bolstered by trainees coming back from out of programme activities (such as research) and final year medical students becoming interim foundation doctors (FiY1s). The former need to get back to their research or other fellowships and it would be outrageous to pull them back out again so quickly. The latter won't be an option after August as they will all be FY1s and the following medical school year are too far from graduation. Therefore, we must identify locally which 'returners' are around in which specialty and make plans with them for how best to utilise their considerable skills.

One challenge will be ensuring they can work safely and are not exposed to unnecessary risk. We should learn from our shielded doctors about how best to do this. We know that about 3% of physicians are currently shielding and have been able to support the NHS brilliantly from home. Our survey a couple of weeks ago looked at this group. 34% would be willing to come back to the wards, 19% want to stay shielded and the rest to work in non-ward settings.

Follow you follow me – training issues

There has been a lot of progress around training this week although one person described the past few months as 'unsettling times' for trainees. I would put it more strongly and the uncertainties over career progression, exams and jobs have been very stressful for many. Exams, training and CPD are all run by the three colleges of physicians working together as the Federation (and I have the honour of being the current chair of the Federation board). Trainee committees from all three colleges feed into our work and have been instrumental in guiding our way out of the crisis.

On exams, the written exams will start again in September and we will be piloting online exams with proctoring. We will give trainees the option of what to do but it seems likely that online exams will become the norm moving forward. As I have said before, clinical exams are much more problematic to get going due to the infection risks. Internationally some of our partner countries are keen to get going with 'traditional' PACES and we hope we can start this in the autumn in those countries. In the UK we are looking at a few options and working with the trainee committees to decide which we should go for. Some of the stations in PACES (2&4) can be set up in a minimal-risk setting so we are looking at ensuring that we deliver this at the very least this year.

We have been looking at ways we can support those trainees completing CMT but unable to get an ST3 place. The statutory education bodies (HEE, HEIW, NES and NIMDTA) rejected our suggested formal support structure for this group so we will be looking to provide support in less formal ways. For example, all such trainees will have free access to the ePortfolio to allow them to continue to gain competencies to support future applications.

I have also been involved in discussions about medical students. There is a big push to get students back into placements but there are concerns about PPE supply, risks and teaching capacity. Getting them back is critical as the short duration of clinical training means that every week lost is important.

Advanced clinical practitioner and physician associate trainees have stayed on the wards during the past few weeks so we know it is possible. I am aware, though, of the challenges of risk assessing large numbers of students and we should be grateful to any of our colleagues involved in that process.

And then there were three – departing specialty presidents

In all the carnage of the past few months the annual conferences that many of our specialties would be having have been cancelled. These conferences act as handover points for the leaders of those specialties and the opportunity to celebrate their achievements and say thank you has been lost.

Ruth Murphy (British Association of Dermatologists), Elizabeth Price (British Society for Rheumatology) and Cathryn Edwards (British Society of Gastroenterology) are all standing down as presidents and I would like to give them a big shout-out. They have been fabulous leaders, exemplars of what it is to be a physician, role models for those following and have had to cope with extraordinary times. They all have contributed positively to RCP Council discussions and I have valued their counsel and support hugely. Thank you Ruth, Liz and Cathryn (imagine a virtual standing ovation at this point).

Land of confusion – BMJ news item on the RCPE

On Friday the BMJ published an article on the resignation of Andy Elder PRCPE, which I mentioned a couple of weeks ago. I am now even more confused about what is going on and am concerned that Andy's role as medical director of the MRCP(UK) was seen as a conflict of interest. The MRCP(UK) is such an important part of what the physician colleges are about that surely having a deep understanding of it is an essential criteria for any president. The implication that there is a problem with the exam as expressed in the article is as great a concern and I have written to the acting PRCPE, Professor Angela Thomas, for clarification.

I will keep you all informed as to what is going on through these bulletins and would like to reiterate my support and admiration for Andy without whom the exam would not be the world-leading exam that it is.

That's all – and finally …

While writing this bulletin over the weekend, the water mains supplying my area burst and we were without running water. When it came back on the relief of seeing water come out of the tap and the ability to flush a toilet was a revelation.

It has made me reflect how we can take things for granted in our own little worlds that many cannot in other parts of the planet (and indeed our own countries). Let's all celebrate the things we have around us and not take them for granted.

29 June 2020

Much has happened in the 2 weeks since my last bulletin and the world is slowly trying to get back up on its feet. Nations and countries are moving at different rates and each have their own challenges. The NHS too is shifting gear and while we cannot say we are 'post-COVID' as the virus is very much still around, we are now in a new phase in the UK.

Don't stand so close to me – social distancing and the 2m rule

Last week, to much celebration, the UK prime minister announced a planned relaxation of some of the social distancing guidance. The change from 2 metres to '1 metre plus' was heard by many as '2 metres to 1 metre'. This was partly because the cheering from some of the suspiciously undistanced group drowned out the 'plus'. Yet the 'plus' actually forms quite a large part of the new rules.

The 'plus' is the mitigation that needs to be taken if the 2m rule cannot be observed. There are '39 steps' in this mitigation as described in a detailed SAGE document. I presume the 39 steps were a fortuitous number with a PR friendly phrase … at least I hope so. The SAGE paper is a good review of the evidence for each step, including international comparisons, and worth a read if you have the time. If not, *The Sun* has a much easier to read summary (my weekly medical literature review is as eclectic as my music collection). However, the headline about the 2m rule being 'slashed' to 1m sums up the way the rule has been misinterpreted by many.

The mitigating factors centre around eliminating the virus from some settings, substituting activities to reduce exposure, re-engineering of spaces to reduce spread, and administration of these spaces. The final group is our old friend PPE. The individual steps all make sense, except perhaps step 31: 'Maintain 2m distancing' – and I can't decide if this is a tautology or an oxymoron. The SAGE paper

has estimated the increased risk at 1m compared with 2m as a doubling. This will have been seen by those with an eye on business and the economy as a change in risk worth taking. Many of us from the health side of the equation are perhaps less convinced (and the CMO made that clear when the PM made his announcement).

Too rapid an exit from lockdown and the virus re-emerges, as being seen in several states in the USA at the moment. We will know if the changing of the 2m rule has had a significant effect on the epidemiology of the infection in early August. The photographs of the reported 500,000 people on Bournemouth beach last week imply that many people underestimate the 2m distance already.

The other confusion we have in the UK is that the rules around social distancing vary between the four nations. When I talked about masks in hospitals a fortnight ago it only applied to England (and I omitted to make that clear, so many apologies for that). This variation and confusion is not helpful in public messaging.

All over the world – the impact of COVID-19

The impact of the COVID-19 pandemic in different countries has been highly variable and has thrown up both questions and answers. Political responses, health resources, geography and national behaviours have all contributed to this variation.

Like many, I have been shocked by the pictures and stories that have emerged from Yemen over the past week. Estimates of mortality from COVID-19 approaching 25% are a shuddering reminder that the provision of healthcare services in many countries is a critical factor in determining the outcome from the infection.

We have much to learn from each other and tomorrow will see the start of a series of global webinars hosted by the RCP. Focusing on 'COVID-19 stories from around the world', tomorrow's webinar will have contributions from Africa, the Middle East, South East Asia and America. This will be followed over the next few weeks by further online events, including a series of joint webinars with the American College of Physicians involving over 30 countries.

I smell winter – preparations under way for next winter

As last week saw the hottest day of the year in the UK it is the time to ensure we are ready for next winter. The added challenge this year of a potential second wave of COVID-19 makes this more complicated but we mustn't forget the basics.

Flu vaccination is already being thought about and additional supplies of the vaccine ordered. The annual debate about whether vaccination should be mandatory for all staff has restarted and I've been quite vocal that the variation between hospitals is one of opportunity rather than anything else.

Like it or not, we are all pretty similar as groups of healthcare workers across different hospitals. Our values and jobs are much the same. The huge variation in vaccine 'uptake' must therefore be due to something other than one hospital's staff being more or less accepting of vaccination than another. Those hospitals that make it as easy as possible to get vaccinated (eg teams of vaccinators regularly visiting all areas of the hospital) have better rates of uptake.

Preparing for a second wave will require us to understand what worked well and what didn't during the first wave. That is why I was happy to sign an open letter in the BMJ asking for a rapid inquiry. Some want a far larger inquiry apportioning blame but while I am sure this will happen at some point I still think it is too soon (we are not out of the woods yet). However, a formal assessment led in a cross-party way will help us be more ready for whatever COVID-19 still has up its sleeve. It is what we would do for a serious untoward incident in a hospital.

Start me up – the NHS reboot

I've written about the NHS restart many times in this bulletin and much of my time in the past few weeks has been in discussions with the specialties, NHS bodies and leaders, the DHSC and the health secretary on this.

I am due to give evidence to the Health and Social Care Select Committee tomorrow morning and in preparation we have worked with the medical specialties and members to create the evidence base. This is summarised in our report 'Returning the NHS to an even keel' which will be published on our website at midnight tonight.

The challenge of the size of backlog for many specialties, the limitations to providing a service in a COVID-19 world, and the new workload that the pandemic has created are huge. However, understanding the problem allows us to plan how we will address it. I have been much cheered by the enthusiasm of all those I have met to get things to a new steady state of a reinvigorated, innovative and modern NHS. We are working closely with our sister colleges across all specialties but especially the RCGP, RCEM and RCS to ensure a collaborative approach to finding solutions.

Call me – PIFU

'PIFU' stands for patient-initiated follow-up and this is something we will be seeing much more of in the rebooted NHS. The idea is that for certain conditions patients will be given the ability to initiate their own follow-up rather than waiting (often in vain) for a regular clinic follow-up appointment.

Many specialties already use such principles for groups of conditions and we know the nature of most long-term conditions is that patients' symptoms do not mirror the patterns of outpatient scheduling. The rapid conversion to virtual consultations in both primary care and secondary care will also facilitate such follow-up. We are working with the RCGP on joint principles in this area.

I do have a couple of concerns about such policies. Firstly, they tend to favour those patients who have good access to technology and the ability to understand and use the system. We must guard very carefully against such systems widening health inequalities and work with patients to do this. Secondly, the gain of 'freeing up' outpatient capacity may not be as great as some envisage. Demand for new outpatient appointments has been increasing at over 6% per year in the UK. This needs as much focus as how we handle follow-ups.

Siren song – COVID-19 antibodies

Ever since developing 'COVID toe' without any other obvious symptoms I have awaited the opportunity of getting an antibody test to see if I have had COVID-19. The answer came last week and I am antibody negative. This has produced a mixed reaction and many of you have probably had the same. Disappointment that I am still at definite risk of getting the infection and a feeling of relief that my PPE technique and adherence to IPC principles has afforded me protection.

For those who are antibody positive the question remains whether it is of any protective effect. This week I have been learning more about PHE's SIREN study which is looking at this. The aim is to recruit 100k healthcare workers and through a programme of regular swabbing and serological tests understand the epidemiology of healthcare worker infections and the relevance of antibodies to future exposure to the virus.

Apparently some trusts have already started recruiting and the information about the study on the PHE website is a little thin. I am in contact with those running the study and once I understand more detail I will share it via this bulletin as this is really important for physicians to get involved in.

We are the champions – great things happening in Liverpool

I am happy to confirm that Liverpool FC are champions of the English Premiership (that is football by the way). While my main affiliation is to the mighty Plymouth Argyle (promoted this year if you missed it), as a child I was a dedicated LFC fan and spent many a restful night sleeping under the watchful eyes of Kenny Dalglish, Bob Paisley and Graeme Souness spread across my bedroom walls.

This has led to a fair buzz around the city over the past week and that buzz has been added to by the sound of drones around our new building in Liverpool. The views are magnificent and Liverpool City Council's regenerating Liverpool project have been posting videos on their Twitter feed. There hasn't been too much to get excited by over the past few months, but views of The Spine show that there is a big and bright future ahead.

And finally...

I know that the physician body is feeling rather knackered at the moment (I accept such a term is not on any official wellbeing scale). Those physicians I've spoken to who have managed some time off in the past few weeks have found it incredibly helpful both for physical and mental 'restoration'. If you get the chance to have some time off it is important to take it. We need everyone as fit and healthy as possible for whatever the future holds.

13 July 2020

In a non-COVID world this week I would have been musing on the upcoming Olympics and discussing the blue skies of summer holidays. Both seem a world away, and while UK ED admissions are back up to 85% of pre-COVID levels and the weekly ONS data show that excess deaths have now fallen to below 2019 levels, life feels anything but normal.

It's over – oh no it's not

It was 'Super Saturday' in England last weekend with many lockdown measures being relaxed. This was viewed by some commentators as evidence that the worst of COVID-19 is over in the UK and that normal life is just around the corner. Politically this is a big deal, showing that the economy can get up and running and the government has succeeded in controlling the outbreak. Many outside of healthcare will be keen to underplay the risks still present.

Anyone who has seen the case and death curves for the USA will realise that such an underplay should be viewed suspiciously. The 'saddle shape' of the cases curve with a large second peak well established shows that, sadly, our American colleagues still have a long way to go before 'victory' can be considered. We must not be smug. The local outbreaks in Leicester and last week at Hillingdon Hospital are likely to be repeated throughout the summer in other towns and sites.

Some of these events have come 'out of the blue' and colleges have only heard about them at the same time as the media. If we are all to work together to understand hospital outbreaks and reduce them this must change. The system needs to be open and honest so it can act quickly to recognise risks and reduce them. Patients (especially those who have been discharged) need to be informed and screened. Staff and contacts need to be identified and removed from the workplace quickly while being screened. Many in PHE agree with this.

As an aside, PHE has taken a lot of flak in the medical and non-medical media recently. We need to be careful as many PHE staff have worked their proverbial socks off over COVID-19 and continue to do so with relatively limited resource. Most of us in the NHS understand the challenges of having to deliver with inadequate workforce. Thank you to all those staff for their efforts to protect the public and NHS staff. It has not been easy.

Face the music – masks and PPE

PPE hit the headlines again last week with Treasury documents showing £15 billion having been allocated to PPE so far during the pandemic. On the positive side the UK has moved to a much stronger positive balance of PPE and it is now being stockpiled for a second wave. The UK-based (but not necessarily UK-owned) manufacturing industry has also been secured for future supply with large contracts going to companies such as Honeywell. Yes, this is the same company that makes the boiler thermostat on your wall – it is much larger than I had ever imagined and they make PPE.

One of the problems the UK has faced is that we use FFP3 masks while the rest of the world uses FFP2 masks. Thus there is little demand for FFP3 outside of the UK and as we are a small customer globally (3% of the market) many manufacturers will focus on other larger markets (and this will become very relevant once we leave the EU completely). FFP2 masks use 75% of the materials of FFP3 masks and are cheaper to produce by the way. FFP3 mask shortage therefore remains a bit of a Sword of Damocles over us. Supplies of the popular 3M 1863 mask (my personal FFP3 of choice) may be soon joined by its industrial cousin the 9330 (who'd have thought this would become my Mastermind specialist subject?).

I think most of us are now both used to and 'comfortable' with wearing Type IIR masks most of the time in hospitals. Compulsory use of masks in enclosed spaces such as shops has been brought in in Scotland and is being considered for the rest of the UK. I'm told the main evidence for this recommendation comes from evidence of spread inside restaurants in China. I am therefore slightly perplexed that indoor dining in restaurants without masks may be allowed when shorter exposure in shops will only be allowed with a mask. Is there other evidence I've not seen?

The way life's meant to be – eradicating racism and inequality in healthcare

We held our first webinar on racism in healthcare last week. Sir Simon Stevens and I were the only two white men on the panel which was brilliantly chaired by journalist Henry Bonsu. The other panel members were Lord Victor Adebowale, Dame Elizabeth Anionwu, Mala Rao and Yvonne Coghill and it was a privilege to be on the panel with them. They pulled no punches and it was a challenging and uncomfortable conversation to be part of.

This is a good thing. Unless we are uncomfortable with the situation as it stands we won't be motivated to change it and 'allyship' is critical. Yvonne talked eloquently about the seven 'A's of authentic allyship that those who are not in the minority need to move through to be able to enact change and make a difference. Do you have the Appetite to tackle this? Ask questions and educate yourself about the issues. Accept there is a problem. Openly Acknowledge this. Apologise. Don't Assume anything and instead develop informed views. Take Action.

We are discussing our own equality, diversity and inclusion report at RCP Council this week and will release it in the next few weeks with a clear action plan. This work was commissioned last year but is as timely as never before. It doesn't just tackle race and covers all aspects of ED&I. I have previously struggled a bit in understanding the difference between the D and the I. The quote in the recent King's Fund report Workforce race inequalities and inclusion in NHS providers makes it easy to understand: 'Diversity is being invited to the party. Inclusion is being asked to dance.'

Can't get it out of my head – the sequelae of COVID-19

Thankfully, parliamentary recognition is now being given to the long-term effects of COVID-19, both after hospital admission and in the community. The need for rehabilitation after hospital admission, and especially ITU admission, has resulted in a framework being produced by the BSRM in collaboration with the ICS. This is much-needed a nd as I have said before in this blog, the need to invest in and grow the rehabilitation medicine workforce is critical.

The population that is causing disquiet is the cohort who stayed at home with their COVID-19 and indeed may never have had formal confirmation of their diagnosis. The NHS has just announced the launch of 'Your COVID Recovery' as a portal to allow such patients to get the support and rehabilitation they need in the community. I very much welcome this, but as the significant neuro-cognitive effects of COVID-19 are being recognised and many who have been severely affected by COVID-19 are older and poorer, an online screening tool cannot be the gatekeeper to these support services.

All over the world – RCP Global news

Among the bits of good news this week was the appointment of Mumtaz Patel as the new vice president – global to replace Ali Jawad as he demits. I'm delighted to have Mumtaz in this role which is ever more important as the RCP looks to develop and strengthen its links with members across the globe as well as other colleges of physicians.

Such collaboration was demonstrated in the best way with the first of our global webinars a couple of weeks ago – well worth a watch on the RCP Player. The insights from Oman, Zimbabwe, Pakistan, Malaysia and the USA were both fascinating and helpful. While the different healthcare systems and resources have created different challenges for each country it is very useful to hear how the same problems have been tackled. As you might expect, testing and lockdowns are recurrent themes.

We have yet more good news in the shape of new appointments and elections - vice-president for education and training (VPET), Linacre fellow and new Council members. Our newly-elected VPET Aine Burns takes up the role at this crucial time for education and training. Also very welcome is Jo Szram who has been appointed to the role of Linacre fellow, focused on the development and leadership of the RCP's network of college tutors and associate college tutors.

And if all that good news wasn't enough, we now have over 38,000 members! We are not the largest college yet but look out RCGP here we come.

Secret messages – extraordinary meeting

Talking of other colleges, our sister college the RCPE does things a bit differently from us and I have raised my worries about the (now withdrawn) resignation of Andy Elder as president before in this column. There was an extraordinary meeting (EM) of RCPE fellows just under 2 weeks ago to consider this and there is to be an independent review. I have written to the acting president to say that I would like to give evidence to this review.

I did not attend the EM as I am not a fellow of the RCPE but a few RCP fellows who are also fellows of the RCPE did, and have expressed concerns to me about some of the messages given about the Federation of Royal Colleges of Physicians and also the RCP. I have asked for clarification about what was said and a transcript of the meeting to ensure accuracy. I will continue to keep members and fellows informed through this bulletin.

Whatever the outcome of all of this within the Federation, we will not allow it to distract us from the issues important to trainees. Federation staff and teams in all three physician colleges continue to work very hard at getting exams ready to start again in autumn and ensure that training is back on track. Substantial progress is being made and we hope soon to have some dates sorted for the clinical exams. The exam will be COVID-adapted but not so

radically different from previous iterations of PACES that those who have prepared for pre-COVID PACES will be disadvantaged.

Getting to the point – the Cumberlege review and devices regulation

First do no harm, the review by Baroness Julia Cumberlege into pelvic mesh, sodium valproate in pregnancy and Primodos, was published last week. The review makes some hard-hitting recommendations about medicines and medical device regulation and has reported in just 2 years, which is unusual and impressive for such reviews.

We have had a bit of criticism for not providing evidence to the review and I think this criticism is not unreasonable. When we were asked to contribute we understood the review would have a narrow focus on the three interventions and we felt they were outside our areas of expertise. As Baroness Cumberlege explains in her report, it became clear as the review proceeded that its remit needed to expand to be seen as 'the independent review of medicines and medical devices safety'. This is very much in the RCP's bailiwick and the report makes many recommendations that we would not only agree with but have been calling for ourselves (for example in our submission to the Medicines and Medical Devices Bill currently running through parliament).

A central patient-identifiable register of devices is one such recommendation. I had the opportunity to discuss how this is best achieved with Baroness Cumberlege in the months prior to lockdown. The application of unique (but globally standardised) identifiers is already in use in some hospitals such as my own. We need to nationalise such a scheme as soon as possible.

Medical device regulation was due to change in line with the EU in May this year. However, due to COVID-19 it has been postponed by the EU until next year. As we will have left the EU by then we won't be using it and will need to write a completely new set. This will be a big undertaking for the MHRA and if their remit is to expand as envisaged by the review, they will need to upsize. The opportunity, though, to produce regulation that is fit for a modern NHS (such as covering AI, software and other digital devices) is there to be taken.

The diary of Horace Wimp – CPD

I am sure that those of you who use the CPD diary have kept it fully up to date and the certificate is already in your appraisal folder. For those few, such as me, for whom completing the diary for 2019–20 is still on the to-do list, this is a gentle reminder that the closing date is 31 July. While we have relaxed the requirements due to COVID-19 everyone will still need the evidence in their diary to get a certificate.

Last train to London – jobs and opportunities at the RCP

There are always opportunities to get involved with the RCP and two are currently open for applications.

The Harveian librarian has been an important role for centuries but, thankfully, has changed to fit as time has passed. Professor Simon Bowman has done a stellar job over the past 4 years and has also had an important role supporting the treasurer. We are at an exciting time of deciding how we will deliver our library and museum offerings across both sites in Liverpool and London, as well as our digital content. The librarian also oversees the RCP Medicinal Garden (which has survived under the care of Jane Knowles during lockdown) so the successful applicant will have a varied job.

We also need a clinical lead for the chief registrar programme. If you haven't heard of this (where have you been?), it is the flagship work-based leadership programme for senior trainees and we are keen to build on it. Chief registrars have been central in leading some hospital's responses to COVID-19 and it is a model that many are keen to emulate.

If neither of these are for you, fellows can still contribute at the AGM which has been moved to 24

September 2020. You won't need to catch a train to London as it will be virtual.

Don't bring me down – and finally…

Jeremy Hunt has a mixed fan base among medics and was pictured at the end of last week on a tube platform wearing a mask to promote mask-wearing on public transport. Nothing wrong with that, except that his mask was back to front resulting in a new world record of opprobrium on social media.

The same morning, a little late, I rushed to put on my mask in the hospital bike shed before walking into the hospital to get changed into scrubs for the day. As I laid down my helmet in the changing room one of my colleagues pointed at my face. I gazed into the mirror and saw (in horror) that I had 'done a Hunt' in my haste and my mask was back to front. It seems quite common too now I look carefully as I go around the hospital. Be careful out there.

27 July 2020

I've been on call this weekend so this bulletin may be a little more rough and ready than normal. I do enjoy the opportunity to immerse myself in the weekend take, although the calls in the middle of the night are less of a pleasure as I get older. The early hours 'scoping of GI bleeds has lost almost all appeal due to lack of 'golden slumbers' but the delay in getting patients to the endoscopy room does have fringe benefits. I've been able to do some reading around public attitudes to COVID-19 related issues which I'll try and thread through this bulletin.

Come together – public behaviours and COVID-19

As regular readers will have noticed I have a slight fascination with the use of masks and it seems that the public does as well. An Ipsos MORI poll last week showed that 86% of British people think mask wearing is important or essential. The same survey showed that only 28% wore a mask themselves (do as I say not as I do) and 52% that they did it to protect themselves. I was the only person in my local supermarket wearing a mask a week ago which surprised me.

Our attitudes to non-pharmaceutical interventions (NPIs) for COVID-19 change depending on our perceived risk. There is a good review in the Singapore Medical Journal of how 'health beliefs' guide our behaviours specifically around masks. I was also struck by another paper in *PLOS ONE* showing that (understandably) compliance with NPIs such as self-isolation increases with age. This effect seems to plateau around the age of 65, which in itself is interesting.

Maxwell's silver hammer – the promise of vaccines

As the initial results of the Oxford vaccine group have come out there is increasing excitement about the possibility of an effective vaccine. The Oxford vaccine uses a chimpanzee adenovirus vector (so-called ChAdOx1) which includes the SARS-CoV-2 surface spike protein sequence. The vaccine development is being supported by AstraZeneca and so the vaccine is also referred to as AZD1222. Large phase III trials in Brazil, South Africa and the US are underway.

We do need to be a little cautious about over-expectation here. Although the initial studies of ChAdOx1 nCoV-19 were conducted in around 1,000 volunteers, the news headlines have been based on the findings in ten volunteers who had two doses. The challenges of delivering a two-dose vaccine to large numbers of people are considerable and adenovirus vaccines do have significant symptomatic responses. We also know that attempts to find a 'one shot for life' vaccine for coronaviruses in the past have failed.

It seems unlikely therefore that we will have a vaccine like that used for measles and that we may all need repeated boosters or even an annual vaccine as we do for flu. The UK is at the forefront of research in this field and the NIHR is pushing forward with clinical studies on many of the vaccine candidates. We will need to support them in this endeavour.

So, while we cannot guarantee a successful vaccine yet, even if we are able to identify one the question is 'will people have the vaccination?'. Data from my own county suggest 27% would not. I will let you draw your own conclusions about whether your populations would mirror us in Derbyshire.

Something – bodily fluids, science and COVID-19 testing

The possibility of home saliva testing for COVID-19 as a way to monitor and control the infection is tantalising and if the trials in Southampton are successful it will make regular testing of healthcare staff much simpler (and cheaper).

The technique used for saliva samples is 'direct RT-LAMP' which I've had to look up. It stands for reverse transcription loop-mediated isothermal amplification (apparently) and does not need the thermal cycling used in traditional PCR techniques so is cheaper and quicker. The downside is that creating the primers is not easy, but once up and running it is a good technique for detecting RNA viruses.

NHS England's Test and Trace service continues to attract headlines and there was a fascinating exchange at a recent Health and Social Care Select Committee about testing and tracing at the start of the pandemic. The bottom line was we did not have the capacity for wide and large-scale testing and tracing when we needed it. There will be much argument over the coming years as to whose 'fault' that was.

The current Test and Trace service will use the Joint Biosecurity Centre (JBC) to support it. The JBC sits with the service and was helpfully described to me recently as the analytical arm of Test and Trace. The vision is that the JBC will be able to collect information from multiple sources and then the Test and Trace service will be responsible for acting on potential and actual outbreaks. One such non-NHS information source is the presence of the virus in sewage. This idea was new to me when I heard about it and I was going to write a bit about it in this bulletin. However, the *BMJ* has beaten me to it and gives a much better review of sewage monitoring than I can.

Here comes the sun – climate change

The challenges we faced pre-COVID have not gone away and climate change remains the biggest threat the world faces long term. Last year we (the RCP) committed to divesting from fossil fuels and we've made fast progress. We had previously stopped all direct investments but still had some investments in our managed portfolios. Over the winter I'm pleased to say we reduced these investments to <1 % which is great progress.

This has had some fringe benefits. The decarbonising process encouraged us to loosen our investment targets and look beyond our normal fund range. We find that our new cleaner, more diversified portfolio is more resilient and with other measures has given our funds some protection from the downward pressure of COVID-19 on the markets. It may therefore act as a stimulus for others to decarbonise their investments. Road traffic, though, is increasing back to pre-COVID levels and all too quickly the environmental benefits we saw in the early days of the lockdown are being forgotten – this is recidivism for the addiction to fossil fuels.

Carry that weight – the new government lines on obesity

Obesity is another issue that hasn't gone away during the pandemic and needs major policy change. Following his 'COVID-19 scare' (the press have adopted a cancerous tone), our PM has taken up the baton and the momentum this is creating should be welcomed. The policies announced today are a good start but more can be done. On the positive side, the ban on advertising of high fat, sugar and salt (HFSS) foods before 9pm, the ban on special offers in store and online and the details of calories on menus are all significant progress. It is disappointing that mandatory calories labelling on both alcohol and foods is only a consultation – affirmative action on these would have been better.

The announcement of the 'Better Health' campaign is also good but I have concerns about the shifting of too much onto individuals and the notion that taking personal responsibility for obesity is the main key to success. Countless studies and interventions have shown the complex societal and genetic determinants of obesity cannot be overcome by such thinking except for in a few instances. The use of technology to support weight loss is a mixed blessing as many of the poorest in our societies have the least access to it.

What more could be done? I like the idea of a tax on HFSS foods and this has been modelled in a study to show it would be even more effective than increased active transport, although both together would be best. Mexico has shown this can work. Such a tax will be resisted strongly by the industry in the UK. Indeed, the food and drinks industry is an enormously powerful lobbying group and the 9pm watershed policy announced today will have been fought with tooth and nail. It is refreshing that our PM is keen to take them on.

I was unaware that COVID-19 is not the first pandemic to show such strikingly worse outcomes in those with obesity. The 2009 H1N1 pandemic showed a similar picture, suggesting that the increased risk is more host-related than pathogen-related. Increased cardiovascular risk factors, impaired immune and metabolic responses, impaired ventilatory capacity, thrombogenicity and poorer nutrition are all implicated.

Finally on this topic, I did an interview for the BBC this morning. The new measures had been bounced off the top of the headlines by the quarantine restrictions on holidaymakers returning from Spain and the Spanish islands (the relative importance of the two issues would form an interesting debate). When I prepare for such interviews I try to ensure I've got some data to hand and the House of Commons library document on obesity stats is a mine of information. Well worth a quick glance.

She came in through the bathroom window – hospital admissions

The weekend has demonstrated that emergency admissions are 'ramping up' (sorry, couldn't resist it) quickly and both EDs and AMUs are bearing the brunt. I've said before that we cannot go back to the pre-COVID ways of crowding in the acute areas of our hospitals and that is why the RCP has produced joint guidance with RCEM, RCGP and the Society for Acute Medicine on improving pathways for acute care.

Over the past year there has been considerable work done by NHSEI together with colleges and patient groups on the potential alternatives to the standards for urgent and emergency care (the 4-hour standard), cancer (2-week and 31-day) and elective care (18-week) under the 'clinical review of standards'. The 4-hour standard has come under particular scrutiny with most hospitals struggling to meet it, such that it has become almost meaningless. It was undoubtedly a major innovation when it first came in and improved patient outcomes and flow, but long trolley waits remain an issue and we need more sophisticated metrics to measure and improve flow.

The whole urgent and emergency care (UEC) pathway needs overhaul from reducing attendances to improving discharge. The use of NHS 111 services increased massively during COVID-19 and this will form a central plank to UEC moving forward. It will need support and the public will take a while to get used to such a change, and indeed it will only work if it is seen as easier and better than going to ED. To judge by the success of NHS 111 online over the past 6 months of its life this isn't such a stretch of the imagination. The NHS Digital annual report published this week included a graph showing that on 16 March this year there were 751,995 uses of NHS 111 online. Just imagine if those contacts had been via other services.

Because – what the RCP is there for

This week will see the publication of our internal review of equality, diversity and inclusion (EDI) by Ben Summerskill. The review pulls no punches and shows the work we still have to do in relation to both membership and staffing. There is a clear vision of what we need to achieve and the implementation of the recommendations has already started. It needs to be part of our core business. The report will be available on our website from Wednesday.

Talking of core business, the policy shaping and influencing role is seen by many outside of medicine as what the RCP does. As those of you reading this will know, the evidence and authority for our influence comes from our central roles in training, education, member support and clinical standards, and our work in those areas has carried on during COVID-19, albeit at a reduced rate.

For clinical standards, the National Asthma and COPD Audit Programme (NACAP) has been fruitful and several reports are being released this week (see useful links below). The Education Department is ready to support the next wave of courses, some of which are also listed below. The 'Springboard to leadership' course is particularly important in relation to how we will improve the EDI aspects of college and NHS life.

Thank you for your generous donations to the RCP's COVID-19 Appeal. The funds are already being used to help our members and the health service manage the response and longer-term consequences of the COVID-19 pandemic. The appeal is ongoing and all donations are gratefully received.

The end… and finally

It has been a tough weekend for me clinically and as always, the trick to getting through it has been a mixture of positive attitude, great colleagues and interesting patients. It is a tough job but hugely rewarding and the smiles of patients in response to the magic seven words 'I'm happy for you to go home' make it easier.

For the first weekend in many months I didn't see any patients with COVID-19. Long may this last.

11 August 2020

Apologies that this bulletin is 24 hours later than normal. I'm on holiday in gorgeous, sunny Wales (apart from the occasional impressive thundershower) so have been in slightly more relaxed mood. The 'policy people' in UK governmental circles have been less relaxed since my last bulletin and the RCP too has been fairly prodigious in its output so there is a fair bit to update you on.

Don't believe a word – great expectations for the NHS reset

A week last Friday all NHS organisations in England were sent a letter from Sir Simon Stevens and Amanda Pritchard explaining the next phase of the 'incident' that is COVID-19 – the so-called 'phase 3'. This had important governance information and funding details for commissioners and trusts but my eyes were drawn to some of the stats, the three key aims of phase 3 and the detail behind those.

It seems that so far there have been 107,000 hospitalisations from COVID-19 (so if you feel you have been busy, you are right). The three aims of phase 3 are to 'accelerate' the return to near-normal levels of non-COVID activity, prepare for winter, and to do both of these in light of what we have learned from COVID-19 so far. No arguments with that.

The details, though, seem a little ambitious. Compared with activity for the same period in 2019 it is expected that day case and overnight activity will be at 80% in September and 90% in October. MR, CT scanning and endoscopy will be at 100% by October and outpatients the same (virtual appointments count). This just doesn't feel realistic to me. The knock-on effect of infection prevention and control, lack of staff and ongoing COVID-19 rotas in some hospitals will have a massive impact. I fear we are setting ourselves up for a fall.

The infection prevention and control issues have been drawn into sharp contrast by the NICE guidance for planned activity published a couple of weeks ago (with little fanfare). It looks simple enough but closer inspection shows that anyone having sedation (and that amounts to a significant number of physician-related procedures) will need to have a PCR test up to 72 hours beforehand and self-isolate from the day of the test until admission. This will be a challenge for many, particularly those who work, and the logistics of carrying out the tests and issuing results are not insignificant. I know many trusts are struggling as to how to apply this guidance.

Killer on the loose – flu hasn't gone away

While it is good that hospital admissions remain low, the recent increase in COVID-19 cases means that we should still be prepared for further waves. We (the RCP) have published our asks for planning for a future wave of COVID-19 focusing on six key areas: estate, flu vaccination, workforce, PPE, partnership working and testing.

The estate planning includes an ask for the increased bed base and facilities contracted from the independent sector to continue. I know that many members and fellows are passionate about keeping the NHS public (as am I) and the involvement of the private sector is uncomfortable at best. However, this additional capacity has been vital in many areas for keeping the NHS train on track and we must thank our colleagues in private hospitals for helping to 'take the strain'. The lesson to be learned is that we need more NHS estate in the long run but that won't get sorted overnight so we mustn't slide back to relying on an inadequate bed base.

The workforce call includes a focus on the 28,000 professionals who have offered their services as returners to the NHS. We have been a bit more detailed in our guidance document for hospitals and, as I have said many times before, we must make the most of this fantastic resource.

Regarding the flu vaccine part of the plans, we called for vaccination of all of those over 50 against flu and I'm pleased to see that this is now in the national flu plan announced last week. Vaccination will also be open to anyone caring for or living with someone on the shielded list and for year 7 school children.

Our rationale (and hopefully PHE's) for lowering the age for vaccination for all from 65 to 50 is simple: it should reduce hospitalisations and ITU admissions by a third, even if take-up is only 75%. We know that flu vaccination reduces hospital admissions with flu by around 40% on average. Vaccination is more effective against A(H1N1) viruses than A(H3N2) or B and thus there is variation in success rates depending on what strains are circulating. In a good year, vaccination may be 60% effective and in a bad one 20%. The last flu season wasn't too bad but there were still around 450 ITU admissions to HDU/ITU and 900 per 100,000 hospitalisations for the 45–64-year-old group. Reducing this by a third would create much-needed additional capacity.

Are you ready – latest COVID-19 survey

We have now published the results from our latest COVID-19 survey of members and fellows. The survey focused on plans and preparations for the future. It also asked about antibody testing. The striking findings revealed the lack of engagement about future COVID-19 wave and winter preparedness.

The findings made the front page of the *Daily Mail* which has a very large readership in print and online so is a good way to raise the profile of issues (even if not every member would describe themselves as keen readers of that paper). The results causing most concern were: 48% of members saying it will take more than 2 years to get back to normal, 60% that they are worried that their non-COVID patients have come to harm (mostly due to delayed diagnostic tests), and the long delays for such diagnostic tests.

My eye was also caught by the antibody test results: 79% of members had had a test and only 5% were not able to access this if they wanted it. 25% of us are antibody positive with no differences by grade, sex, region or ethnicity. Who knows what the implications of this are for future immunity but it shows just how widely exposed we all were.

Read the full survey results.

The boys are back in town – Hancock's (not half) hour

At the end of July, the RCP building in Regent's Park saw significant activity for the first time in 4 months. We were pleased to be able to host the secretary of state presenting his vision for the future of healthcare to a small audience in the Seligman Theatre. It was odd sitting in a sea of sparsely populated seats among masked occupants from the health and social care sector, but it also felt like a significant step after lockdown.

The speech was almost an hour long and included much that would be expected from Mr Hancock. The headlines the following day were about his call for 'Zoom medicine' and the use of virtual consultations as the default setting. He was also clear that cooperation and collaboration between all the sectors in integrated care systems remains a clear intention for this government.

The bits that didn't make the headlines were what struck me – so much so that I remarked to him they were not what would normally be expected from the SoS of a Conservative Party (he raised his eyebrows a bit at that). A strong focus on prevention and public health with a particular attention to health inequalities was great to hear, as was the focus on the workforce. There wasn't any promise of more staff but there was a clear statement that all of the support services for wellbeing put in place during the pandemic were to remain.

This attention on the workforce was timed with the release of the next stage of the NHS People Plan. This document has had a rather protracted labour and delivery and I first wrote about it almost a year ago. There isn't much new in there and it has been seen as a plan to prepare for winter rather than a long-term workforce plan for the NHS. We are promised more on how the NHS will 'grow' the workforce. If we don't do this, all the promises of improved working lives will struggle to be achieved under the pressures of workload.

Do anything you want to – ghosts of secretaries of state past

Keen to be seen to do his bit, the former health SoS Jeremy Hunt MP has also been very busy. He chairs the Health and Social Care Select Committee which has spent much of the past few weeks looking at the governmental response to the pandemic (I was briefly interviewed by the committee a couple of weeks ago). As an extension of this he has established an expert panel along 'CQC' principles and appointed my inspirational predecessor (and mentor), Dame Jane Dacre, to chair it.

The panel will act on behalf of the Health and Social Care Committee to provide an independent evaluation of government progress in key areas of health and social care policy. You could apply to be part of this as they are looking to appoint to the panel. The role requirements and application details are online, with a closing date of Thursday 10 September. I suspect the meetings will be fascinating.

While on the subject of the CQC, it seems they have teamed up with Healthwatch England and other health and care partners for a new campaign. The 'Because we all care' campaign calls on everyone to help shape health and social care by actively providing feedback on the care they receive. This follows research showing nearly two-thirds of people would be happy to actively provide feedback on their care to improve it if they were supported to do so. People also say they are more grateful for their healthcare services since the COVID-19 outbreak.

Whisky in the jar – our (dysfunctional) relationship with alcohol

Some of you may be reading this with a glass of something in your hand, either at the end of the day or while on a well-earned holiday. The effect of COVID-19 on UK drinking habits has been the subject of some debate. A good review by the Institute of Alcohol Studies shows a mixed picture. In the weeks before lockdown, sales of alcohol in shops rocketed but then so did sales of toilet paper and this may have simply reflected a stockpiling by the nation. Trade (pub and restaurant) sales obviously plummeted during lockdown and the increase in supermarket sales of alcohol matched this. Since lockdown was eased, though, supermarket sales have increased substantially (up 41% compared with last year) even as pubs have reopened.

Studies suggest that while a third of people were drinking more during lockdown, others were drinking less. Importantly, the proportion of 'risky' drinkers (drinking at a level that is associated with medical and social harm) increased during lockdown from 25% to 38% and it is unclear whether there has been a knock-on effect on the NHS. The Alcohol Health Alliance (AHA) is carrying out a short survey about COVID-19 and alcohol harm to help set the agenda moving forward. The deadline for responses is 19 August. I have seen a few patients admitted with worsening alcohol abuse due to social isolation during lockdown and suspect there is a hepatological time bomb brewing.

While talking about alcohol and liver disease it would be remiss of me not to mention the sad death of Professor Roger Williams. A giant of a man (and voice), his impact of the development of liver services both in the UK and globally cannot be understated. He was a previous vice president of the RCP and when I last saw him just before lockdown he was as passionate and driven as always in his efforts to influence governmental thinking. We have lost a great advocate for patient care and public health. Rest in peace, Roger.

And finally...

I have to be honest and say that alcohol does feature in my life – and not just from a professional point of view as a gastroenterologist. As I sign off there is a crown symbol staring me in the face with glistening condensation across it. For once I am delighted to have a (small) case of Corona close to me with people eager to share it. I hope you too have the chance to have a break and unwind over the summer and spend time with family and friends. Work is important but family more so.

24 August 2020

I'm writing this between cases on my weekend inpatient endoscopy list, waiting for the aerosol droplets to settle before moving on to the next patient. There is a loud hum in my ears from the air filter pump into my hood and hearing others in the room speak is a challenge, although at least I can see their lips move without masks on. Time moves frustratingly slowly in 'the hood' and my wonderful holiday in Wales last week seems a world away.

Even then I couldn't fully escape the world of medicine and politics – I am sure many reading this were or will be affected by the events and some left in dire straits because of them.

Your latest trick – reorganisation of public health

The first big news of the week was the leaked plan to close down PHE and set up a new National Institute for Health Protection (NIHP). The formal announcement was made on Tuesday, but the early leak must have been awful for staff working in PHE. As I have said before, those staff have worked as hard as anybody during the pandemic and without their sterling efforts we would be in a much worse place than we are. Such leaks may sell newspapers, but they have a very damaging effect on morale and the ability for health services to work as well as they can. It is hard to see how such leaks are 'in the public interest'.

The announcement itself is not completely unexpected as rumours of a change have abounded for several weeks but, as I said on the day, the timing is poor. We are still in the midst of the pandemic and now is not the time to reorganise the part of the service that is instrumental in the response. I am worried that disillusioned staff may leave, just when we need them the most.

The setting up of PHE as the fall guy for deficiencies in the pandemic response is also misplaced. It is ironic that the last reorganisation of the public health system that created PHE removed some of

the functions of health protection that PHE have been blamed for not providing. Given that £10bn has been set aside for the new 'test and trace' system that will now sit under the NIHP, are people actually surprised that PHE – with an annual budget of £287m for all its responsibilities – did not create such a system in February? It does make you wonder what might have happened if PHE had had such funding at the outset of the pandemic.

We all await the NIHP with great interest, not least because it will need to get up and running very quickly to orchestrate our response to any second wave. My other big concern is what will happen to the 'prevention' functions of PHE. We know that public health and prevention are essential to reduce health inequalities in our society and all the progress we have made around smoking, alcohol, obesity, air pollution and more mustn't be lost as we move forward.

To be fair, I do think that Matt Hancock understands this and is keen to engage with the profession on how the new body charged with improving the health of the population might look. Back in February we wrote to the prime minister about the importance of public health in reducing health inequalities and enabling the government to meet its commitment to improve healthy life expectancy by 5 years by 2035. COVID-19 will have derailed that plan by a couple of years but the train must be put back on the tracks as soon as possible.

So far away – Australian flu patterns

Talking about public health in pandemics, in my last bulletin I focused on the need for effective flu vaccination in the plans to prepare for next winter. The flu season in the Southern hemisphere (hello to all on that side of the equator) is a good barometer for what is heading our way in the north. Like us, the Australians produce a weekly flu update as the season progresses and I've been watching these with fascination. Some of the usual ways of assessing the impact (cases of 'ILI' or influenza like illness and deaths) have been skewed by COVID-19, but the data on laboratory-confirmed cases is undeniable. Figure 9 on page 8 of the latest report is staggering, showing that cases appear to have 'flatlined' since the COVID-19 lockdown. This year's flu season is very different from any previous year.

This raises a few tantalising questions as to why and whether we will see the same. The impact of social distancing, improved hand hygiene and wearing masks must have had an effect and hopefully we may see a degree of similar outcome in the UK. There are a couple of caveats to this. Firstly, COVID-19 hit Australia just at the start of flu season and thus the above non-pharmaceutical interventions (NPIs) were welcomed by the local public. As the British flu season hits in a few weeks I wonder whether NPI-fatigue here will have an impact. The other thing to say is that the flu season down under is not over yet and in the same way we have seen a resurgence in COVID-19 in some parts, flu is more than capable of having a strong second half of the season.

We therefore cannot be complacent and flu vaccination remains our most valuable weapon in preventing unnecessary admission and deaths from flu this year. We all have a responsibility as clinical leaders (at all grades) to get vaccinated and encourage others to do so.

Telegraph Road – giving evidence to the APPG on coronavirus

In preparing for winter and the next part of the COVID-19 pandemic (and sorry to seed the thought but should we worry about COVID-20 or -21?) we need to understand what we have learned from the pandemic so far as a forward-looking exercise. An 'all party parliamentary group' or APPG on coronavirus has been set up to do this and I gave evidence to them last week. The internet connection dropped out for a minute mid-evidence-giving, which I think was a sign that the weather in that part of Wales was bad and the demands on the bandwidth of the telephone broadband were

stretched by holidaying kids and adults accessing the internet. However, I managed to get across the points I wanted to make.

APPGs usually produce reports (which have a variable impact) and the selection of witnesses for this particular group has been wide and included the usual and some unusual suspects. I suspect some parliamentarians are keen to keep the blame game high on the agenda, but I am very much of the mind that there is plenty of time for blame in the future, and now is the time for learning not blaming. My themes focused on the need for simple consistent messaging from all parts of the system, ensuring we keep non-COVID services running in a second wave and that while we can learn from other countries (Germany and South Korea have been cited repeatedly) we should not expect to get exactly the same results as them even if we tried to apply the same organisational structures. The British public are unique.

Twisting by the pool – A-level results

A year ago, the Goddard household was not a happy place as A-level results were not as hoped. The past 10 days have seen a similar situation in many other households around the UK. A-level results have caused much twisting and turning by students, parents, teachers and universities to resolve the problems created, while some politicians have stayed poolside. Given the flawed algorithm (under the control of the former lead of the Dr Foster ratings I note with raised eyebrows), the decision to use teacher rankings was probably the only option, but the ramifications of this are far-reaching.

Medical school places were significantly affected, and the UK national cap on places initially meant that most students who had delayed achievement of the grades needed looked like they may have to wait until next year to take up their places. This was bad for many reasons and likely to impact on those from poorer backgrounds more than most. It would also have meant that many students who would ordinarily breeze into medical school next year would face a much stiffer competition ratio and we might lose some of most promising future doctors.

After much wrangling, behind the scenes negotiating and public lobbying, the cap was suspended and a promise of funding for future training places made. This is fantastic news, although I'm obviously biased as increasing medical school places has been top of my wish list for many years. We still don't know how many places this will create with estimates of 600–1,500 being bandied around. We also don't know where the places are and that is a potential issue. The geographical maldistribution of medical staff has been a difficult problem to fix for many years and London continues to have double the number of trainees and consultants per head of the population and hospital beds than the rest of the UK.

If the number of new offers from London medical schools is similar to the rest of the country, then the maldistribution problem will be perpetuated. If they are more, it will be aggravated. We must ensure that we train doctors to work in the rural and coastal parts of the UK as our population ages and redistributes over the next couple of decades, as well as correcting the disparity in doctors/population across the country. I suspect there will be some from the London medical schools who will be slightly aggrieved by my comments on this, but the data are compelling.

Reflecting on the medical school application process reminded me of the disappointment I felt as a sixth former being rejected by three of the big medical schools of the time (too young and no potential apparently – I'm not a bitter man). I also remember the joy of an offer and the bigger joy of getting the grades. I am delighted for all those whose grades have met the offers they have received and wish them all the very best for their future careers.

Walk of life – steroid emergency treatment cards

While I was a medical student I can remember clearly someone dying from undiagnosed adrenal apoplexy and the excitement of the pathologist at the post-mortem (does anyone go to the post-mortems of their patients anymore?). It is therefore not surprising that one of my obsessions on post-take ward rounds is not missing adrenal insufficiency (and it is remarkably common once you look for it).

Our clinical director of QI and patient safety John Dean has been working with the Society for Endocrinology and others to coordinate evidence-based guidelines published in *Clinical Medicine*, the development and launch of a patient-held NHS Steroid Emergency Card, and the underpinning mechanisms for integration into practice across the NHS through the National Patient Safety Alert published recently. We hope the new emergency card and this guidance will increase awareness of the need to start steroids promptly in patients at risk of an adrenal crisis, particularly those presenting in the emergency department or to acute medicine teams and those undergoing surgery or invasive procedures.

Private investigations – the need for improved care for patients with diabetes insipidus

Endocrinological emergencies are the flavour of the month and I have been reminded about the potential lethality of diabetes insipidus (DI). I am pleased to hear that Miles Levy has taken on a leadership role to improve the care for these patients. Deaths from DI still occur, which is tragic as the treatment (fluids and DDAVP) is simple.

One thought is that changing the name may help as patients, the public and healthcare professionals confuse the diagnosis with its rather dominating big sibling. Pituitary insipidus (PI) has been suggested (vasopressin deficiency was considered and rejected) and PI has a good ring to it, although clearly it makes some (older readers) think of Magnum, PI (as a complete aside I see Barack Obama is buying Magnum's old Hawaiian home).

It may be we need to think about a similar card for DI/PI patients as we have for preventing adrenal insufficiency. Whatever, in my mind failure to give fluids and DDAVP in the setting of diabetes insipidus should be a never event.

Brothers in arms – thank you for your support of the RCP COVID-19 Appeal

Early in the pandemic we established the RCP COVID-19 Appeal and I have been bowled over by the response from members and fellows and your generosity. To date we have raised £132,000 and we are now planning to use the funding to support research and service change in response to COVID-19. The support we have all given each other during the pandemic has been inspiring.

The focus on research is important and I am keen that the RCP continues to push for increasing clinical research and support to do that from the system. Cheng-Hock Toh, our academic VP, and his team have been working hard on our new research strategy that is coming out on Thursday this week. Your feedback on our plans will be more than welcome.

Separately, we are funding and planning a memorial to colleagues who have died in the pandemic and I will update you via this bulletin as those plans come to fruition. You may have heard about the plans for a cenotaph for emergency service workers – our memorial will be on a much smaller scale and particular to the RCP.

And finally…

There is ongoing debate as to the role of physical activity in preventing obesity and helping and maintaining weight loss. I'm convinced that it has a major part to play and the additional advantages of activity make it the safest medicine there is. I major in cycling these days as my knees no longer allow my first loves of hockey and football.

We get many unusual requests for help but one has caught my eye and I'm happy to promote it as it supports people to keep healthy. Hampton and Richmond Borough FC is looking to appoint a club medical officer to support them through the COVID-19 pandemic. The role entails checking protocols around testing and NPIs, attending home games and liaising with the National League in the event of a player or member of staff being identified as having COVID-19. You would need to be on the GMC register but not necessarily practising. I am aware advertising this post may cause a tsunami of similar requests from other sports clubs and so this probably has to be a once only use of this bulletin to spare those readers less enamoured with sporting activity.

7 September 2020

If I were a head teacher, I would be welcoming people back to a new term and talking about the promise of the next year and those starting school for the first time. We have a fair few more starters this year in our medical schools (see later) and I suspect there are some parents who are relieved that traditional educational establishments are open for business again. COVID-19 continues to feature highly in my meetings and the NHS generally but there is also a 'back to school' feeling which I will try and express in this week's bulletin. Four top trials start us off.

Reach out – steroids and trials in COVID-19

The news this week about the benefits of hydrocortisone in the management of COVID-19 was very welcome and showed the success of large collaborative trials. *JAMA* has published three trials and a large meta-analysis as well as a very useful editorial on steroids in COVID-19 which I would recommend reading.

The success of the UK RECOVERY trial showing that dexamethasone reduces mortality of mechanically ventilated patients by 29% was, paradoxically, a problem for the hydrocortisone trials as they stopped recruiting when use of dexamethasone became ethically imperative. This reduced the numbers of participants and hard end points were not achieved, although trial methodology was helpful for interpretation of the UK study. The REMAP-CAP study used Bayesian modelling to show hydrocortisone was superior to placebo. It is the meta-analysis that really seals the deal though.

The WHO-sponsored REACT analysis combining the seven trials of glucocorticoids in COVID-19 treatment showed an impressive reduction in mortality of 34%. This therefore seems to be a class effect rather than limited to dexamethasone (although the RECOVERY trial featured heavily in the REACT analysis). There remains uncertainty about dosing for hydrocortisone but given all the debates

over the years of the benefits of steroids in sepsis this is a remarkably clear answer.

The last trial I would like to mention is one that I hope members will be able to contribute to. The UK-REACH study led by a team in Leicester will examine the relationship between ethnicity and outcomes in UK healthcare workers, and is NIHR and UKRI-sponsored. As well as looking at the differences in disease outcomes in those infected with COVID-19, it will assess the impact on physical and mental health in healthcare workers from a BAME background. Ambitions for the study and more on COVID-19 and inequalities are covered in this month's *Commentary*.

Back to school again – medical school places update

Two weeks ago I wrote about the impact of the A-level regrading on medical school places and thought I should update you. The scale of the issue is now clear – just under 1,000 students need placement above the normal medical school intake. This is fairly evenly distributed across the UK (which is good) and the medical schools have worked hard to create additional capacity to provide these places. It seems likely that a number of places will have to be deferred but this will be less than 150 and thus the impact will be minimal on the 2021 intake. I had not thought about it before but I guess the attractiveness of a gap year at the moment is limited – difficult international travel, a weak temporary job market and uncertainty about the future of the COVID-19 pandemic – and few will want to defer unless they have to.

There is one further concern about this impressive expansion of medical school places – that it won't be replicated in future years. Although the UK government committed to increasing medical school places in their manifesto, they never committed to a permanent increase. We will continue to push hard with the case for a wider scale expansion of medical training, and a united voice from the colleges and medical schools will be needed.

It's the same old song – Brexit

A year ago many were worried about a no-deal Brexit and as the negotiations continue to labour over the future relationship between the UK and the EU it doesn't feel like we have made much progress. This week is key as formal talks in London are set to take place prior to the European Council summit in October. Talk of a 'light deal' seems as positive as we will get and a 'no-deal' remains highly possible.

The transition period finishes on 31 December but the key next date in the Brexit calendar is 31 October, by when the European Commission have said an agreement will need to have been made to allow ratification by the EU. You may have missed it but in early August there was guidance published as to how the NHS should prepare for the end of transition. Brexit has never been easy to get one's head around (in many senses) – a good summary of the current position is available on the NHS Confederation website.

The issues that are most concerning are around access to medicines and devices, public health linkages, research networks and of course immigration and the impact on the healthcare workforce. Other aspects such as the cessation of EHIC cards also need to be thought about. Our patients may be unaware of the need for insurance cover if travelling to the EU. On the positive side, the success of the UK in leading the COVID-19 research above shows we have still much to contribute and hopefully other countries will see this.

Standing in the shadows – the lesser known RCP activities

A traditional (and fair) question I have thrown at me is 'what has the RCP ever done for me?' My response is usually to draw attention to the huge output and work done by the staff and volunteers. If you want a clearer idea of this a quick flick through the RCP annual review will help. Some of the things we do may come as a surprise to many and there is a balance to be had between our roles as a membership body, standard setting organisation, education provider and policy influencer.

I guess the key thing that differentiates us from unions such as the BMA or HCSA is that we only represent physicians and physician associates rather than all parts of the workforce. Our leading role in education and standard setting also allows us to be seen differently by politicians, some of whom are very suspicious of unions or activists. We may not be as radical as some would like but that does not stop us successfully pushing for change.

However, we do need to continuously look carefully at what we do and assess what we should do less of if it is not good 'value'. Our annual report will give you a good idea of what we spend our income on. Within the RCP leadership team we are currently looking at the budget and strategy for next year. Like many charities, COVID-19 has impacted on our income and thus the budgeting process is even more challenging than usual.

One of our biggest 'departments' is the National Guideline Centre, which is funded by NICE and has produced many of NICE's guidelines over the past 11 years. This is important work – clinical standards are one of the RCP's 'golden threads' and we run the centre at a cost to the RCP. A personal frustration for me has been the lack of RCP badging on these guidelines and I continue to push for this. It is important that those RCP staff and members who contribute to this work get the recognition they deserve. I wonder how many reading this had no idea of our involvement.

The annual report is something we produce each year for our AGM which is going to be held on the 24 September. You can attend virtually if you are a fellow but will need to register beforehand. Following the AGM you can watch the annual FitzPatrick lecture on the same afternoon. This year's lecture is being given by the immediate past vice president global Professor Ali Jawad, and is on the life of Sir Harry Sinderson Pasha or 'Sindbad' as he was nicknamed …

Loco in Acapulco – the global situation

Talking about global matters, I have been watching the evolution of the pandemic in different countries and my thoughts are with all our international members who are affected. The situation in India is particularly concerning and I know many members have families in south Asia and the lack of air travel makes the separation even more difficult.

I was due to be in Mexico for the World Congress of Internal Medicine in early December but COVID-19 has dented those plans. We have all been using virtual meetings in our daily lives and the recent success of the completely online European Society of Cardiology conference with over 116,000 attendees from 211 countries shows there is a silver lining to this cloud. Expensive (and polluting) air travel has prevented many of our global colleagues accessing educational opportunities over the years and the increased opportunity to participate in conferences online is to be welcomed.

Getting all hospitals to accept that such events need study leave in the same way as face-to-face conferences has not been easy for some. Given the savings hospitals make on travel and accommodation costs for the leave, I think those that are making life difficult are being short-sighted. I would welcome examples of any such difficulties.

Walk away Renée – sodium valproate and pregnancy

Back in July I wrote about Baroness Cumberlege's review into medicines and medical devices safety, *First do no harm*. One of the main themes of the report was the need for significant changes into how dangerous drugs like sodium valproate should be monitored. This is not a new observation and the risks of valproate in pregnancy have been understood for a while. In 2018 the MHRA changed the rules for how valproate is prescribed in the UK.

I have learned much about sodium valproate over the past few years and it is, like many drugs, a two-faced coin.

Valproate is derived from valeric acid which is naturally found in the plant valerian (no relation to Valyrian steel). The anti-convulsant effects were found by chance when it was used as a carrier (it is an organic solvent) for other drugs. Its mechanism is not clear but it probably acts via sodium channels to increase GABA levels. Sodium valproate is used for two main indications – epilepsy and bipolar disorder – and is recommended by NICE in those situations. It is undoubtedly effective for many patients with differing forms of epilepsy and some patients do not get adequate seizure control with any other drug.

It is also useful as a second-line agent in bipolar disorder and historically has been used in migraine, although is now no longer recommended for that indication nor for chronic pain. The other side of the coin is that as well as having a range of side effects on the patient (it is associated with polycystic ovary syndrome for example) it is highly teratogenic.

Around 10% of children exposed to valproate in utero will have a congenital defect such as spina bifida, cleft palate or atrial septal defect. Up to 40% will have a neurodevelopmental condition with the risk of autistic traits particularly high. It is estimated that up to 15,000 women of child-bearing age in the UK take valproate and thus there is a high patient safety risk. Sodium valproate can no longer be prescribed for women of child-bearing age unless they are part of the pregnancy prevention programme.

Managing these risks is highly challenging. Stopping sodium valproate is not without risk in pregnancy and the deaths from SUDEP in maternal mortality reviews make grim reading. The impact of uncontrolled seizures in young adults cannot be underestimated (worth thinking about the next time you 'nip to the shops' in your car). For many female patients, walking away from the product of the innocent looking valerian flower is not a simple thing.

And finally...

My hospital is changing over to a new electronic patient record system (which will remain nameless) this month and there is much consternation. I was watching a programme about the computer revolution of the nineties and was reminded of the (oddly) rapturous welcome of Windows 95 with an advertising campaign that included the Rolling Stones – 'Start me up' was used at the launch – and Friends stars, costing around $200 million.

I'm not sure any EPR is going to get that sort of backing but I suspect that the Stones' song 'You can't always get what you want' is probably going to be more appropriate.

These bulletins will go back to being monthly for the moment but obviously if needed we will increase the frequency again. My next bulletin will be on 5 October.

21 September 2020

I ended my last bulletin with the words 'These bulletins will go back to being monthly for the moment but obviously if needed we will increase the frequency again. My next bulletin will be on 5 October.' Famous last words – we need to increase the frequency again (or strictly speaking, not decrease it yet).

I have been writing this bulletin over the past couple of days, and the news conference by Professor Chris Whitty and Sir Patrick Vallance this morning is a timely adjunct (thankfully the electronic presses can be held to allow last-minute editing). The CMO presented compelling data on the increase in hospital admissions over the past 2 weeks and the reasons why non-pharmaceutical interventions (NPIs) are as important now as ever. I fully support their position and recommendations.

It's raining again – the second wave

We have all watched the increase in cases in the UK with growing alarm. There has been an increase in hospital admissions, but at much lower levels compared with daily cases than seen in the first wave. There has been much speculation in the trinity of medical, mainstream and social media about why this is. To me, it is pretty simple. We are now looking at a wave in high definition, whereas before we were looking at it through a glass, darkly.

By the middle of April, past the first wave peak, we were only doing around 20,000 tests a day and many of these were in hospitalised patients and staff. Of these, around 5,000 were positive. This was just the tip of the iceberg of cases and while we will never know for sure how many were infected in that wave, seroprevalence data suggest that it was around 7–10% of the UK population. The UK Biobank data are helpful in showing the geographical spread and differences between groups (accepting that it is a slightly skewed population).

Currently we are testing 200,000 people a day and detecting 4,500 cases. Almost all of these tests are being done in the community or on asymptomatic people in health or social care settings. Large numbers of people under the age of 25 are being tested, a rarity during the first wave. We are therefore looking at other bits of the iceberg as well as the tip.

To compare the two waves is not easy, but the Office for National Statistics (ONS) has a method that gives us some insight. The ONS has modelled estimates of the percentage of the population testing positive each week, based on who is being tested and the results. They currently estimate this at 0.1% of the population, compared with 0.5% in mid-April. The current rates in those aged over 50 are well below 0.1%, and in 17–24-year-olds they are well over 0.5%. The ONS has broken down their rates by area of the country and age group; their graphs are well worth a peruse.

We are therefore looking at the second wave much earlier in its progress than we were able to look at the first wave, and are at a tipping point. All of the graphs are going in the wrong direction and unless the NPI manoeuvres work, we should expect the older age groups to start to succumb and be hospitalised, and deaths to increase. Obviously things are different this time, with improved treatments and awareness of those at most risk. However, public (and that includes all of us) behaviours now will be the most critical to deciding how the second hand we have been dealt will play out.

Take the long way home – staff absence and testing delays

There has also been much noise in the system over the past 2 weeks, as NHS staff with family members with symptoms have had to self-isolate and await testing and test results. This reached such a point that it required governmental intervention to improve access to testing for NHS staff. I'm not convinced that the problem is fixed. I have seen many colleagues in my own hospital have to self-isolate

with family members and spend many hours on the phone or internet trying to get a test. In the peak of the first wave we saw a similar pattern, with 'sickness' rates for physicians due to having household contacts with COVID-19 approaching 7%.

Most colleagues have been off for many days only to get the news that the swab was negative and that their snotty, feverish child was not a danger to the lives of others. I have had the opportunity to put this current situation to Matt Hancock and I think he gets it. We had a falling-out in the first week of April over the issue but have made up, and he now knows that our data are very helpful to understanding the reality of the situation.

We have set up a brief survey to provide contemporaneous data on this issue. It is short, open for just 24 hours, and will take only a couple of minutes. It would be brilliant if you could complete this survey. If you would rather read on for the moment, there will be another link at the end of this bulletin

Crisis? What crisis? – the impact of COVID-19 on medical research charities

The pandemic has had a major impact on all charities, including those in the medical sector. This has been crystallised this week in the statement from the British Heart Foundation. They have seen a 50% reduction in their income, as shops have had to close and fundraising events have been cancelled. This has necessitated a downsizing and restructuring, and should be a wake-up call to anyone who wasn't aware of the crisis facing the charity sector and medical research.

The impacts are far-reaching beyond charity restructuring. COVID-19 has had a very positive effect on related research and this should be seen as a good thing. Non-COVID research, though, is in a much darker place. In the first wave, many clinical research projects were suspended, staff and lab space repurposed and new applications for funding suspended. The impact in my specialty on inflammatory bowel disease trials was significant and while things are slowly coming back online, some studies may never recover.

The poor financial health of medical research charities means that future grant funding will be much reduced for years to come. This is bad for the UK health system, trainees and patients. It is right that much focus has been put on 'fighting' COVID-19, but non-COVID disease has not gone away and is casting an ever-lengthening shadow as time goes on.

As a charity with income from many sources, the RCP has not been immune to the financial impacts of COVID-19. This has meant that we are having to do some hard thinking about our plans for the next couple of years. We are in a reasonable financial position compared to many, but there are some tough decisions to be made. Meetings around the budgeting process are framed with a quote from the vice president of the White Star Line shipping company in 1912: 'We place absolute confidence in the Titanic. We believe that the boat is unsinkable.' Now is not the time for hubris and at our AGM on Thursday, I will be clear about the challenges facing us as a charity.

I am very open to ideas as to how we might raise additional funds to support our work through the next few years. We have made major strides forward in the past few years in modernising ourselves, developing our membership and how we are positioned to fulfil our charitable aims. Our vision remains to improve health and healthcare for everyone.

The logistical song – the MRCP(UK) and PA national exams are back

Last Tuesday we held the first sitting of the MRCP(UK) part 1 exam since lockdown. This was not an easy point to get to and there were lots of logistical issues (and yes, I know I've played fast and loose with the title to this section – Messrs Hodgson and Davies will understand).

We (the RCP, the Royal College of Physicians and Surgeons of Glasgow and the Royal College of Physicians of Edinburgh) have been thinking about

moving to online provision of the MRCP(UK) written exams for a while, but the failure of the equivalent Australasian online exam a couple of years ago has led to some caution. COVID-19 caused a further rethink. The ability to have large numbers of candidates in exam halls was limited and some venues that we have traditionally used were closed. Despite these issues, we managed to deliver the exam to over 5,000 candidates, 2,300 of these in the UK with 459 of the UK candidates doing the exam online. This was apparently the largest-ever sitting of this exam.

It went well, but not perfectly. Huge thanks must go to all the staff in the Federation exams, digital and comms teams and all three colleges. Right up to the last couple of weeks, centres were pulling out and alternatives were having to be found for rightly distraught candidates. The foresight of the team to create some additional capacity in the online provision and ensuring the legal clarity of the exam as an essential professional activity mitigated much of this, but unfortunately we could not prevent some candidates not being able to sit the exam. While this was a very small number, we are truly sorry about this.

The emotional impact on trainees created by these cancellations and logistical problems cannot be understated and I am grateful to those of you who have supported trainees through this. Some cancelled candidates did not want to sit the exam online and for them, as well as others who were unable to complete this sitting, we are looking at another sitting later this year.

The online exam went well, although there were problems for some with Wi-Fi connections and formatting of a dozen questions (which will be taken into account when processing the results). The experience from other colleges with online exams in the past couple of months showed a significant problem for about 6% of candidates and while we did better than this, there is much we will learn for the future about the tribulations of exams in a COVID-19 world.

The physician associate (PA) national exams are also underway and the OSCE exams are in full flow in Liverpool. As the number of candidates per sitting is much reduced, the exams are running over 4 weeks, which is a huge undertaking for all involved. It does show, though, that OSCE exams are possible and that we need not lose the bedside skills assessments that are so important in medicine.

Give a little bit – differential attainment

While talking about exams, the RCP has been working with BAPIO (the British Association of Physicians of Indian Origin) to understand how we might reduce differential attainment (or differential award, DA) in postgraduate examinations. In case you were not aware of the scale of this issue, a UK graduate is 30–40% more likely to pass postgraduate medical exams than an overseas graduate, and even among UK graduates there is a 10–15% difference between white candidates and BAME candidates.

The reasons for this are complex and well known. Doing something about it is much more difficult. Our rather disconnected training system and lack of systemic support for those who are not in training posts are part of the problem. As an educational supervisor, I get to know my trainees for a year, but rarely get much from the system about their previous progress or am asked by later parts of the system what my trainee and I had learned together.

Reducing DA will require early identification of those who need support, much improved communication between different parts of the system, improved feedback from exams and workplace-based assessments and a little bit more time for supervisors to bring this all together. I will continue to push for trusts to recognise the importance of time and support for educational and clinical supervisors to allow this.

Last week, with BAPIO, we (the RCP) hosted a joint workshop with many of the main players in the postgraduate training space and the NHS to focus on how we can take this agenda forward. It was a positive meeting and I am hopeful we can make some progress quickly.

Goodbye stranger – proposing for FRCP

One thing I have learned over the pandemic is the huge contribution that many members have made to both the NHS and the RCP. Proposing individuals for FRCP is one way to show how they are valued by colleagues, and I'm often surprised how many excellent physicians are not FRCP simply because no one has ever thought to propose them.

Proposal is relatively simple and we do not need the works of Tolstoy to describe someone's achievements. If fellows can see who in their departments should be recognised this way, that would be brilliant. The closing date for the next round of proposals is 1 November, so if you can get nominations in before then it would be much appreciated.

Dreamer … and finally

Listening to people interviewed on the radio or on television (I think I'm still allowed to use that term) about their experiences of trying to get tests currently fills me with a slight dread. We know that the PCR tests miss up to 30% of positive cases. Therefore when people say 'Thankfully I've had the all clear' I can't help thinking that for many this is not true, and wonder about the implications for those they come into contact with.

The tests we have currently are far from perfect. I know some dream of a world where we do millions of tests a day. We are a million miles away from that, or at least 239,000.

Talking of testing, you can take the survey now.

6 October 2020

The past 2 weeks have been rather busy so I will start with a couple of apologies. The first is to anyone who has sent me an email and not had a reply. My email inbox 'over-floweth' and if it were paper the local council would be sending officials around to complain about the mess. Fear not, I will respond and hope to have things more in control by the end of this week.

The second is about my attire in the photo attached to this bulletin, which the eagle-eyed have noticed has been getting more casual over the past few weeks. This is not intentional so I am pleased that we can 'redress' things with a photo of me in full PRCP regalia. This was taken at our AGM 10 days ago, and was the first time I've worn it since the first case of COVID-19 hit our shores.

I will come to the AGM later but let's start with a COVID-19 update.

I want to break free – local lockdowns, lock-ins and outbreaks

Anyone with children currently at school or university has spent much of the past couple of weeks waiting for that phone call to say said loved one or a classmate has tested positive. The impact of children being sent home with a fever continues to be a significant one for the NHS.

Thanks to all those who responded to our latest COVID-19 survey in my last bulletin. We published the results the weekend before last. This got a fair bit of press coverage, although I think it is safe to describe the 6.30am Saturday morning slot on BBC Breakfast as 'less frequently viewed'. I also got the chance to write a commentary on the survey for this week's *BMJ*. The headline was that 1 in 15 physicians were off work on the day of the survey with over 40% due to having to self-isolate while awaiting a test on a household member. Getting quick and easy access to testing for staff and their families is the answer and I am told there is a commitment to get capacity in NHS-run testing (so-called pillar 1) to deliver this by the end of October.

This will avoid staff having to navigate the vagaries of community testing.

The pictures of students 'locked in' halls of residences with messages made from post-it notes in windows will be an enduring image of this phase of the pandemic. Following the BBC interview last week my first job was to drop my youngest at a hall of residence in the middle of Nottingham to begin her new life as a uni student. It is not hard to see how such environments can promote the spread of viral (and other) pathogens.

I am in no doubt that it was the right decision for students to start or return to university. The impact of COVID-19 on that generation will be bigger than for any other and giving them all the opportunities that the university experience will bring was essential. That this would result in large-scale infection of that generation was predictable and some universities have been better than others at mitigating the risks of either contracting the virus or spreading it outside the campus. It seems that almost all infection in that age group is mild or even asymptomatic and my only concern is that we do not know if there is a strong risk of 'long COVID' (see later). However, it is vital that students are supported through self-isolation and careful attention is paid to the effects on mental health.

The increasing use of local lockdowns will hopefully avoid the need for a national lockdown. The critical bit of Chris Whitty's recent comments about the second wave was that it is different from the first wave. Public behaviours are different both in a personal sense (hands, space, face in whichever order you prefer – and some seem quite upset about the order) and societal one (reduced use of public transport, home working). Although in no way perfect, testing is much more readily available in the community to allow a more sophisticated and localised approach. There will also be some loss of transmission due to a small degree of herd immunity. I think the latter is important in hospitals as our survey confirmed that one in five physicians have been infected and most of them have antibodies. These little breaks in the chain of transmission will be important.

Some of these themes were explored in a Royal Society of Medicine webinar on COVID-19 I took part in last week. Also on the panel were Sir Simon Wessely, Sir David Spiegelhalter and Professor Eleanor Riley and it was a very lively discussion with no holding-back of views.

Hammer to fall – the second wave and its impact on medicine

The variable geographic distribution of COVID-19 hotspots means that some hospitals are feeling the impact more than others. In the same way, some specialties are too. One of the differences between the first and second waves is that there was a reduction in acute activity before the first wave hit and many elective services had been stood down to be ready, freeing up physicians to help out in acute areas. This is not the case now. Urgent admissions this time around are at almost usual levels for this time of year and elective activity continues to be ramped up (we haven't heard that phrase of late).

Acute medicine, respiratory medicine and geriatrics are therefore carrying the brunt of the second wave. This is not sustainable in an already fatigued workforce and we will all need to pull together to support the acute areas of the hospital. It is right that we keep elective and outpatient services going for as long as we can in the second wave but the timing of shift to 'surge management' must also not be left too late. If you are not having those discussions in your units, now is the time.

It's a hard life – long COVID

The concerns about the long-term effects of COVID-19 are now a focus for NHS planning. The impacts of a prolonged hospital stay, mechanical ventilation and long-term direct organ damage are well recognised and the need for additional rehabilitation services clear. What is less clear is the impact of COVID-19 on those not needing organ support, the vast majority of whom never reach secondary care. 'Long COVID' is being used to describe the patient-group with ongoing symptoms after infection.

While there is no doubt long COVID exists – a similar condition was seen following SARS – its definition, frequency and the best way to manage it are areas of much debate. The recent BMJ webinar is very helpful and suggests that it is more common in women, fatigue is the predominant symptom and it follows a fluctuating course. An estimate of 10% of people having sufficient symptoms to need NHS services is being used in planning although, again, this is a guesstimate.

We know that large numbers of healthcare workers were infected with COVID-19 in the first wave yet when I ask trusts about ongoing sickness rates following infection they say long COVID is not a significant problem. This may reflect a worrying degree of presenteeism among health workers or that long COVID is less of a feature for healthcare worker infection. I am eagerly awaiting the ubiquitous 'further research is needed' in this area.

Don't stop me now – trainee concerns, exams and clinical academic training

I had the chance to meet with a group of trainees from the Queen Alexandra Hospital in Portsmouth last week as part of the first RCP trust visit we have done virtually. It sounds like a good place to train and the trainees were full of praise for their trainers and the hospital for supporting them during the pandemic.

They were slightly less fulsome in their praise for communications that they have received from colleges and education systems over the frequent changes to training and exams that have happened in the past 6 months. It was useful to have the opportunity to explain the challenges from the colleges' position, but I agree the issue of comms is something that needs urgent action. While we have tried to communicate through as many channels as possible, on reflection this needs to be simplified. The confusion created by some activities being run by the RCP and others (most) being run by the Federation of Royal Colleges of Physicians of the UK also doesn't help. A new rapid and simplified comms policy is being drawn up so trainees will know where to go for information.

It will be needed. The rapidly changing situation with exams was exemplified with the short notice of closure of part 1 examination sites I mentioned in my last bulletin. Local lockdowns may cause some venues both in the UK and internationally to close. We have increased the number of online places available for the part 2 exam in preparation for this, but many trainees are still opting for the paper-based exam hall experience.

While on the subject of communications it reminds me we are doing a survey on what members think about our comms. Please give us your views.

Back to exams. The clinical exam has now restarted and although there were a few glitches with the new virtual stations, in general it went better than expected. The physician associate national exam (an OSCE) has also continued successfully through increased measures in Liverpool. This shows that clinical exams are possible in the new world, but for at least the next 6 months we will need to be adaptable to whatever the pandemic throws at us.

It is also important that trainees know that they will not be disadvantaged by any changes made to exam formats compared with pre-COVID, and that any changes will be taken into consideration in analysis of results. Furthermore, everyone is fully aware of how stressful the late cancellation of exams was at the beginning of the pandemic and the stress that taking clinical exams creates.

One final issue regarding training and COVID-19 is that there has been much thought put into how clinical academic training should be managed during the second wave. Many trainees were happy to come out of research and help out in the first wave but the impact on their research and professional development was significant. Most are only just getting back into normal working

again and a 'second hit' would be catastrophic. The Clinical Academic Training Forum (CATF), which brings together all the key stakeholders (such as the deans, NIHR, the Medical Schools Council and medical royal colleges including the RCP), has produced a useful position statement for the next few months. This lays out the responsibilities for all involved in clinical training to minimise any impact.

The show must go on – Medicine 2021 and the AGM

We have now made the decision that Medicine 2021 will be an all-virtual conference. We had been working with the ICC in Birmingham to look at face-to-face options but felt that the risk of cancellation in January was too great. Far better to go ahead virtually than not at all. The conference will still have over 100 speakers, poster presentations, small group discussions and many of the features of the traditional conference. It will remain a meeting of medical minds. You can learn more and register here.

Another virtual 'RCP event' was the recent annual general meeting (AGM). This year's AGM was postponed from July to the end of September in an ultimately failed attempt to allow a face-to-face meeting. When it became clear that this was not going to be possible, we set up the AGM to be viewed by fellows via livestream with questions asked using the Vevox app. We considered using Zoom but the thought of potentially 200 people on one Zoom call was a little frightening.

A handful of fellows struggled to get into the livestream (apologies if you were one of them) and we managed to resolve the issues for all but a couple. We had a rule of six procession and the Dorchester Library had not seen anything like it before with gowns and masks only being 50% PPE. With only 2 hours there was much to get through and time was tight. My address, Professor David London's response and the senior officers' reports will all be available to members shortly.

The main topics of debate were the RCP finances and the possibility of selling some of our non-medical assets to support them. This is a discussion that will go on beyond the AGM, and the balance between ensuring we remain a viable charity, avoid large-scale redundancies and preserve our reputation as a protector of heritage is very difficult. I know that some people are very upset about any sale of assets and completely understand this. However, we are in unique times and discussions at the Board of Trustees and Council have shown that we have to explore all options.

We are not alone in having to think about such things and, while on a different scale, I've watched the discussions around the Taddei Tondo at the Royal Academy with a heightened interest.

The AGM also approved our revised bye-laws. I'm biased as I've been involved in the revision for 3 years, but it was a much-needed step as we continue to modernise and ensure we are seen as a well-run and organised charity.

Breakthru' – progress on diversity and inclusion

We have now had our first meeting of the RCP diversity and inclusion delivery group set up in the wake of the report by Ben Summerskill. The 29 recommendations in the report are being used to create an action plan with a set of milestones. Once the final plan is available I will link to it via this bulletin.

If you were not aware, October is Black History Month and we will be marking this by sharing stories and achievements of black physicians through our various media. It is good to celebrate this month, but as a colleague from the RCN reminded me, one month is not enough – 'I'm black all the time', she said.

We are the champions – Dr Peter Tun FRCP

I was devastated when I heard the news that Peter Tun had died from COVID-19 in the midst of the first wave. Peter was a universally loved associate specialist in neurorehabilitation in Reading and I had worked with him on various RCP committees. Historically, we have not awarded the FRCP posthumously but once we became aware that Peter had not known that fellowship was now open to SAS doctors we thought it would be a fitting celebration of his contributions to medicine. This received lots of lovely coverage in the local press.

Save me – social distancing guidance from the RCP circa 1665

I'm very grateful for a regular reader of this bulletin spotting an article in the *Daily Mail* on advice given by the RCP to the population during the Great Plague of London. Avoiding crowded places and use of quarantine remain as good advice now as back then. Suggesting this might cure the plague may have been overstating things but let's not dwell on that.

And finally – out of the mouth of babes

If governments are looking for future advisers they could do well to consider employing the son of one of our Council members who wrote to the tooth fairy recently with some pretty insightful and demanding questions: 'Can you get COVID?' 'How do you keep 2m distance?' 'Do you wear a mask?' The tooth fairy was not expecting those.

19 October 2020

There is still a group of people in the UK and other countries who deny that we are in a second wave of COVID-19. For those working in hospitals bearing the brunt this is a little hard to stomach. The situation continues to change rapidly and keeping members abreast of the situation and aware of some of the stuff that doesn't make the headlines is the main purpose of this bulletin.

As in the first wave the impact on ITUs is (reasonably) taking the lion's share of the news coverage but as I keep reminding politicians, 85 % of hospitalised patients with COVID-19 are under the care of physicians for all of their stay. It is going to be a tough winter for us all. Over the weekend my ward has become a COVID-19 ward again. Beware the Ides of October.

Controlling the spread of infection is key to mitigating the impact of the second wave and the three tiers introduced a week ago come with many fears. Let's consider those first.

Mad world – tiers, circuit breakers and politics

Last Monday's announcement by the prime minister (it seems rude to refer to him as just 'Boris') that there would be three tiers of local lockdown restrictions for England came as no surprise to anyone, given it had been leaked from the No 10 policy folder over 2 weeks ago. Cock-up or conspiracy? The latter seems to have backfired if it was the plan.

It is important to distinguish between the public health aspects of the tier system and the politics. Many local and national politicians have struggled with this. While it is not really appropriate for me to comment too much on the detailed economics

of the options, there is much we know about the health impacts (which by default will impact on the economy).

Firstly, it is wrong to say that the lockdown is only thought of as a way to reduce the number of COVID-19 cases. Everyone I work with is only too well aware of the impact on non-COVID patients during the first wave and is desperate to avoid a large-scale shutdown of services again. Thus, not only do local public health measures reduce COVID-19 cases, they reduce the impact on the burden of non-COVID disease. It is good for the health of all the population to reduce transmission of COVID-19, not just those with the infection.

Secondly, the 'circuit breaker' (or 'fire break') proposal has merits but a nationwide imposition would result in little positive health impact in those parts of the country with currently low levels of infection. It would also have a large impact on the economy in those areas (you can imagine the conversations that have gone on between the chancellor and others on this). It is also probably a little too late for a circuit breaker to be effective with such high levels of transmission making identification of individual outbreaks (where circuit breakers are traditionally used) almost impossible. We don't really know what might happen, so the impact of lockdowns in Wales and Northern Ireland over the next 4 weeks will be as important for the whole of the UK as for the people of those nations.

Thirdly, tier 3 does allow local government to be fairly extreme in their measures to reduce transmission without the need for a national lockdown. Schools need to stay open (and the evidence is that infection rates in schoolchildren have stabilised) and this is 'baked in' to the tier 3 guidance. Whether local politicians will take the responsibility for using the restrictions to their full potential as regards controls on local businesses remains to be seen. I worry that things may be left to a national decision due to the 'optics' of such decisions being made locally.

Lastly, while it may not be portrayed as such, the use of local escalation policies is probably the fairest way to control transmission in different communities at the moment. The problem comes when it is messaged by politicians as being unfair for particular communities, at which point public engagement and confidence is lost, rules are not obeyed and it becomes a self-fulfilling prophecy of failure.

All governments have the responsibility to minimise the hardship created by their actions. It may be that we will end up having another national lockdown in England but when we reach that point things will be very grim. The current strategy is not ideal, but neither is a national lockdown (whatever it is called). There is no simple or easy way out of the second wave.

Memories fade – reinfection and the immune system

The report in *The Lancet* this week of a case of reinfection with SARS-CoV-2 in Nevada, USA, brings the number of proven reinfections globally to four. While concerning, this must be viewed in the context of 40 million proven infections worldwide. The four cases we have good information for came from across the globe (Hong Kong, Belgium, Ecuador and the USA) and all had mild initial infections. Two of the reinfections were worse symptomatically, one less severe and one asymptomatic. We still don't really understand how many initial infections are asymptomatic but the four and 40 million will be a considerable underestimate. What does reinfection imply about the immune response to the virus and for potential vaccines?

We don't know the antibody status of all the cases but the fact that the reinfections were too genetically different to be due to mutation of the original strain suggests that 'immune escape' is unlikely. However, reinfection with a different strain suggests that relying on community infection to create herd immunity is a flawed policy (notwithstanding the other challenges with such an approach). As I've said before, I'm no immunologist but as I understand it this is not the death knell for vaccines yet. In fact, it

strengthens the vaccine strategy, as an effective one should protect against multiple strains.

We should also not be surprised that the immune response the virus induces fades with time. This has been accepted from the start of the pandemic. How long the immune memory lasts had been the big question and the answer is now clearer – not long enough.

Everybody wants to rule the world – remdesivir

Not everybody wants to rule the world but some do and some pharma companies wouldn't mind having a global monopoly for COVID-19 treatment. We know that the current president of the USA thinks remdesivir is a great drug, a great great drug. Following a WHO trial this week, though, Mr Trump is increasingly on his own in thinking that Gilead's anti-viral is the solution to the pandemic.

The Solidarity trial published its interim results last week. It found that all four treatments evaluated (remdesivir, hydroxychloroquine, lopinavir/ritonavir and interferon) had little or no effect on 28-day mortality, need for ventilation and duration of hospital stay in hospitalised patients. The trial included 2,750 patients treated with remdesivir across 30 countries. The ACTT-1 study published earlier this year in the *NEJM* had shown a reduced median time of recovery from 15 days to 11 days in 1,052 patients compared with placebo, so what are we to make of this?

In short, only steroids seem to have an effect on mortality and the value of remdesivir is at best limited. The news that Mr Trump had brokered a deal with Gilead for most of the global production in July, August and September this year was greeted with dismay, but this can now be seen as less catastrophic than it first appeared. That the EU secured a deal with Gilead just before the Solidarity results were made public is now causing consternation. Veklury (the trade name for remdesivir) will be a talking point for the next few weeks, however effective it may be.

Sowing the seeds of love – my reflections on the first wave

The latest RCP Medicine podcast features Amie Burbridge interviewing me on the impact of the first wave and my thoughts about the future. I make no apology in trying to be as upbeat as possible and talking about the positives as much as the negatives.

It was recorded in September and already some of the thoughts seem a little out of date, but if you want an idea of what makes me tick, it is worth a listen.

Shout (out) – physicians in the Queen's birthday honours list

With all the doom and gloom around at the moment we need to hold on to the positive things when they appear. I was therefore delighted to see the recognition of several RCP members and fellows in the recent announcement of national honours. It is good to see that many are frontline clinicians from all parts of the country.

The honours system is far from perfect and there will be many people who have worked as hard and are as deserving of recognition but were not awarded honours. However, it is still good to celebrate the achievements of a few in honour of the many. The diversity of those physicians receiving awards speaks to this.

The RCP contributes to the honours award process and makes several nominations each round. We rely on colleagues who know the individuals well to let us know who deserves recognition and to help write citations for which we can collect support (while ensuring the individual is unaware). We try to do this in as fair a way as possible and although not all of our nominations are successful, hopefully a read through the list will reassure you that it is not just 'the usual suspects' who are recognised.

Pale shelter – selling off the family silver

Readers of *The Times* on Saturday will have seen an article on the potential sale of non-medical assets (previously mentioned in this bulletin and discussed at length at our AGM). We had a heads up that this was going to be published and I was quoted – although, as ever, a bit selectively. Most of the article was reasonably accurate and indeed referred to a couple of books I'd not heard of, which was helpful.

There were a couple of bits, though, that I take some exception to. The first is that the books cited (and I do not know why those books were chosen by *The Times*) were 'critical to physicians understanding of nature'. The history of Troy and The Canterbury tales are both historic literary works, but I doubt that even William Harvey was turning to their pages when tested by a difficult case. It is wholly right that these are treasures of the RCP collection, but let us not pretend they are something they are not.

The article also states that there is a deficit of £11.8 million over the past 5 years (which includes 2020). It is true that we have run an intentional operating deficit over the past 4 years of £8.8m due to significant investment in things such as the regional offices to boost member support, the development of the physician associate exam, the work of the National Guideline Centre, the Chief Registrar Programme, our work in quality improvement and patient safety following the Future Hospital Programme, and the RCP annual conference (although that made a profit last year). However, income from our investment portfolio means that the actual deficit for those 4 years was only £1.4 million or roughly 0.7% of our turnover for that period. As I have stated before, the difference for this year and next is that our deficit is not planned for and is a direct result of loss of income and an increase in pension liabilities due to the COVID-19 pandemic. The trustees of the RCP have been fully involved throughout this period with the planning of our finances and share the burden with me of navigating the next few years after the impact of COVID-19.

Lastly, the article suggests I compared the organisation to the Titanic. Those who heard my speech at the AGM will know I was referring to the attitude of the White Star Line directors rather than the ship itself. For the sake of clarity I will repeat that we are faced with a very difficult situation and have already undertaken some fairly severe restructuring and are desperate to limit the number of redundancies affecting our staff and their families. Yes, the RCP is a museum and we will do all we can to ensure that it remains so, but its main purpose is to be a body that educates, improves and influences for the best health and healthcare for all. That was why the RCP was set up over 500 years ago (long before we had any assets) and it remains our core charitable purpose. We forget that at our peril.

Finally, to hopefully reassure that I am not the vandalising philistine some might believe, only those versed in both the musical arts and the works of Henry Moore will fully appreciate the title of this section.

Elemental – oxygen and William Harvey

One book that you would probably have to kill me before I would allow it to be realised as an asset is *De motu cordis* by William Harvey. His recognition of the importance of the circulation to life by linking the heart, lungs and body together is a seminal moment in the history of physicians and the RCP. The annual Harveian lecture celebrates him and subsequent great physicians who have carried on his tradition.

This year's oration is being given by Sir Peter Ratcliffe. A Nobel laureate and renal physician, Sir Peter's work on oxygen-sensing by cells has revolutionised how we think about the oxygen homeostasis of the 40 trillion cells that make up the human body. His oration will look at the importance of oxygen-sensing in health and disease and will be given on Tuesday this week. Do make sure you register to listen.

Everybody loves a happy ending – and finally

Looking at the above, regular readers will appreciate that books have taken up most of my waking hours in the past couple of weeks (and many of those hours were in the middle of the night). I did learn about one literary reference from one of our committee chairs that made me smile (both at the reference itself and the chair's wide reading list).

The doctor will see you now is a book about the trials and tribulations of GP life by Amir Khan, a GP and 'TV doctor'. In the book he describes one of his trainees who develops an unrequited crush on a member of the practice staff. That the trainee is called Andrew Goddard and that my wife works in a GP practice all seems a bit too close to reality for it to be chance…

2 November 2020

Regular readers of this bulletin are a fantastic barometer of the 'physicianly mood' and I am always happy to receive emails about any topic I write about. It is important we listen to those voices and the postbag last week contained a fair few frustrated with the new format of this bulletin. Hence we have reverted to the previous format, or as a branding consultant might call it, 'bulletin classic'.

The second wave has been escalating in the 2 weeks since I last wrote and for many of us has taken up much of our time. That we are now in national lockdowns in three of the four home nations says much about the state of play. The effect on our professional and home lives has been highly variable and I will try to bring you up to speed with where we are in the former.

Waves of fear – the great geographical divide

The news that England is joining Wales and Northern Ireland in a national lockdown from this Thursday came as the impact of the current wave on the NHS and predictions for the future became increasingly bleak. I suspect the lockdown will be harder to stomach for those in parts of the country still to see a significant amplitude from this wave.

I saw an image on the HSJ Twitter feed this week that put the current situation into clear relief, graphically showing the difference in the way the second wave has hit hospitals across England. It ranks trusts in England by proportion of 'acute and general medicine' beds occupied by COVID-19 cases over the past 9 weeks. There is a hundred-fold variation between the lowest and highest, with 0.3% for Yeovil and 31% for Blackpool.

You will be able to see your own hospital and where you are in the league table. As in every season, Derby is 'pushing for promotion' which is not a good place to be in this table. The inexorable shift from green through yellow to red is also striking. This wave has

a long way to go and it will be important to see how this image changes over the next 4 weeks.

With such variability it is difficult to get a cohesive insight into what is happening with regard to absence rates, impact on services and how well the NHS is supporting its staff. We felt therefore it was the right time for our next COVID-19 survey. We know that we have thrown a lot of surveys at you all (and there will be another one in a couple of weeks – see below) but these data are enormously powerful and the CMO and NHS find them a useful 'source of truth'. Therefore, if you are working in the NHS please could I ask you to fill in this week's survey.

What's good – more steroids please

COVID-19 has been a good test of the ability to get new treatment protocols established in the NHS. The use of steroids and in particular dexamethasone, is an important one. The RECOVERY and REACT studies which I have previously mentioned in this bulletin were published in June and September respectively and showed a clear survival benefit in patients receiving steroids. Data soon to be published from the CO-CIN group has been looking at the rate of use over time since the RECOVERY trial was published.

In short, we've made good progress but we could do better. At the end of June around 15% of eligible patients were getting steroids and this has increased to around 75% at the end of September. Thus, all of us looking after patients admitted with COVID-19 should ask the question 'why are they not on steroids?' There will be a good reason for some but it is hard to believe that 25% of patients have contraindications or other conditions that would lead to withholding dexamethasone.

Hangin' round – how safe are hospitals?

Over the past few months I have had numerous conversations with patients who are petrified about coming to hospital for tests and especially endoscopy. Some fear of the procedure is normal (I'm sure the sight of me in scrubs with a colonoscope in my hands is not a pleasant one) but most patients are really worried about catching COVID-19. There is some pre-print data that is reassuring though. Hayee and colleagues have looked at over 6,200 endoscopy procedures followed prospectively in 18 UK centres. Three patients had COVID-19 detected pre-procedure on swabbing (all were asymptomatic) and no cases occurred in patients or staff in 14 days of follow-up. This is useful data when having discussions about risk, as the risk of dying from COVID-19 contracted during a colonoscopy for a 65-year-old man can be estimated currently to be 1:500,000 (at worst). For my screening patients the current risk of having cancer is 1:11.

However, we mustn't be too complacent, and as the second wave hits, community spread will increase and we will see more asymptomatic cases both in patients attending for tests, and staff. The latest data from the SIREN study suggest almost 2% of staff working in the hospitals in the areas of highest COVID-19 prevalence are testing positive through their regular PCR swabs. This matched the community prevalence and shows that our chances of meeting someone who is infected is the same inside the hospital as it is outside. We must continue to be vigilant in how we distance from each other at work as much as we do outside the hospital. This distancing does have some unwanted side effects though ...

Satellite of love – not all screens fill us with love

Microsoft Teams has become ubiquitous in the NHS and 'death by PowerPoint' has become 'catatonia by Teams'. Ironically for many, Teams has had a negative effect on team morale and structure. Together with Donal, our registrar, I have been conducting some trust visits over the past few weeks via Teams and this has given us a revealing insight into the positives and negatives of the pandemic on consultant and trainee physicians. Many have reported that the inability to have a coffee together after a round or during clinic due to social distancing has had a very negative effect on team structure and cohesiveness. I also note that many of the

'wellbeing areas' established in the first wave are not being re-established due to fears about nosocomial spread.

There are no easy answers to this (and if anyone has found good ways to mitigate the problem please let me know). I guess we will have to redouble our efforts to ask after each other in one-to-one settings and online.

The long-term effects of this distancing of the team worry me. One of the positives from the first wave was the increase in the number of team members on wards and the positive effects that had on workload, training and team belonging. You will all know I am a great fan of the triad of autonomy, belonging and mastery as the keys to professional happiness. They are all equally important and unless we spend time together, belonging disappears.

Another concern that the trainees raised on the trust visits was the impact of not rotating between posts last April. This will be the first topic for a new RCP venture which I will talk about later.

Perfect day – membership ceremonies

Teams is not all bad and showed its good side this week. My perfect day as PRCP would always end with a membership or fellowship ceremony as they are the best bit of my job. Seeing the brilliance of the future of medicine is inspiring and at the moment we need all the inspiration we can get. I was therefore chuffed to bits that we were able to hold our first membership ceremony since the beginning of the year this week.

We had 18 diplomates from all over the world and while I was not able to see them resplendent in purple robes in the Dorchester Library or hand them their diplomas, the new format did allow for a much more interactive affair. Donal and I were able spend a couple of minutes with each diplomate to talk about their hopes and fears for the future as well as their reflections on the exams.

Each membership ceremony has a personality and this week's seemed to be quite cardiological with many of the diplomates training in that specialty – our clinical vice president Sarah Clarke must have been having a word. Everyone's experience of the pandemic was slightly different but the positivity that Donal and I heard and saw was a real boost.

Remarkably the diplomates were almost all very positive about their memories of doing PACES (it may be post-traumatic amnesia). This, though, reinforced how important the exam is to a physician's training. So how are the exams going throughout the second wave?

Walk on the wild side – changing the format of the exam

For those in charge of guiding the MRCP(UK) exams through the pandemic it has been a really difficult year. We have had to introduce new formats for both written and PACES exams, accept the risks that come with those and do our best to mitigate them. As Ken Dagg, the Federation lead for exams, put it this week, 'we are trying to build on ever-shifting sands'.

This was demonstrated last weekend as the RCOG made the very difficult decision to cancel their MRCOG Part 3 exam. This is a clinical exam and is slightly different from PACES in so far as it involves very large numbers of candidates going to London. It is also an exam that is sat at ST6–7 level and is needed for CCT.

Given that COVID-19 seems set to be with us for a long time we have to be prepared for the current logistical problems we face with exam delivery being a long-term issue and not something we can just 'weather' for a few months. A clinical assessment of skills is an essential part of the training of a physician and the current model of PACES with some virtual stations and some face-to-face stations has had good feedback from both candidates and examiners. The new exams have been on a smaller scale and thus will be needed in larger numbers of sittings going forward.

We are prepared for the worst-case scenario of going 'all virtual' if needed but that we have been able to deliver the exam with patients in sites such as Liverpool shows what is possible. The team that oversees PACES is meeting weekly to assess how we

can respond to changes in the pandemic. We will do our utmost, though, to keep this part of our activity going through the lockdowns.

We had the MRCP(UK) Part 2 written exam this week. As with the Part 1 there were some IT issues, and we are just working through those. It seems there were some problems for a handful of candidates needing additional time for the first paper. This will have caused unnecessary added stress and therefore this is something we need to resolve urgently once we understand the specific problem.

Communication with candidates has been a problem over the past few weeks with multiple lines of information causing confusion. From now on the MRCP(UK) website should be seen as the single source of truth and there will be a weekly newsletter as well as a fortnightly Q&A session on Twitter. However, as the MRCOG decision shows the sands will continue to shift and we should all be prepared for that.

That's the story of my life – Clinical Excellence Awards (CEAs)

CEAs are a divisive topic. Some think they are a good way to reward those who have gone above and beyond in their professional lives. Others think they are a 'jobs for the boys' scheme and are unfair.

The RCP view is that they are flawed but that we should still support physicians to apply to them, and as a nominating body we have the ability to influence from 'inside the tent'. The last round of CEAs was suspended due to the pandemic and what happens next is open to consultation. If you want to share your thoughts with ACCEA (who run the scheme) you can view the consultation documents.

Walk and talk it – RCP educational opportunities

Last week we held the annual RCP 'Acute and general medicine' conference via the RCP Player. This was a great success with over 1,200 people joining. I was trying to multi-task by being in the hospital and watching talks between commitments. While this flexibility was great in one aspect, it also made me wish I could spend longer watching content as all the talks I saw were excellent.

I won't make this mistake for Medicine 2021 which is being held on 7–8 January. I will be ensuring I am free of clinical commitments for those two days (I also suspect the conference organisers have a few ideas up their sleeves for me and my avatar). It is early days but we already have 600 people registered. Do find out more and register for our annual conference.

If you are a college tutor or associate college tutor don't forget there is a half-day conference especially for you on 11 November.

Lastly on this topic we are starting an 'RCP journal club' (#rcpjournalclub). This will be a bimonthly Twitter session based on RCP journal articles and will be in the form of a debate. The first one is this week on Thursday 5 November at 7pm for an hour and will focus on the impact of halting rotations during the first wave. The debate will be hosted on @Clin_Med and @FutureHealthJ and I hope you can join us for some social media fireworks – especially if you find yourself at a loose end on the first day of the England lockdown.

Magic and loss – Inequalities in Health Alliance and RCP finances

Last week saw the formal launch of the Inequalities in Health Alliance, a coalition of 80 health organisations that the RCP has been bringing together over the past 9 months. The problem of inequalities in health is something I feel passionately about and it was a big problem before COVID-19. The first wave exacerbated the issue substantially and we have called on the government to take action. To go with the launch I wrote a letter to the prime minister exhorting the government to act and create a coherent strategy for health inequality, including enacting the socio-economic duty of the Equality Act and ensuring a 'child health in all polices' approach.

I will not go quietly on this one, and will be shouting about it until I demit as PRCP and beyond. I will need to be vocal as the launch only received scant

press coverage, unlike the potential sale of books from our library which was granted a leader in *The Times* following the open letter I received from 437 fellows, members and non-members on the issue. You can read my response to that letter.

While I fully understand the concerns expressed that we should have to consider selling some of our assets (and hope my response reassures the writers of the open letter), I have made no secret that my priorities as PRCP have been focused on our stated vision of 'the best health and healthcare' for everyone and that while I love the history of the RCP I am more concerned with its future. Achieving this in the harsh economic environment will be the topic of my leader in *Commentary* this month.

Given the difficult choices we have to make moving forward we want to know what you, the membership, think we should prioritise. We will survey these views in a couple of weeks.

Whatever we as a college decide to do moving forward I remain committed to ensuring we represent the wide diversity of physicians and that we act to improve the health and healthcare of all society, especially for those who need it the most.

Sweet Jane – and finally …

One of my favourite parts of working at the RCP is having the RCP Medicinal Garden visible from my office window and a short walk away. Jane Knowles, our head gardener, and her team have been instrumental in keeping the garden in fine fettle through the pandemic. The garden is not just for the staff nor indeed the membership and the therapeutic properties are not just pharmacological.

The week before last, in a collaboration with Mind, a small group from the 'Healthy Minds' programme at the Mary Ward Centre visited the garden. The visit was a great success being for some the first time they had ventured out since March.

Sometimes we forget the beauty of nature around us and the therapeutic benefit it can create.

9 November 2020

Given that the second wave is hitting us all hard, this bulletin will increase to weekly for the moment. I am only too aware of how full inboxes are but given how rapidly the situation is changing I want to keep members abreast of all the relevant issues. If you feel that weekly is too much, please let me know (Mrs G has already given her views). We will keep the bulletin in this format.

Stop press: This morning it was announced that the Pfizer and BioNTech vaccine BNT162b2 is '90% effective'. I've been in clinic all afternoon so have only had time to digest the headline and need to look at the data further (it is preliminary data after all, on only 94 evaluable cases). However, this is obviously very exciting and I will update you all next week.

The Wales firebreak finishes today, so it also seems a good idea to give an upbeat nod to that.

Just looking – a COVID-19 sitrep from the RCP survey

We carried out the 7th survey of members' experiences of COVID-19 last week and the results frame nicely where we are on many issues. We had 451 responses which is lower than previous surveys, and I think shows both how busy people are and also that survey fatigue is hitting many of you.

There are lots of data in the results which will be released officially tomorrow. Here is a preview. Most respondents were consultants but there was a good geographical spread. 89% have seen increases in admissions from COVID-19 in the past 2 weeks and 92% are worried about the impact this will have on their hospital's ability to deliver care. The curves do seem to be flattening off in some parts of the UK and the ONS graphs I've linked to in this bulletin before give a useful 'bird's-eye view' of what is happening in the different regions.

PPE remains a concern with only 82% feeling their organisation had the necessary PPE to tackle the second wave. While on the subject of PPE, many of us may be faced with UK-manufactured kit for the first time. This is especially true for masks and so it is vital that fit testing is done for a new mask type. I asked the NHS for a list of manufacturers but have been told it is too long a list to be practicable (make of that what you will). If you don't recognise the mask you have been given, make sure you get a fit test.

Back to the survey. Absence rates remain low (6%) compared with the first wave which is good, although some hospitals are seeing ward outbreaks leading to whole teams having to self-isolate. We also know that the rates in the hardest-hit hospitals are much higher (11–12%). The impact on an individual service can therefore be much bigger than an overall 6% figure may suggest. 8% of BAME physicians have still not had a risk assessment and this is 24% for white respondents.

PCR tests remain a challenge and although 84% could get their test in 24 hours, getting the results takes much longer. Only 29% got the result in less than 24 hours and 31% waited 3 days or more. It seems that regular staff testing is getting closer and the use of antigen-based lateral flow tests will form part of that. Saliva samples seem also set to be a key feature of regular testing.

Long COVID is placing an increasing demand on clinical services with a quarter of respondents having treated patients with long COVID in the past 2 weeks. Fatigue is the commonest symptom. There has been a fair amount of information published on long COVID this week but I found the NHS national guidance for post-COVID syndrome assessment clinics fascinating. In it is a link to the British Thoracic Society guidance which is very helpful as well. I think we are all going to need to know how to access these services for our patients and the challenge of determining if new symptoms are due to recent or previous acute COVID-19 will be a regular occurrence in clinic and on the wards.

Finally on the survey, one finding that really concerned me was that 30% said their non-COVID patients had more severe illness than expected. This shows the dilemma we are in. If we don't get over this wave quickly we will not only lose lives from COVID-19 but the impact on all our patients will be more damaging.

Pick a part that's new – mutations in mink

The news on Friday that a new mutation of the SARS-CoV-2 virus found in the mink population has been detected in 12 Danish patients is a worry. Viruses often move between species and while not proven, the pangolin has been proposed as the likely intermediary between bats and humans for this virus originally. The problem comes with the inevitable mutations that occur as the virus 'passages' between hosts and species.

SARS-CoV-2 has now been detected in mink, dogs, cats, lions and tigers (a challenging nasopharyngeal swabbing process). Mink-variant SARS-CoV-2 has been identified in Denmark, the USA, Spain, the Netherlands, Sweden and Italy. The new mutation has been called 'cluster 5' and seems to have a similar clinical course to the strain currently circulating in the UK. There are concerns that it is has less sensitivity to neutralising antibodies and thus what this might mean for vaccines.

It is too early to know if this is a new chapter in this pandemic or just an interesting footnote. From a practical point of view, it is worth us all being a bit more careful about travel history and if you see COVID-19 in someone who has come in from any of the above countries (but especially Denmark) let your ID teams know and if in England follow the latest guidance. If you want more information the WHO webpage is helpful.

Maybe tomorrow – what is happening with exams?

The cancellation of clinical exams I mentioned last week in relation to other specialties has now come to pass in PACES and the SCEs. PACES was cancelled in Edinburgh and Tunbridge Wells mid-week and the cardiology SCE (which is a European exam) at the same time.

The Edinburgh exam is organised by the RCPE and I don't know all the details. In Tunbridge Wells, the hospital's decision to withdraw from hosting the exam was based on infection control concerns which I completely understand. Given the candidates wear PPE and are screened with temperature checks and a questionnaire, it is hard to know how else we can mitigate such risk, but we are working with the trust to see how we can address those concerns and reassure them that we can host an exam safely for both candidates and patients.

The impact on candidates who have exams cancelled at late notice is nothing short of devastating and we are looking at how we can both support them at this time and put in place additional sittings at the earliest possible convenience. If you have trainees or colleagues involved please support them as much as you can. I worry, though, that unless the second wave is brought under control quickly it will significantly impact the first diet of PACES in 2021. All involved in exams in the Federation want to be able to give concrete answers about future dates and know 'maybe tomorrow' doesn't wash. However, as I said last week, the sands continue to shift under us and things change on a seemingly daily basis.

The cardiology exam is delivered by Pearson Vue who made the decision to cancel as they were struggling to deliver the exam in Europe. I understand that there are potential plans for an online exam early next year. Talking of Europe …

Traffic – Brexit effects

Brexit is rearing its head with timing that can be described as unfortunate at best. New acronyms proliferate with EoTP (end of transition period), RWCS (reasonable worst-case scenario options) and NSDR (national service disruption response) filling emails and updates.

Reading some of the documents it seems highly likely that there will be issues at the border as most small and many large businesses are not prepared for the EoTP and border arrangements. It is not clear how accepting EU countries will be for transport vehicles whose paperwork is 'not in order' but the image of long queues of stranded lorries is not a distant possibility.

The NHS seems reasonably prepared if those in charge are correct. Trusts have been asked not to stockpile more medicines, consumables and devices above what would be considered business as usual on 31 December. Trusts have been warned that delivery times may be longer and there is a central coordinating response for most goods that we use. If you have concerns about something that has an unusual supply chain for your patients it may be worth exploring the advice in the EU exit system stand up letter.

I wouldn't believe your radio – fake news and science denials

An article published in *JAMA* this week about the neurocognitive basis for science denial and COVID conspiracy theories is a quick and interesting read. Capgras syndrome occurs in Lewy body dementia and causes the patient to have the false belief that their loved one has been replaced by an imposter. The neurological pathways are reasonably well understood and the lack of reliable sensory data reaching the appropriate part of the brain is the simplistic explanation (neurologists are currently spitting out their coffee).

This may offer a useful insight when considering how the public view COVID-19. If we receive wrong, insufficient, indigestible or conflicting information we will not be able to process it, and false beliefs will occur as the brain seeks other sources of data.

The statement by the Office for Statistics Regulation last week on ensuring COVID-19 data presented to the public is accurate makes this point indirectly as well. We should always aim to avoid getting the facts to fit our theories (confirmation bias) and the battle between truth and spin is as relevant now as ever.

The bartender and the thief – individual needs and the new shield

In England the new lockdown has come with support for those defined as 'clinically extremely vulnerable' (the observant will have noticed our PM using that phrase in his briefing last week). This is essentially everyone who was on the 'shielded' list in the first wave plus two other groups: adults with Down's syndrome and those with stage 5 chronic kidney disease.

Like many I suspect, we have been fielding calls from patients keen to know if they should 'shield'. This is not a simple yes/no conversation and depends on individual patient circumstances as well as specialty guidance. Based on this, if we as specialists think any of our patients should be on the CEV list we can get them added by contacting the COVID-19 digital lead for our trust. This will allow them to self-isolate at home with additional support.

There are still some trainees, consultants and other physicians whose careers have been put on hold or changed radically by being in the CEV group. If you have been affected in this way I would welcome your thoughts on what hospitals, the RCP and the system can do to support you moving forward.

Handbags and gladrags – fair care for older people

Older people bore the brunt of the first wave either as patients, relatives or isolated individuals in different settings. Most of us believe that the second wave is harder than the first and it seems likely that it will hit the older people in our societies harder still. I therefore welcome the British Geriatrics Society's new campaign to raise the importance of this issue – you can lend your support and follow the campaign on Twitter using the hashtag #BGSFairCare.

The BGS is calling for five things: policy decisions and allocation of resources must be made on the basis of evidence and need, not age; the backlog of pent-up demand for NHS and social care services must be addressed; care homes must be supported; the harm to physical and mental health caused by lockdown must be acknowledged; and NHS and social care staff must be appropriately trained, supported and remunerated. It is hard to argue with any of these and I hope the campaign is a success.

Have a nice day – furlough Fridays

The debate as to how to balance the RCP books in light of COVID-19 goes on and I am in regular correspondence with members concerned about the option of a sale of assets to try to work together to agree a way forward. All are agreed a membership survey is an important next step and we are seeking to ensure the survey asks the right questions and is seen as a fair assessment of the membership's views.

While these conversations go on, we are continuing to find ways to reduce our expenditure this year and next. We furloughed many staff during the first wave and the extended furlough scheme to support the second wave is helpful and will allow RCP staff to move to a 4-day week from the end of this week. Therefore, while we will be able to maintain 'normal business' throughout this period, you may find that email replies take a little longer especially on a Friday which we aim to make the designated furlough day for most staff.

Dakota … and finally

I have got into trouble in previous bulletins for commenting on the politics in the USA so I tread carefully here. Apparently there has been an election on the other side of the Atlantic and as I write this the incumbent has not conceded to the victory of Mr Biden. Some commentators have expressed concerns about the behaviour of incumbent presidents and the graciousness of accepting defeat.

The letter from George Bush senior to Bill Clinton on handing over the Oval Office shows how it should be done and is worth a read (it takes less than a minute). This is how to be presidential.

16 November 2020

It has been a week of huge highs and lows. The positivity following the announcement of exciting results from the BioNTech/Pfizer vaccine on Monday was more than cancelled out by the death from COVID-19 of another consultant from Derby, Krishnan Subramanian, at the end of the week. This pandemic takes more than it gives.

I will endeavour to make this bulletin as positive as I can to try to lift the gloom that COVID-19 is casting. This will not be easy as the overriding sense I have had this week from conversations with physicians around the UK and indeed the world is one of fatigue. People are tired physically, emotionally and intellectually. RnR is needed by many, although following a challenge issued to me last week, the best I can do for you is Gn'R.

Knockin' on heaven's door – a pivotal week for COVID-19 vaccines

I squeezed in a 'stop press' statement in last week's bulletin when the Data Monitoring Committee (DMC) from the BNT162b2 phase III trial announced its interim analysis on Monday morning. Stock markets soared and there was a collective 'we can beat this' feeling of joie de vivre around the world.

Outside of the DMC no one has seen the details of the trial. We know 38,955 of 43,538 participants have received two doses of the vaccine, that there have been 94 symptomatic cases of COVID-19 in participants and that 'above 90%' were in people receiving placebo. The DMC states that 42% of trial participants have 'racially and ethnically diverse backgrounds'. All of this is positive and even if the final efficacy of the vaccine when the trial is complete is lower it will still almost certainly be more effective than most flu vaccines and be a major contributor to controlling the pandemic.

But as Jonathan Van-Tam has said we need to be cautious (JVT actually used a penalty shoot-out analogy which must be a first for a deputy CMO). What we don't know is as important as what we do know. We don't know how many of the trial infections were in older vulnerable people. Given that this is the group that needs protecting most this is a rather important gap in our knowledge. We don't know if the vaccine prevents infection, just that it prevents symptomatic infection. Until we know this it remains a tool for reducing mortality and hospital admission rather than one to create herd immunity. We don't know why over 4,500 participants have only had one dose (it can't all be slow roll-out) and whether this demonstrates the challenges of getting a two-dose vaccine distributed using a -80 degrees centigrade cold chain.

The final Rumsfeldian known unknown is the safety of the vaccine. Ever since the Cutter incident of 1955 (when symptomatic polio in recipients of vaccines made by the Cutter company resulted in mass recall as well as terrible morbidity), the risks of new vaccines have tempered the public enthusiasm for their use. It is likely that this vaccine is safe but it is a new technology and given we have not used mRNA vaccines in humans at such scale before we need to be absolutely scrupulous in patient safety monitoring. Large numbers may be needed to detect significant risks – the risk of Guillain-Barré syndrome with swine flu vaccine in the 1970s was estimated at 1 in 100,000.

But, and it is a big but, this is a massive step forward. It seems likely that other vaccines will quickly follow and if this one works more are likely to (indeed even as this goes to press Moderna have just announced equally exciting results with their vaccine). There will then be a set of complex decisions to be made about who gets which vaccine and how these are delivered (the Oxford vaccine does not require storage at such low temperatures). This isn't new – just think of the different flu vaccines used for different age groups – but a new two-dose vaccination programme will be quite a challenge for the NHS to deliver over a difficult winter.

Sweet child o' mine – exams and addressing concerns of trainees

As I have written about many times in this bulletin, the running of exams during the pandemic has been a great logistical challenge with 'the sands constantly shifting' beneath us. It is therefore nice to report some positive news.

Earlier in the week I was copied into a Twitter conversation about PACES and applying for places for the next diet in early January. The Federation IT systems are in need of upgrading (an upgrade is planned) and one legacy of the current systems is that to apply for a place for the next exam you need to pay up front. Those who have taken the exam this autumn are still awaiting their results (I'll come on to that) so as things stood would have had to pay up front again just in case they needed a resit. This was obviously a needless addition to the stresses, financial and otherwise, for those candidates.

We have now sorted this such that when the window opens for applications (on 25 November) those without results will be able to apply for a place without having to pay up front. We are also getting much closer to being able to release the PACES results. We have had to wait for a much larger number of candidates than usual to complete the exam to ensure the results are fair following the introduction of changes in format due to COVID-19. We should be able to start releasing results in the week commencing 23 November. For those who have taken Part 2, the results should be available a week later.

There has been considerable pressure to move to a non-clinical exam format for physicians in light of the pandemic. This would be challenging for many reasons. The ability to detect clinical signs, interpret and communicate them is core to who we are as physicians. We know that such skills improve patient outcomes, save resources and reduce legal costs for health systems. As these systems come under more pressure in the years to come these skills will be needed more than ever. Importantly, trainees also want a clinical exam and as is almost always the case they are right on the mark.

The last thing to say on exams is that we have successfully completed our first diet of PACES in Pakistan despite the pandemic. This was due to the hard work of local examiners (a big thank you to them), support of the government and frequent rapid testing. The latter has to be part of the solution for ensuring we can continue training and examining successfully during the pandemic. Which brings me on to …

It's so easy – improved testing strategies

I'm not going to talk about NHS Test and Trace (I am keen to keep my blood pressure in the normal range) nor mass population testing in Liverpool and other cities but there does seem to be progress with regard to regular testing of healthcare workers in the UK.

We know that nosocomial infection is a significant problem as community prevalence rises and hospitals strive to keep elective activity going. Some infections in healthcare staff will be picked up at work but most are picked up in the community. The problem is that as we all work in teams the detection of one individual in a team often results in mass self-isolation and has a subsequent impact on that team's work. Regular staff (and patient) testing allows hospitals to keep 'COVID-secure' areas going as well as staff working in the hot areas. Traditional swab-based PCR is clumsy as a way to do regular testing as it is not only unpleasant but has considerable delays in processing.

Lateral flow tests seem to be the answer in this setting. Such tests rely on detection of viral proteins as opposed to RNA and thus can be much more 'near patient'. At the moment most still rely on a swab but the use of saliva is looking promising. Nine such lateral flow tests have just been assessed by Oxford University and PHE with an overall sensitivity of 76.8% and specificity of 99.7%. Both are important.

The low sensitivity is the price we pay for looking for antigens rather than amplifying RNA and there is a school of thought that says this is not a problem as those with highest viral loads are the most infectious. There is of course no evidence for this but it does seem unlikely that those with really low levels of detectable RNA are infectious. It does mean that we will miss a quarter of infected people with a one-off test. Thus, twice or even thrice weekly staff testing may be needed to improve sensitivity.

The significant, if small, false positive rate of 0.32% is also important. My trust has 13,000 members of staff. If they are tested twice weekly this will result in almost 100 people having false positive results and if they and all their work contacts self-isolate quite an impact will be felt. This impact would be reduced considerably if a PCR test is used to confirm the result and thus minimise false positivity rates. Such 'reflex' testing will be the norm once these tests are rolled out, although the logistics for this will need to be sorted such that results of reflex tests are available quickly to prevent any unnecessary staff absences.

Welcome to the jungle – how hospital services are perceived by the public

The hard balance between COVID-19 facing services and urgent and routine non-COVID services can only be achieved with regular testing until a vaccine solution is realised. It is interesting how this has changed the way health services in the UK are perceived. The Richmond Group of Charities has just published the results of work on how COVID-19 has shaped experiences and views of health and care. In short, the pandemic has reinforced already strongly held views – the NHS has caring and dedicated staff and is overstretched and understaffed.

What has shifted is the way 'service users' (I'm not sure I like that phrase) think the NHS will always be there for them. Many feel left behind and fear the effect the second wave will have on their long-term health. There isn't anything in the report about the fears of catching COVID-19 when coming to hospital. I found this surprising as this is something many patients have said to me but maybe this reflects my patient group. I think many also worry that access to healthcare is getting harder because of the pandemic and it will be harder to navigate through than before.

Paradise city – the unrecognised success of non-ITU care

One of the things that has frustrated me throughout the pandemic is the focusing of the media on intensive care settings when reporting. There is absolutely no doubt that the ICM community has been a brilliant example of how close collaboration and research by clinicians can improve patient outcomes. I was lucky enough to be part of the opening session of last week's Society for Acute Medicine conference where Mervyn Singer reflected on this aspect of COVID-19 care.

However, more than 85% of hospitalised COVID-19 patients at any one time are under physicians on the respiratory and medical wards and this seems to be forgotten by the media and politicians. The figure is even higher once length of stay and pre- and post-ITU care are taken into consideration. We may not have as many machines that go ping (although we do have a few) but without the tireless work on the medical wards we would not be able to cope with the pandemic.

Such work has resulted in the rapid progress of respiratory services. Respiratory support units (RSUs) do not have the profile of critical care units but at the moment they are one of the jewels of the acute medical services. For those who have not heard of RSUs, they are dedicated areas in respiratory wards where CPAP, non-invasive ventilation and high-flow nasal oxygen therapy can be delivered by specialised teams. Before COVID-19, 77/136 English hospitals had such units and in the context of COVID-19, hospitals with such units have had lower rates of escalation to ITU compared with those without.

It would be great if such success could hit the headlines more often. ITUs are great places but paradise and home for me is the medical ward.

Down on the farm – other positives in the RCP world

This week membership of the RCP passed 39,000. Since I became a consultant the RCP has doubled in size and its activity has followed suit. It is a very different organisation to the one I became a fellow of in 2005. We have seen a downshift in median age and big increase in diversity since then. Both strong positives.

My first 'big job' at the RCP was as director of the Medical Workforce Unit which runs the annual census. This has proven a most valuable tool in providing data and analysis to influence the political agenda. Being able to quote that only 57% of consultant physician appointments were filled last year is much more powerful than just saying 'we need more consultant physicians'. This year's census will be launched tomorrow so look out for your personalised email.

Our education and conference offerings for personal and career development as well as the added bonus of CPD points continue unfettered by COVID-19. Many of these are now virtual but we are planning ongoing face-to-face events in the early part of 2021 depending on the situation. Find out more about these educational opportunities.

Registration for Medicine 2021 is still open and I understand that the Tom and Jerry of the medical cartoon world (that's the academic vice president and me) are about to appear again to promote it.

...and finally

Last week I 'celebrated' my birthday (in a touch of irony not lost on me I share my special day with the Bodleian Library). It was fun day although it would have been much better if the family could have got together. I received a lot of books and vinyl (two of my passions) as well as a few personalised gifts. One demonstrated a modern dilemma in the 'Amazon era'.

Someone sent me a most marvellous tree of fudge via the post but alas it came with no clue as to who sent it. Not saying 'thank you' is rude and asking people if it was from them is embarrassing for all. I can use this bulletin as a public way to say thank you (so I will – thank you anonymous hero) but what will I do if I am faced with this situation in the future when no longer writing such bulletins? Answers (non-anonymously) on a postcard please.

23 November 2020

Another week has flown by in a blur, and as cases in many parts of the UK start to plateau and more news is released about vaccines, there is a more upbeat feel in our world. I've been on call this weekend so this bulletin may feel a bit more rushed and disjointed than usual (much like I do when on call).

There's no other way – vaccines and regular testing

As expected, vaccine news is coming thick and fast. Moderna announced the results of their phase III trial a week ago and the Oxford/AstraZeneca group the results of their phase II trials on Thursday. The Moderna vaccine, like the BioNTech/Pfizer one, is an mRNA vaccine and the results are impressive. We then awoke this morning to the Oxford/AstraZeneca phase III interim results showing a 70.4% efficacy. However, the same cautions I suggested last week apply – we need to understand efficacy in the most vulnerable groups, see the trial data in more detail and safety data is needed.

The Oxford/AstraZeneca vaccine phase II paper was really helpful in exploring some of these concerns. It looks like the oldest people who got that vaccine were 83 (in the single dose 70 years and older group) and 82 (in the double dose 70 years and over group). The median age in these groups was 73–74. Given that the median age of people admitted to hospital with COVID-19 is 72 and the average age of care home residents is 87, data on older age groups are vital.

The results this morning appear superficially less impressive than for the other two vaccines for which interim phase III data have been released. However, this most recent study showed evidence in reduction of asymptomatic infection (a new but critical finding) and the easier storage requirements for the Oxford/AstraZeneca vaccine are helpful. This, together with the fact the UK has bought large amounts of this vaccine, means roll-out should be a question of when not if.

The NHS has now published its COVID-19 vaccine deployment strategy. The plan is for the system to be ready by the beginning of January even if the vaccines are not. There are three delivery models for the vaccines – NHS trusts, large scale vaccination sites, and community/primary care led. The vaccines themselves will be critical to deciding which and when based on cold chains and vaccine stability. I note my trust is on the list of vaccine hubs and I know we are getting geared up. The Oxford/AstraZeneca study also showed that there are a lot of systemic side effects and this is likely to result in some operational issues. If someone gets a temperature of over 38 on day two (like a significant number do), do they need a COVID-19 test?

On this subject, like many of you I have now received my lateral flow antigen tests for twice-weekly testing. Mrs G, who works in a GP practice, is most jealous but for any GPs reading this I understand your time will come very soon. The throat swab remains deep and unpleasant but at least the nasal one is only an inch in (for younger readers that is 2.5 cm). The last time I had to read a lateral flow test in anger was over two decades ago when my daughter was minus 8 months old. I'm not sure back then I would ever have entertained it becoming a twice-weekly routine.

To the end – risks of haemodialysis during the pandemic

As things stand the plan is for care home residents to be among the first to receive the vaccines when they become available (pending all the caveats I have mentioned). While the risks of COVID-19 in this group are well-recognised there are other populations at as high a risk who receive hospital-based care.

One such group are patients on haemodialysis (HD). The latest data from the renal registry are alarming. In the UK there have been 683 deaths from COVID-19 in ICHD from a population of around 24,290 (2018 figures), nearly 3 %. Shielding only works so far and when patients have no choice but to travel frequently to a dialysis unit it is unsurprising that there is a higher rate of infection in this group. That the infection has such devastating consequences for these patients also needs to be recognised.

Parklife – vitamin D

Sunshine is good for you and the vitamin D story continues to develop. Several studies show an association of vitamin D levels and severity of COVID-19 (including in hospital staff) and a recent paper in *Nature* suggests a protective role of UVB radiation and COVID-19 mortality. The traffic is not all one way but certainly much heavier in the direction of more than just association. There are also emerging data that supplementation may alter outcome.

A group in Córdoba (in Andalusia, Spain) have shown a reduction in ICU admissions with calcifediol supplementation in what they describe as a pilot study. The trial was a 2:1 design and the reduction was impressive – 13/50 in the control group needing ITU compared with 1/50 in the calcifediol group. Patients all received azithromycin and hydroxychloroquine as well and the relevance of this is unclear. I also don't quite understand why such an impressive result gets published in a journal many of us don't tend to read – the *Journal of Steroid Biochemistry and Molecular Biology* – but there is a multicentre study looking at this treatment in Spain (the COVIDIOL study) and I await this with interest.

A paper in *Clinical Medicine* this month is also worth reading as it suggests that we are not using an adequate recommended dose of vitamin D for those at risk of deficiency. Having read this I can see that it is reasonable for those at highest risk of deficiency (eg care home residents) to have 800–1,000 IU a day. The RCP will look formally at these new data to see if our current stated position should change. Whether everyone should be on vitamin D supplements will remain a topic of hot debate for a while.

Chemical world – dexamethasone in older people

I have been struck by the side effects of dexamethasone in the patients on my ward during the second wave. Indeed, I have spent most of the weekend juggling insulin and fluid balance as well as managing the odd mood disturbance (in both patients and doctors). The patients on our ward are older and many not for escalation and it has made me wonder whether the high dose used in the RECOVERY trial is right for this age group. Looking at the *NEJM* paper there is no discussion about side effects of treatment, although many of the trial participants were over 80, showing dexamethasone is effective from the COVID-19 point of view in this age group.

There also doesn't seem to be any evidence of increased risk of side effects in older people for 6 mg dexamethasone in my brief read of the literature (done on Saturday evening while waiting to take someone to theatre). It is quite a high dose, equivalent to 40 mg of prednisolone, and while this may be fine for a 60-year-old man who is 110 kg, I suspect for some of the 85-year-olds who are half this weight it might be a little excessive. WHO doesn't raise any concerns in its guidance either but I would be fascinated to know if others have noticed this or whether we are just having an unusual few weeks.

On the whole it seems that 'older' people have proven more 'resilient' to the mental health impacts of COVID-19 and the measures to control the disease. This obviously doesn't apply to care home residents and the ways in which the impact of isolation can be mitigated by rapid testing of visitors is being explored by Adam Gordon (the president-elect of the British Geriatrics Society (BGS) and a Derby consultant, not that I'm biased) and others. The BGS website has some excellent resources on managing the pandemic in care homes.

Coffee and TV – Medicine 2021

I don't know where you are reading this but hopefully it is in a relaxing setting with a cup of coffee or similar. More likely, though, it is squeezed between bits of clinical work. It is important to try and take dedicated time out to learn as well as reflect on the good bits of medicine. That is the concept behind the RCP Medicine 2021 conference in January. We've been working hard on trying to get a good mix of CPD-related educational talks, some slightly different talks and opportunities to relax. The format will allow people to attend as and when they can as well as join in with the more unusual aspects.

If you want to know more (or just want to see what a fool I can make of myself in cartoon form) check out the conference video or Medicine 2021 website.

Trouble in the message centre – update on the potential sale of RCP assets

I remain the recipient of a large postbag from librarians across the world very concerned that they have been told that the 'RCP has announced it intends to sell a large number of books and manuscripts'. For the avoidance of doubt we have made no such announcement. If we ever do decide to sell some of our assets it would almost certainly only be a small part and books whose content is non-medical.

Over 700 fellows, members and non-members signed an open letter to me expressing similar concerns about the finances of the RCP and the sale. I have responded in depth to this letter. One of the outcomes from my response was a commitment to survey the membership. In that response I offered to meet some representatives from the signatories to talk through their concerns. This happened last week and the meeting focused mainly on the finances. We had hoped to agree the details of the survey in that meeting but ran out of time. The survey will happen but may be delayed by a couple of weeks.

Our financial position continues to improve weekly due to the hard work of many people and the impact of steps we have already taken.

You're so great – research award winner and research news

While on paper we have some fairly large funds in our accounts, many are 'restricted' ie can only be used for the purpose stipulated when they were given to the RCP. Although this makes managing the current financial issues harder it does mean we can continue to support activities that COVID-19 has hit hard, such as research. We had a recent bequest from Dorothy Whitney-Wood which stated:

'…this money be used to establish the 'Whitney-Wood Scholarship' such scholarship to be awarded from time to time at the discretion of the President and Officers of the Royal College of Physicians for research in the field of medicine preferably concerned with the understanding and management of cancer'.

I'm delighted to say that we have now awarded our first grant (£50,000) under this fund to Dr Stephen Sammut whose project aims to investigate whether breast tumour T-cell dynamics during chemotherapy are associated with response, and to develop a Bayesian predictor that uses on-therapy molecular data to enable physicians to identify treatment failure at an early stage. Well done Dr Sammut. While I need to look up Bayesian methods to understand them it is good we have brilliant people like this who don't need to.

Talking of research, we launched our research and innovation hub last week. This is a focal point on the website for those interested in research and acts as a resource to support development of research skills. This is part of our research strategy. COVID-19 has shown how strong and effective our research groups are in medicine and we must do all we can to build on this.

The final thing to say about research is that we have been working hard to develop the role of 'associate principal investigator' with the RECOVERY trial teams and this is going well. Incidentally, we will have a plenary update of that trial at Medicine 2021.

Turn it up – audit, guidelines and census

This week is Clinical Audit Awareness Week. Clinical audit is a huge part of our identity as a college and part of our 'improving the health and healthcare of everyone' vision.

The RCP has a long-standing history of leading and championing national audits. These currently include the National Audit of Asthma and COPD (NACAP), National Mesothelioma Audit, National Lung Cancer Audit (NLCA) and the Falls and Fragility Fracture Programme (FFFAP) which encompasses the National Hip Fracture Audit (NHFD) the Fracture Liaison Database and the National Audit of Inpatient Falls (NAIF). These are internationally recognised leading audit programmes and have led to significant improvements in the quality of care for patients as well their clinical outcomes.

At the onset of COVID-19 the mandatory requirement for data to be entered was relaxed in recognition of the pressures on clinical teams. This impacted on our audits in different ways. The NHFD impressively delivered an additional facilities audit focusing on how the pandemic was affecting hip fracture services, and had very high completion rates.

In other areas including the NACAP and the FLS-DB, pressure on frontline staff (mostly physicians) and redeployment of staff negatively impacted participation in the data collection and improvement work. For NACAP, the participation level of trusts has fallen from 96% to 51% during COVID-19. However, it is vital that we understand the impact of the pandemic on our patients with airway diseases and lung cancer and so if your teams contribute to the audit please lobby your organisations hard to get data flowing again.

Our audits sit alongside other activity to improve patient care and the lives of physicians. We have just produced two important new sets of guidance – on PPE and specific ward round guidance during COVID-19.

Collecting and interpreting data are a powerful way to demonstrate the need for change. Our census, which I mentioned last week, provides the most powerful evidence for increasing the medical workforce. We sent it out last week but not everyone got it as it went into some people's spam filters (we try hard to prevent this but it is not always successful). If you haven't seen your census email please do check your spam folder.

And finally...

I had an email this week titled 'book news'. My heart sank as I opened it expecting another email about the 'sale of RCP books' and to be told I was a 'vulgarist pillager' or similar by someone with a far better vocabulary than mine (while many emails on the topic have been balanced and helpful, some have been most unpleasant).

To my wonderment it was from a fellow who has written a book to help reframe public understanding about ageing and asking if I wanted to read it. This was the easiest decision of the week and I am now devouring the book's pages and will update you all when I've finished it.

It made me realise how much emails and their contents can impact on our lives and moods. I hope all your email traffic today makes you smile.

30 November 2020

There are now less than 4 weeks to go until Christmas. The biggest news in the UK this week was the PM announcing the government's plans for how households can mix over a 5-day period forming the so-called 'Christmas bubbles'. In our household that phrase usually refers to a particular Canadian singer and I'll come on to the implications of the new rules later.

The past week has seen the release of a whole shelf full of reports and papers which I will try to cover but first I'll update you on the hot topic of the moment, vaccines.

Gotta be patient – vaccines

There has been a bit of furore in the past week over the dosing of the Oxford/AstraZeneca vaccine. If you missed it there was a dosing error in the phase III trial that resulted in 2,741 of the participants receiving a 'half-dose' for the first of their two injections. This error has been explained as a problem with the process of how the concentration of vaccine was measured. We don't know the details of this, only that the regulators were informed and the trial allowed to continue.

In a twist of medical fate this error has proven to be very fortuitous with the results in this group being better than for those who received two full doses: 90% versus 62%. We need to see the details of this study before being able to understand this fully and, while very promising, the interim results have been undermined somewhat by this situation.

Of course, big leaps in the treatment of infectious diseases have been down to such serendipity before. What if Fleming hadn't left his window open and La Touche hadn't been working with Penicillium rubens in the room below? What if the culture plates with *Helicobacter pylori* hadn't unintentionally been left in the incubator for 5 days instead of the normal 2 over the Easter break? We will need to wait for the full results and the wisdom of the regulators (the MHRA in the UK) who will have access to much more

data before we know if this will go down in medical history as a great leap or a small mis-step.

The biggest challenge, though, will be ensuring healthcare worker and patient confidence in whatever vaccine strategy is eventually employed in different countries. Vaccine hesitancy is a significant hurdle to the success of using vaccines as a way to control any infection. Confidence in trial results is part of this, but understanding the safety data a bigger part. This is why we must be patient and await the final trial results for all the putative vaccines before rushing ahead.

Reading through the various trial interim press statements and related articles has got me thinking about the shift we have made from the era of blockbusting drugs to blockbusting vaccines. More intriguingly, will the vaccines get a similar makeover afforded to such drugs as omeprazole and gain a 'catchy' name? What will AZD1222 be called – 'protectazole' perhaps?

Finally on vaccines, it is important that we do not forget the flu vaccine especially given the news this week that avian flu is ruffling a few feathers both literally and metaphorically. While flu rates remain low it is still important we encourage our patients (and ourselves) to get vaccinated this season.

Cry me a river – the eye-watering costs of PPE and the pandemic

This week the National Audit Office released its long-awaited report on the supply of PPE in the first wave of the pandemic. The amounts of money reported are staggering and can be summed up by this statistic: in 2019 the NHS spent £146 million on PPE, between February and July 2020 it spent £12.5 billion (almost two log orders more).

The report is sympathetic to the challenges of acquiring large amounts of PPE against a background of low/absent stockpiles in a global market where demand far outstripped supply. It praises those involved in setting up and delivering the new supply chain. However, it does not hold back on the mistakes made and cites our and others' data on the lack of availability of PPE on the frontline. This still seems to be denied as a real problem by some.

Hidden in this report is another chilling stat I had not seen before. Apparently, employers have reported 126 deaths to the HSE that they believe were due to occupational exposure to COVID-19. £12.5 billion may not have been too little but for some it may well have been too late.

Another long-awaited financial landmark this week was the Treasury's plans in the Spending Review. The NHS fares well but public health and social care have not had the support they will need, which seems a bit odd given what the pandemic has taught us about the health inequalities present in our society and the need to focus on prevention rather than cure. You can read my blog on the Spending Review.

To my understanding most predict that we will not get back to 2019 levels of GDP until around 2024. The times of austerity are back.

Whatever it takes – treatments update

The NHS alert system was used this week to highlight the promising results with tocilizumab in the REMAP-CAP study. Tocilizumab is an IL-6 blocker and has been used in the 'immune-modulator' arm of the study. In patients needing mechanical ventilation it improves outcomes by 87%. The study hasn't been peer-reviewed so a little caution is needed, but this suggests a better effect than dexamethasone.

Talking of which, in my bulletin last week I raised the issue of the side effects of steroids in older people and your responses suggest that I am not alone in observing an effect. One seemingly positive side effect noticed by others is a feeling of euphoria, no bad thing in those facing death.

Indeed, I am hearing that a few relatives of those who have sadly died from the virus have had their grief slightly ameliorated by seeing their loved one happy in their final days.

Some might have misinterpreted my comments last week as saying 'don't use dexamethasone'. Regular readers will know I am a fierce advocate of steroids in COVID-19 and the number needed to treat (NNT) of 13 to prevent death is a very impressive one in the context of this disease. The mortality of COVID-19 in the over 80s in the RECOVERY trial was 43%. Yes, beware side effects, but please carry on using it where indicated.

The other 'drug' I mentioned last week was vitamin D and I note the UK government has now announced plans to distribute vitamin D to all care homes and offer free delivery of supplements to all those on the clinically extremely vulnerable list.

It's beginning to look a lot like Christmas – time for a double-peaked wave?

The number of cases and number of hospital admissions in the UK have now seemingly passed their peaks for the second wave. In some parts of the country these are falling very quickly and the tier 3 and lockdown rules seem to have had an effect. The REACT study results published today show a 30% drop in the number of infections in England since its last report. In Wales, which had a 2-week firebreak to good effect, levels in some parts are worryingly on the rise again. We have to wait to see how this will pan out but it does show that how society behaves (within any rules or outside of them) is the main determinant of the course of this pandemic.

In that context, then, what are we to make of the idea of 'Christmas bubbles'? We mustn't underestimate the political pressures within any government being as important a definer of pandemic policy as medical and scientific evidence. There is a strong voice calling for relaxation of social distancing and the perceived benefits this will have for families.

We have to be honest, though, and say that allowing three households to mix over a 5-day period involving multiple generations is unlikely to be a harm-free policy. SAGE have said so in their subgroup's rather benignly titled paper 'Notes on the festive period'. It makes for a quick read but they are in no doubt that the number of cases will increase, potentially by a large amount.

I suspect that this weekend there have been lots of hard conversations in the households of those reading this bulletin about how to 'play' Christmas. 'Less is more' probably sums up the conversations we've been having in mine. My suggestion of putting one of my in-laws in the shed on Christmas Day was felt to be unhelpful.

Fly me to the moon – RCP at The Spine

If you want a distraction from the all-consuming world of COVID-19 and want an idea of what the future of the RCP looks like you can now do a virtual fly-through of RCP at The Spine in Liverpool which is opening next year. It looks absolutely stunning and the short video will give you an idea of what members will be able to get from the building.

I know there are still some who do not 'get' why we would want another home outside of London but the development of the medical science sector in the north-west is moving at pace and we are at the heart of that.

Where or when – a new NHS bill looms

The medical press know that the public board meetings of NHS England often contain some very important documents, and last week was no exception. The likely future plans for integrated care systems (ICSs) were laid out in the paper on integrating care, together with legislative proposals.

There isn't much new in this as it pretty well matches the vision laid out in the NHS Long Term Plan and reiterates recommendations made over a year ago for legislative changes to support a statutory role for ICSs. However, it is a very firm steer about what the NHS says it wants and it seems

likely that legislation will follow soon. For those with longer memories this will recreate a system not too dissimilar from the health authorities of old. For those with shorter memories, whatever happens we mustn't have a repeat of the chaos that surrounded the 2012 Health and Social Care Act.

The Health Foundation released a report this week on the use of integrated care teams in one part of the UK and the assessment was rather guarded. Introduction of both types of service increased local hospital admissions rather than reduced them. As always cause and effect were unproven but the benefits for patients of new models of care will need to be clearly demonstrated if the 'system' is to buy in to such models.

Fever – managing the long-term sequelae of COVID-19

Progress is being made in the complex area of long COVID. NICE, in conjunction with SIGN and the RCGP, have produced a COVID-19 rapid guideline on the management of the long-term effects of COVID-19 which is currently out for consultation. On another front, the NHSE long COVID taskforce (which I sit on) has been hard at work.

At the meeting of the taskforce this week we had a presentation from the IAPT team. IAPT is the Improving Access to Psychological Therapies programme of the NHS and, as we know COVID-19 results in significant mental health problems in over 5%, maximising the appropriate use of such therapies is going to be really important over the next couple of years. The programme has resulted in a 52% recovery rate and 68% improvement rate for conditions where psychological therapies are appropriate. The place of IAPT in long COVID is being defined and it seems that it will be an important part of the system response to COVID-19.

The reasons why some patients develop long COVID in the absence of specific end-organ damage and others don't are not yet understood. One theory is the persistence of virus in some, and there are emerging reports that might support that, including in the olfactory mucosa of those with persistent anosmia. I would hasten to add that this is still all rather circumstantial but like all hypotheses is worthy of the ubiquitous 'further research is needed' comment.

Stardust – the RCP book club and podcasts

Like my music tastes my reading habits are rather wide-ranging and eclectic, from Gaiman, Harris and Rankin in the fiction genre to Plokhy, Powell and O'Mahony in the non-fiction one. The latter's Can medicine be cured? was an enjoyable read recently and his previous effort The way we die now is the subject of the first ever RCP book club on 9 December at 7pm.

The book looks at how we now view and talk about death in the western world compared with times gone by. Seamus O'Mahony himself will be present to answer a few questions and the event is open to all members. Like me, Seamus is a gastroenterologist but don't hold that against him. Do register to join and take part in the event.

If getting time to read is a little challenging and podcasts are your thing it would be remiss of me to not to plug our own series of excellent RCP Medicine podcasts, the latest of which is on stroke. I recently did a 'non-RCP' podcast with a couple of medical students in the How to become a doctor series which can be found on Apple Podcasts and Spotify. It was a fairly 'heart on the sleeve' trot through my life and what the RCP is all about so worth sharing with friends if they have no idea what we do.

The final media to highlight is this evening's 'Hospital' programme at 9pm on BBC2 which comes from the Royal Free and features physicians in action. I'm told there will be a focus on geriatric medicine which is great to see.

That's all – and finally

I signed off the bulletin before last with the 'mystery of the anonymous fudge parcel' which has now been solved. A kindly paediatrician from Australia was worried about my falling BMI over

the pandemic and felt I need some supplemental mouthfuls of calories. This of course puts my liver at risk of another mouthful – non-alcoholic fatty liver disease (I recently heard this condition referred to as 'fructoholic liver disease' which I quite like).

That same bulletin sign off asked for 'answers on a postcard' as to how to thank people for anonymous gifts. My week was cheered up immensely by receiving exactly that, an answer on a postcard. Email is fast, but snail mail can make one's day.

7 December 2020

It has been another fast-moving week of developments in the world of COVID-19 and rather less speedy in the world of Brexit. This is a pivotal time for the UK – vaccines and trade relationships will shape our lives over the next few years.

It's not just around the pandemic and European politics that there are winds of change. At the risk of sounding very British, the weather itself has also taken a turn this week – snow in the high land and hard rain elsewhere.

Release – vaccines

The big news this week has been the authorisation of the Pfizer/BioNTech vaccine by the MHRA. While some have (falsely) linked this with Brexit there has been very close working between the MHRA, Pfizer and the Joint Committee on Vaccination and Immunisation (JCVI) to ensure all the data have been reviewed by the relevant groups before marketing authorisation was granted.

Many of the safety and efficacy data are not yet in the public domain. I would be lying if I said I was happy about this but I am told these data will be made public later this week. I have also been reassured that the MHRA has seen a huge number of documents relating to the trial data and would not have authorised the vaccine without this. Being a soft touch is one thing the MHRA could never be accused of.

The roll-out of the vaccine will not be without risks but it is the only way out of the pandemic (unless you count doing nothing). Mass testing is not the answer – as someone said earlier in the year 'you can't test your way out of this' – despite some politicians around the world believing so. Therefore, we are going to have to live with and manage the risks that will come with a vaccination programme. Managing risk/benefit in clinical settings is one of the USPs of doctors and as things stand the benefits

of vaccination far outweigh the risks as we currently understand them.

The rationale behind who we vaccinate and in which order is explained beautifully clearly in the JCVI advice on gov.uk. Age remains the biggest determinant of mortality from COVID-19 so prioritising all care home staff and residents and then over 80s as the first two groups makes complete sense. The problem we have this week is that the vaccine is not easy to transport due to the need for ultra-low temperatures, and comes in packs of 975 vials. The logistics of getting this out to care homes is keeping many awake at night. Wasting any of the limited supply of vaccine would be a disaster as well as easy fodder for opponents of a vaccination programme.

There will be public challenge over why healthcare workers should be prioritised over other groups and indeed I have worried about this. It is a no-brainer that having higher risk healthcare workers on standby in the 50 hubs that have been identified for the first part of the roll-out will prevent wastage. There are four other arguments of varying strength as to why it is right to prioritise frontline staff.

Firstly, as with care home workers, there is a high risk of transmission to large numbers of vulnerable patients by a small number of staff. IPC measures will reduce this risk but not eliminate it, and the problems that infection control creates in the efficiency of health services are significant. The fear expressed by many of our patients about coming to hospitals is in itself harming lives.

Secondly, it will reduce sickness absence of staff and thus create 'workforce resilience' both in the short term and the long term. The loss of one in five London-based staff to sickness during the peak of the first wave showed the impact sickness absence has on the delivery of care. For individuals who are unable to work due to shielding or having long COVID, this loss is long term, personally devastating and, in cold financial terms, expensive.

Thirdly, in terms of profession, healthcare workers have among the highest risks of contracting COVID-19, around threefold. There is a duty on the NHS to protect its staff but as any employer knows if you don't look after your staff it rarely ends in success.

Fourthly is the reciprocating argument, ie that healthcare workers put their lives on the line for the public and this is a way of balancing that. I think that this will not hold too much water with certain parts of the press but has a strong ethical basis (I accept I also have a conflict of interest).

The vaccine roll-out will change rapidly over the next few weeks and I will endeavour to keep you up to speed. Supply and logistics will be the main determinants of how fast it happens. We don't know when the Oxford/AstraZeneca vaccine will be authorised nor when other vaccine candidates will be ready. If you want a simple guide to the practicalities of the vaccine programme the Green Book on immunisation now has a chapter on COVID-19.

We could send letters – the fellows 'Green List'

While on the subject of green things, the latest 'Green List' is now on our website for review by fellows. This is the regular list of those who have been nominated for fellowship. It used to be sent around on green paper in the days of mass mailings, hence its name. The list is something to be celebrated as all the named individuals have been put forward for fellowship, supported by their local and national colleagues and agreed by Council. They are a great credit to the profession and medicine in particular.

If you are a fellow and want to see who in your region or specialty has been nominated please log in to view the Green List. Seeing your colleagues or former trainees on the list is a nice thing. Provided there are no significant objections to those on this list they will be contacted and offered fellowship. And don't forget that the nomination process is always open – fellows can nominate colleagues at any time.

Down the dip – the size and shapes of waves

In my hospital and across most of the UK (apologies to those in the parts of the south and east where things are not easing) the number of COVID-19 cases is falling and we are seeing COVID-19 wards being reclaimed by normal winter admissions. I have developed a slight obsession with the local epidemiology of cases both in the form of hospital admissions and local numbers. The BBC website is a very easy way to look at the latter and presents local data in a graph if you input your area or postcode. The differences in shape of the case rate graphs between different areas and cities are fascinating. I have family in Derby, Nottingham and Leeds and have watched the graphs for these cities develop over this wave. Explaining why they follow such different shapes must be able to tell us what works and what doesn't when it comes to local interventions.

The prize for best graph of the week, though, goes to the Nuffield Trust. It shows the weekly number of deaths for the past 20 years and thus the impact of the second wave in a historical context. Many may be surprised by the impact of the 1999/2000 flu season and its size in relation to the first COVID-19 wave. The fact that we had the lowest number of deaths for over 20 years in the summer is also worth reflecting on.

Walk out to winter – what is happening?

Looking at this chart, the second wave is undoubtedly resulting in a tragic increase in death rates but the fact that total deaths are not too far outside the normal variation needs some explanation.

Flu and other non-COVID respiratory illnesses remain remarkably quiet for this time of year. One national reporting system shows this quite starkly. I haven't read the Emergency Department Syndromic Surveillance System reports before but when I heard that EDs were seeing far less respiratory disease (especially bronchiolitis and 'influenza-like illnesses') I thought I should check it out.

You all know I love graphs (see above) but some of these are intriguing in a wider context once you have digested the respiratory ones. There has been far less gastroenteritis since the pandemic started (fewer late-night takeaways or dodgy garden BBQs perhaps?) while myocardial ischaemia is more prevalent. If you are a cardiologist and feel like you are a bit busier this winter – you are right.

Pillar to post – outpatient experience for trainees

The change in the way medical outpatient services are run has been one of the evolutionary jumps in hospital medicine seen in this pandemic. However, the role of trainees and training in outpatient services has been a casualty. Even now I am hearing that trainees are being pulled out of outpatient services to increase numbers on the wards for this wave. This is understandable but will have repercussions given much of consultant physicianly practice is in the outpatient clinic.

Even if not needed on the ward, the ability for trainees to attend outpatients and get high-quality training is a big problem and the thing that tops the lists of concerns about the impact of COVID-19 for our trainees. Virtual (and in particular telephone) clinics do not lend themselves to the traditional model of teaching/training.

We, as trainers and trainees, have to address this and do it soon. Trainers should be making as many opportunities for trainees to attend their clinics as possible, work with their IT departments to install technology that will facilitate training and resist the push for clinics to be done from consultant offices. Trainees rarely have their own desk space and computers these days and are often not thought about when planning new outpatient services. We have to change that.

The bugle sounds again – Medicine 2021

The programme for Medicine 2021 is almost finalised and will be released tomorrow. I am beginning to get excited about the meeting and looking forward to hosting some interesting sessions from key speakers like Chris Whitty.

The first day will start with a 'good morning physicians' broadcast with Matt Hancock and others. While I am not going to go the full Piers or Susanna for that I do hope to get a little more insight into the person behind the persona. This and other parts of the proceedings aim to give Medicine 2021 a slightly different feel from other virtual conferences.

Back on board – ACCEA 2021

The National Clinical Excellence Awards 2021 round opens today for new applications and awards in England and Wales. As a nominating body we (the RCP) will be supporting and the support scheme will open on our website on 14 December. It will close after 6 weeks for new applications and 7 weeks for renewals.

The boy (and girl) wonders – the RCP Christmas lecture

Each year the RCP holds a Christmas lecture aimed at 12–18 year olds. This year's lecture will be at 3pm on 22 December and will of course be virtual. It will be given by Sir Michael Marmot and the title is 'Social justice, health equity and COVID-19'. This may sound a bit stark but talking to teenagers I know they feel as passionately about these topics as any of us supposed 'grown-ups'. Indeed, it is their future more than ours.

I wonder how much Dickens' A Christmas Carol will feature given that he understood the issues better than most but suspect the only muppet present will be yours truly as I introduce the lecture. The event is free of charge – please encourage your children/grandchildren/great-grandchildren to register and I look forward to 'seeing' them there.

And finally...

As Christmas rapidly approaches and many of the RCP staff are furloughed we will be sending out this bulletin slightly less frequently (Mrs G is happy about this). The next one will be on 16 December, and then the first one in 2021 will be on 4 January. Obviously if there is something urgent we need to communicate between these times it will be on the website and in our social media feeds.

Given the next bulletin is on 16 December I would like to finish by mentioning another Christmas event. At 11.30am on Tuesday 15 December we will be hosting a live-streamed Christmas concert at the RCP. The idea came from Max Pitcher, a fellow based at Northwick Park Hospital, who is a gastroenterologist and brilliant violinist. The event is called 'Comfortable classical with the doctors' and in addition to Max the ensemble will include consultant dermatologist Vicky Jolliffe FRCP on the violin, City of London Sinfonia's Joely Koos on the cello, the RCP's very own Julian Ogilvie on the cello and the tenor voice of A&E officer Alex Aldren. Together they will present a short programme of Christmas-themed music to celebrate all that music can do to support mental health and wellbeing, both over the pandemic and in the months to come. We will be raising funds for Crisis at Christmas so do join us if you can – the concert will be available to view on the City of London Sinfonia's Facebook page at 11.30am, and there is no need to register in advance.

Unless you have been oblivious to it, music is something that I believe can both heal and unite us.

16 December 2020

This is my last bulletin before the Christmas 'break'. For those getting a true break from work you will probably need to make the most of it, as many fear that Christmas may break the NHS in January if COVID-19 cases explode like a party popper.

I am conscious that it is not easy to get the balance right between creating a festive mood for this bulletin while accepting we all have sombre thoughts about the year that has almost passed and the rest of winter to come. I will therefore start with the most serious topics and aim to get lighter as I go on.

#RCPremembers

Tomorrow (Thursday 17 December) we will be dedicating the day to remembering our friends and colleagues in the RCP family who have died this year from COVID-19. We have produced a special edition of *Commentary* magazine online with obituaries to many of these much-missed and loved physicians. This will remain an open and ongoing edition so that if we have missed anyone or someone's obituary is not yet ready, we can update it.

While this will be a very sad day in some ways it must also be a celebration of those lives. I'm sure our friends would want us to remember the positive contributions they made to medicine and us all rather than dwell too much on the cruelty of their early deaths. If you have any reflections on a physician you knew or who influenced your life please share it on our social media using the hashtag #RCPremembers

Baby it's cold outside – winter and the second wave combine

After a brief hint of respite, the number of cases is rising again shaped in part by the increase in cases in London and the south east. Following last week's onslaught of graphs I will spare you this week but it did lead to one fellow (thank you, Andrew) drawing my attention to an interactive map of the UK on the government website I had not seen before. This breaks down the country by local authorities and shows the positivity rate in different colours. It is an 'at a glance' sitrep of where COVID-19 is most active and helps explain why hospitals around the Thames estuary, south Wales and in parts of Lincolnshire are currently feeling the pressure.

Magnifying the map and looking at the 'Middle Layer Super Output Area' (or MSOA) level is worrying. With an average population of 7,200, MSOAs are a geographical unit to allow comparison of smaller areas than local authorities (I had to look this up so you are not alone if you have not heard the phrase before). At this level of detail you can see many coastal towns in the south east with very high levels of infection. These towns have large populations of people over the age of 75 and the impact on hospital admissions over the next few weeks is potentially massive. Christmas may be a time of good cheer but not this year.

Stop the cavalry – what are the implications of the new variant?

Monday's statement by Matt Hancock about a new variant of SARS-CoV-2 being identified in the south-east of England has caused much alarm. This probably needs putting into some context. As of 13 December (the latest data on the government website) 1,108 cases have been identified and the relevance is as yet unclear.

Mutations in all viral pandemics are to be expected and although this virus mutates less frequently than many, we have seen over 4,000 different variants this year. For a really good read on the nature of spike protein mutations and in particular the D614G mutation that has swept the world during this pandemic, I recommend an article published in *Nature* in September. It will give you a new view on the spike protein and the beauty of its structure if nothing else (warning: the article contains a graph).

The rapid increase in this new mutation (called VUI – 202012/01, it really needs a PR agent) may simply be due to the rapid increase in cases that is being seen due to behaviour change of the host rather than the virus. However, we cannot dismiss that this mutation may increase viral entry to cells and thus infectiousness. Nor can we yet understand if it will reduce the effect of neutralising antibodies produced as a result of either previous infection with another strain or vaccination. PHE is looking into this and we all await their results with anticipation.

Happy Christmas (war is over) – vaccines roll out

New variants aside, over the past week we have seen the Pfizer/BioNTech vaccine roll-out begin in the NHS, with nearly 138,000 vaccinations in the first week. This has not gone completely smoothly with two significant 'anaphylactoid' reactions on the first day. When I first heard about this I was a little worried but as it transpired the two cases were in people with severe allergies already (such that they carried EpiPens) I was somewhat reassured. I'm pleased that both recovered quickly and the immediate clarification of the guidance by the MHRA was good to see as well as sensible guidance for vaccination centres. Apparently, the word anaphylactoid was used rather than 'anaphylaxis' as the vaccine is novel and the individuals had no prior exposure.

Among the first to be vaccinated was Michael Tibbs. Many older readers of this bulletin (and hopefully a few younger ones) will recognise Michael as a key figure from the RCP in the past. Now aged 99 he was secretary of the RCP (a role that no longer exists) between 1969–76. He was in post when David Pyke became registrar and described Pyke as having 'youthful exuberance'. That Michael has survived David by many years may suggest exuberance is not good for your health. I had the immense pleasure of sitting opposite Michael at a dinner a couple of years ago – his wit and intellect are as sharp as ever.

Quite a few frontline workers have now been vaccinated to prevent any vaccine being wasted at the end of the day, but this is as yet a tiny proportion of the workforce. The limited supplies of vaccine mean we must all continue to be scrupulous in our behaviours in the workplace and outside it. Colleagues in my hospital continue to become infected and it will be many months before vaccination will have a chance to significantly reduce transmission.

Stay another day – Brexit decisions delayed

While it seems a lifetime ago that COVID-19 was first identified, Brexit has been with us for five times as long. Another chapter in that saga will have ended by the time I write my next bulletin, and as I write this one it looks like the much-feared 'no deal' is the only thing left on the table. I don't know if the rumours that our PM was served two courses of fish when he met the EU commission president last week are true, but it seems unlikely we will have more than cordial relationships with the EU from the beginning of 2021.

The DHSC is working to ensure continuity of medicines supply for the end of the transition period and members may be interested in a recent letter from chief pharmaceutical officer Keith Ridge, advising NHS organisations not to stockpile locally and to not change prescribing behaviours.

The UK will spend much time over the next few months/years working on trade deals with other countries around the world. This is important to the health sector both from the point of view of the NHS supply chain but also whether access to and parts of the 'NHS' are used as bargaining chips in negotiations. The latter seems far less likely following the House of Lords amendment 11 to the Trade Bill passed last week.

As with many negotiations it looks like this one is going to go to the wire and, like many, I really hope that we don't end up with no deal.

All I want for Christmas is you – PACES and IMY3 alternative certification

I have written about the impact of COVID-19 on training many times over the past few months. Looking back over the year there have been some remarkable successes in the delivery of exams and the flexibility the system has made for trainees. There are a couple of issues though which are causing me (and, more importantly, trainees) to lose sleep.

The first is the capacity to provide and prepare for PACES. Finding 'COVID-secure' ways to provide the written exams, while not without challenges, has been relatively straightforward. Delivering PACES has been less so as two RCP centres had to cancel at short notice recently (and this remains a risk for the first diet of 2021) and the number of cycles had to be reduced for all. We therefore need as many centres as possible to run in 2021 to catch up with the backlog and ensure all trainees needing to take the exam can do so. We also need to ensure that candidates are supported in their preparations for the exam and practice PACES sessions are a vital part of this. Some trusts are showing resistance to both but our trainees need us to push hard on this. If you can help out please do, for example put on another day of examining if you are a host site.

The second is around the 'alternative certificate' for IMY3. To put this in context, when the transition between CMT and IMT was planned it was always expected there would be some trainees who might fall foul of the system as for various reasons they had finished CMT but did not move straight into ST3. One solution was to have a way to recognise additional training time as equivalent to IMY3 to allow them to enter at ST4. The devil is, as always, in the detail, and the strict requirements (time-based which is a bit odd for a competency-based system) for geriatric medicine and critical care is causing some issues. Thus someone who successfully completed the CMT programme and has PACES may still be unable to get an alternative certificate.

I'm assured that each trainee should be considered on their own merits when applying for the certificate and that there will be flexibility as to how any gap between their training and what is needed for 'IMY3 completion' is removed. This is a matter of urgency for us and I hope that we can get a fair and consistent process for all.

Winter Wonderland? – bamlanivimab

An EUA in my book is an 'examination under anaesthetic' but in the US it is also used to describe an 'emergency use authorization'. An EUA has just been issued for bamlanivimab, a monoclonal antibody against the receptor binding domain of the SARS-CoV-2 spike protein following a phase II randomised, placebo-controlled study (BLAZE-1) published in the *NEJM*. Bamlanivimab can now be used in patients in the US with a defined set of higher risk factors for mortality.

This is a fascinating development in the pandemic but close reading of the paper suggests we should not all rush out to get our infusions just yet. The antibody was administered in one of three different infusion doses to symptomatic patients once they had a positive PCR result and then viral loads were monitored as a primary endpoint and hospitalisations as a secondary one. Only one dose (2,800 mg – the others being 700 mg and 7,000 mg) resulted in a statistically significant decrease in viral load and while the hospitalisations were

6.3% in the placebo group and 1.6% in the treated groups the lack of a p-value in the paper is a worry (on a simple chi-square it would be 0.02).

I was struck by the fact that 88% of patients in the trial were white with a median age of 45. Such a treatment seems unlikely to be cheap and I worry that it will be unaffordable to those who need it the most in our society. The virus has shown itself to be discriminatory but we should make sure we are not when it comes to treatment.

Please come home for Christmas – updated ACT for older people

The acute care toolkits (ACTs) are a perennial favourite download from our website and we have recently updated our ACT for older people living with frailty.

Older people are major users of acute care and the AMU is a key area for initial decision making, as well as for education and training relevant to older people. Different models will be suited to different hospitals, but all need to be able to initiate comprehensive geriatric assessment (CGA) within the AMU and to have strong links with community health and social services. Geriatricians supporting the AMU are able to help identify older people who may be safely managed in the community, improving patient outcomes and reducing hospital bed days.

I have also nearly finished the book about getting older which I mentioned a couple of weeks ago. Although aimed at the public, it is full of fantastically useful information for clinicians. I'll do a more detailed review in January.

Underneath the tree – where do you put your test tube?

My father, a retired chemical pathologist, is a keen collector of historical laboratory equipment and children's chemistry sets. The Goddard family seat has therefore always been full of such equipment but sadly this gene was not passed on. This has created a challenge with regards to home lateral flow testing – how do you hold the test tube? I use a small 'koala clip' brought home from Australia by my daughter just before lockdown which does the job nicely. Asking others, it appears that the toothpick/cocktail stick jar works well as does a sellotape dispenser on its side. Another challenge I would not have predicted a year ago.

It's the most wonderful time of the year – Medicine 2021

Unlike the weather, the programme for Medicine 2021 is hotting up in many ways. I am really excited about joining MasterChef 2017 winner Dr Saliha Mahmood-Ahmed in the RCP kitchens to get a lesson in the culinary arts. Saliha is a gastroenterology trainee so I'm looking forward to hearing her thoughts about the future of our specialty as well as the challenges of training during COVID-19. The cooking session is followed by some more traditional medical education offerings – one on glucose control and one on cholesterol management – you've got to love the programme planners.

Another hot booking is that of Greg Whyte, Olympian and trainer to the stars of Comic Relief and Children in Need. Greg is a vocal supporter of the benefits of physical activity for all and will be helping us all be a little less sedentary during the conference with two sessions.

If you haven't yet registered there is still plenty of time. Wellbeing will be a recurrent theme throughout the conference and if you are looking for some supporting material for your team we also have a new online wellbeing course developed in collaboration with Maudsley Learning. It is free and has a CPD credit.

Another great initiative led by an RCP-convened clinical group is an update to the COVID-19 web tool created to support clinical staff with implementation of the NICE COVID-19 rapid guideline: critical care in adults (NG159). Led by Alastair Gilmore, the online resources support the use of the guidelines and signpost healthcare workers from all disciplines to examples of best practice.

Our National Asthma and COPD Audit Programme (NACAP) published its 2019 pulmonary rehabilitation clinical and organisational audit report, presenting data on the care received by over 12,000 patients. The report is a rich source of information for quality improvement including recommendations, QI priorities and case studies.

It's beginning to look a lot like Christmas – RCP events

Last week I included a link to a Christmas concert by the City of London Sinfonia which we held in the Dorchester library. If you missed it, you can watch it again. One of the violinists, Max Pitcher (my registrar when I was a medical SHO) spoke about a magical moment in his hospital where music and COVID-19 came together. It was very moving.

Our last hurrah for Christmas is the RCP Christmas lecture which will be given by Sir Michael Marmot at 3pm on Tuesday 22 December. It will focus on health inequality and is aimed at 12–18 year olds (at heart as well as in reality).

And finally...

As 2020 draws to a close I suspect we would all like to take it back to the shop and get our money back. It has been an annus horribilis for many of us and 2021 cannot come soon enough.

Yet arguably it has been a year of some of the fastest advancements in global medicine seen in our lifetimes: discovery of a new pathogen to roll-out of a vaccine in less than 12 months; transformation of outpatient activity to the virtual world; successful multi-centre drug trials on a scale never seen before; and a realisation of what we have forgotten – human life is precious and must be valued.

Medicine at the end of the day is all about people. 2020, if nothing else, has brought us back to that.

2021

6 January 2021

Welcome to the first bulletin of 2021. This was due to go out on Monday but delayed until today following Donal's tragic death at the weekend. The situation for some of the issues I have covered has also changed in those 2 days, which says much about the times we live in. It has also been a remarkably busy 3 weeks since my last bulletin: the AstraZeneca/Oxford vaccine has been authorised, a trade deal signed with the EU, most of the NHS in the UK is experiencing the busiest time in its history, Christmas and New Year's Day passed as never before, and we have now gone into our third full lockdown in England.

One …

As many of you will have seen from Monday's email, the RCP year began with profound sadness at the death of our much-loved registrar, Donal O'Donoghue. I wrote almost all of this bulletin before learning of this tragic news and considered either not sending it or changing the content substantially. Donal said he always enjoyed reading the bulletins and on reflection I know he would not have wanted it changed. He always looked on the brighter side of life, and would want us to as well.

We will be honouring Donal's memory with a full tribute in our *Commentary* magazine out shortly and thank you to everyone who has shared their love on social media and sent messages into the College which we are collating in a book of condolence for Donal's family. Although the past few days have been difficult, I have been buoyed by the overwhelming number of messages of love and appreciation for Donal, who touched so many people during his life. Most mention his kindness, generosity, warmth and support for colleagues and patients alike.

His support to me (as a friend and wingman) and the RCP has been indefatigable and his illness had already made me reflect on the huge value of friends and colleagues when things are tough. His death has brought this into even sharper relief. Our lives will all be poorer without him.

Over the past year, Donal and I have had many discussions about the future of the RCP. His desire that all the different parts of the RCP should work together as 'one RCP' in 2021 was the main topic of our last conversation. As always, he put the good of the others and 'the many' first. May he rest in peace.

Stuck in a moment you can't get out of – NHS pressures

Many predicted that this winter would be the worst the NHS has ever experienced, and while we all hoped this would not be the case, it is coming to pass. The latest figures on hospital acute and general beds occupied by patients with COVID-19 is frightening and the data as published by the HSJ will show you where your hospital lies. I linked to a similar table a couple of months ago and the difference between then and now is stark in terms of the size of the problem, the geographical distribution and the rapidity of the increases seen.

The North Middlesex University Hospital NHS Trust has 63% (yes, 63% – that isn't a typo) of its medical beds occupied by patients with COVID-19. My hospital (Derby, if you didn't know) feels bad at the moment but is only at 21%. To have three times the occupancy rate is mind-blowing and, to be frank, very scary. The only positive thing about this table is that those with the highest levels 2 months ago are on a downward trajectory. The new variant may put paid to that though.

We also haven't yet seen the full effect of Christmas mixing (all things nice will not be included in this particular Christmas 'pudding'). I haven't seen any data as to how much people obeyed the rules on Christmas Day and know of many who were even more abstemious in their behaviours. The coming week will give us a good idea. I've been asked by

some whether I think a further lockdown is really needed? 'Without doubt' is my response. The jolly wag who said that flattening the curve should have been specified by including the words 'in the x-axis' makes it frighteningly clear just how bad the escalation of the pandemic is.

Even better than the real thing – the new variants

VOC 202012/01 has not changed its name yet but we know much more about it than we did when I last wrote. The paper from Ferguson's team at Imperial College showing it is more transmissible with an R number 0.4–0.7 higher than other strains is quite hard reading but makes the case convincingly. For an easier read on the properties of this variant, the PHE technical briefings are worth a look.

This new variant has multiple mutations but three seem key to its increased transmissibility and all code for the spike protein. The N501Y mutation on the receptor-binding domain (RBD) is probably the most important of these and increases ACE-2 binding. In a vain attempt to match JVT's elegant sporting analogies when describing this to non-medics or biologists, I say the mutations are like wearing a baseball or wicket-keeping glove. It changes the shape of your hand and increases the chance you will catch the potentially dangerous sphere heading your way. PHE also describes the 'attack rate' of the new variant estimating it at 15% compared with 9% – this is the origin of the '70% increased rate of transmission' stat often quoted.

We still don't know if this new variant is as susceptible to the effect of neutralising antibodies and await PHE's in vitro work on this. This new variant grows better in culture than other strains, which is good as it means that studying it is not too difficult but bad as it shows how infectious it is to human cells.

The UK variant has caused concerns (and closed borders) but perhaps we should be as worried about the South African new variant. It has a slightly catchier name '501.V2' and also has three mutations in the RBD, including the N501Y mutation seen in the UK. It seems to be associated with higher viral loads and may be more transmissible because of this as well.

One concern for all three variants that has caused interest recently (the UK one, SA one and Danish Cluster V mutation) is that they may have arisen in particular populations such as the immunocompromised under selective pressure. This may have implications for both vaccines and acquired immunity from previous infection. Let's hope not.

All I want is you – vaccines

The much-awaited MHRA authorisation for the AstraZeneca/Oxford vaccine eventually came on the big news day of 30 December. With this (apart from Brexit news – see later) was the news that the dosing scheduling for this new vaccine and the Pfizer/BioNTech one was going to change and be different from that used in trials. This has caused much angst and the four UK CMOs produced a clarifying statement on New Year's Eve.

In case you missed it, the Joint Committee on Vaccination and Immunisation (JCVI) and NHS have recommended that the second dose of both vaccines can be delayed to 12 weeks (although the wording is subtly different for the two bodies and the JCVI implies up to 12 weeks). The CMO statement gives the reasons why this is the best approach from a public health benefit in the context of limited supplies. For the AstraZeneca/Oxford vaccine the shifting of the second dose has good evidence from the trials (where the second dose was delayed in some groups) and almost certainly improves its effectiveness in the long run for vaccinated individuals. Furthermore, it is backed by those who have run the trials.

For the Pfizer/BioNTech vaccine the position is less secure. I have seen some of the data the JCVI used to make its decision and the evidence that the vaccine is as effective if delayed to week 7 is pretty

robust. Beyond that we have no data and many have noted that Pfizer do not support this move. However, from an immunological standpoint there is no reason to think that delaying the booster will be a bad thing for an individual in the long term and is likely (as for the AstraZeneca/Oxford vaccine and many other vaccines) to be better. Several other things have swung me to supporting this new position though.

Firstly, the impact this will have on the ability to vaccinate those most at risk, including frontline health and social care workers. Given the really high sickness rates among staff at the moment (up to 12%) and the risks to those staff on the frontline in the next 6–8 weeks, surely we should use the vaccine to protect as many as possible. Delaying the second dose gives us a million or so extra vaccinations. Not only does that protect those staff, it protects their families and patients.

Secondly, the data from Polack et al's *NEJM* study show that the Pfizer/BioNTech vaccination is 89–91% effective from day 10. The 52% effectiveness figure for the first dose cited by many critics includes many cases of infection in the first week after the dose which we all know would not have been prevented by the vaccination.

Thirdly, the NNT for those most at risk of mortality from COVID-19 with vaccination is 250. If we used half the extra million doses for staff and half for the most vulnerable it would save more than 2,000 lives directly and indirectly.

There have been few easy decisions during the pandemic and the challenges of moving dates for second dosing and managing concerns have been significant. However, it seems only a few may be disadvantaged by this and many will benefit. I have had some stick for supporting this position and took much advice when reaching it but I was reassured by the support of such independent bodies as the British Society for Immunology.

Mysterious ways – becoming a vaccinator

If the vaccine programme is to be a success we will need to vaccinate 25 million people by Easter and thus will need as many syringe-wielders as possible. Many recently retired doctors as well as those currently practising have offered their help to contribute to the vaccinator workforce. However, this seems not to be as easy as it should be.

Several fellows have been in touch with me expressing frustration about the challenges of becoming a vaccinator. The evidence of learning required is substantial and if you can't find that evidence in your portfolio or it has expired it is a significant effort to get it. As one retired fellow (and someone whose prowess on a bike shows they have more stamina than most) put it, the burden is 'monstrous'.

At the moment you may need to do 22 statutory modules for working in a trust (including neonatal resus, manual handling, radicalisation), two on anaphylaxis (seems reasonable), seven on all the national vaccination programmes (although it seems unlikely that anyone going through this would be motivated to engage with these after the pandemic is finished) and three specifically on COVID-19 and the two vaccines. I'm tired just reading that list and will join the growing throng of voices to get this rationalised.

Tryin' to throw your arms around the world – Brexit

How do you feel now that Brexit has happened? The transition period ended with a whimper on New Years' Eve and the last-minute trade deal has allayed a few but not all concerns. The carnage created at the border by the new variant was a portent of what might come to pass this week but as yet the lorries carrying medicines and consumables for the NHS seem to be moving.

Much of what Brexit will mean for the health sector is a bit clearer and the key issues are summarised in the letter to all staff from health minister Edward Argar on the day of the deal. I find the letter reassuring in some aspects but reading between the lines there is much still to be worked out. A global health insurance card (GHIC) to replace the EHIC is a fascinating (or fantastical) proposition. The sharing of information is good for public health, and research seems a little more secure. As always, I worry about the workforce, especially in the care sector. Only time will tell if EU citizens will want to come and work in the UK in the years to come. It sounds like agreeing mutual recognition of qualifications may be a little easier than it would have been with no deal.

I still haven't found what I am looking for – designated settings

Among all the hubbub of the past few weeks many will have missed the CQC report on designated settings and care home beds published in the middle of December. There is a lot in this short report that is worth understanding. Designated settings are places that inpatients with COVID-19 who are medically fit can be discharged to from hospital. They are vital to maintain the flow out of hospitals and ensure that as many acute beds are available as possible. The availability of care home beds per se has been a worry for years and COVID-19 has created tensions between the health and care sectors.

The report isn't as grim reading as I was expecting but there are some striking findings. When it comes to designated beds there is a huge variation in availability across the UK. This won't be a surprise to those who have struggled to access them and is a worry as the pandemic escalates. The number of care home beds in total remains much the same as it was at the start of the pandemic – 457,000 – and occupancy levels have fallen during the pandemic by about 10%. While increased capacity is a good thing, the nature of funding of such beds means that homes with low levels of occupancy are at great risk financially. One lesson from the pandemic must be to revisit how we fund care homes.

Talking of finances …

The unforgettable fire – the RCP finances, assets and core purpose

In the latter part of 2020 the impact of the pandemic on the RCP's finances became clear (a loss of a third of our income) and some fairly difficult decisions were made about budgeting for that year and 2021. Among the remedial actions considered was a sale of assets to help the situation including some of our library collection. While we never intended to 'sell large parts of our collections' (as reported by the media and some others), we have spent the past 4 months exploring the potential implications of selling any of our assets.

Those due diligence processes are still ongoing but thanks to an enormous amount of work by many within the RCP and the sacrifice of staff with regards to their salaries, we have reached a position where no immediate sale of any assets is needed. There will be further 'belt-tightening' to reach a balanced budget in 2021 especially if the latter part of the year does not allow as much normal business to be achieved.

The sale of assets is not 'off the table' completely and the Board of Trustees is clear that if faced with a further financial cataclysm it would need to be a part of our potential solutions. We must avoid the need for a 'fire sale' in such circumstances and it is right that all the implications of any sale are explored thoroughly and seen in the context of the role of the RCP as a charity. We have in fact already sold some of our 'assets' – a part of our wine 'collection'. I have still not seen this infamous part of the college but suffice to say it is not the treasure trove many presume it to be. We buy wine in bulk and then store it which saves money in the long run as we use it to support our conferences and events function in London. Clearly the wine planned for use in 2020–21 was not going to be needed so it was an easy decision to take.

The review of our finances and functions has concentrated the minds of many in and outside of the RCP as to our core purpose. Last year we asked the membership about this in the context of our strategy for the next 5 years and the response was clear that at that time it was education, improving healthcare, influencing policy and supporting the membership. When the debate around the sale of assets was at its loudest I was clear that the membership should have a say and that we should ask you what you thought about options for raising funds. That survey will still happen but given the situation is now not the urgent dire one we had 3 months ago, we will take the opportunity to re-ask what our priorities should be moving forward as well as views on options such as membership fees.

Trip through your wires – and finally

Our annual conference Medicine 2021 will be streamed over the next 2 days. Due to the difficulties of the current situation the content will be available until the end of April 2021. We had planned some face-to-face bits (albeit socially distanced) but following the lockdown on Monday we changed to it being entirely down the wire. We've kept some of the lighter aspects and hope to finish with a video tribute to Donal.

I've seen much of the recorded content and it should hopefully reignite everyone's enthusiasm for medicine. I hope you can join us.

18 January 2021

Since my last bulletin Medicine 2021 has been and gone and despite the logistical difficulties was the most highly attended RCP conference ever with over 1,400 delegates. I had mixed emotions throughout given Donal's death but (as always) he had the last word which seemed appropriate.

There is no way to dress it up – it is pretty awful at the moment in the world of medicine. Hospital admissions are at the highest ever, staff are tired (knackered, actually) and although there is light at the end of the tunnel, that light seems a long way away (and there is a rather large train on the track blocking it). Our latest survey, which many of you completed over the weekend has just closed, but a provisional look at the data confirms this picture. One person described the situation as 'relentless' to me last week and that one word sums it up well. 'Very relentless' is even better.

In many meetings I've had recently much of the conversation has focused on vaccines. I've found this frustrating given the current situation in hospitals so am keen to start the bulletin by focusing on the acute pressures.

So hard – medicine is busier than it has ever been

As always, the media have focused on ITU bed numbers and the pressure on staff there. This is understandable and the intensity of work in that setting creates an enormous toll on those working there. The prospect of patients being turned away from ITU due to insufficient beds is one that everyone is struggling to avoid. However, there is also the part of the COVID-19 iceberg that media watchers don't see and that is the patients admitted under the wider medical team. The data tell this part of the story quite clearly.

Compared with the peak of the first wave, the number of patients on ITU according to both the Intensive Care National Audit and Research Centre (see Figures 8 and 13) and the UK government is only slightly higher at 3,789. The total number of hospitalised cases, though, is 73% higher (37,475 v 21,684 on Friday) and therefore almost all the impact of these additional cases falls on us medics. Our bed numbers have increased much more than in a normal winter and are spreading like a stain across the surgical bed base. In some hospitals almost 95% of patients with COVID-19 are not on ITU. Respiratory teams and all medical specialty teams are the hidden combatants in this particular battle.

This shift away from ITU needs to be explained. The figure of 3,789 relates to mechanically ventilated patients and it is important to note that ITUs don't just look after such patients. However, the early use of steroids and CPAP have prevented the need for mechanical ventilation in many patients. It probably also reflects the large number of frail patients being admitted. Many such patients do not survive and the toll this is taking on medical ward staff is as great as on any other staff. I sense a growing tension between parts of the hospital looking after COVID-19 patients and those that are not. Unlike in the first wave when most other hospital activity stopped, now life almost continues 'as normal' for some while the pandemic rages out of sight. This will create rifts between colleagues that may take many years to repair if we are not careful. We are all in this together (although some are more in than others).

The ONS data released on 8 January confirm that cases are falling in London and the SE but are increasing in most other areas of the country. This means that admissions will continue to increase for a couple of weeks in those regions. This will increase tensions as well.

It's a sin – barriers to training

The second wave has also meant that any hope we had that we could recover the damage done to training in the first wave has virtually disappeared. Trainees have borne the brunt of redeployment and exposure to the sickest of our patients, and have in the main done this in good heart understanding 'the greater good'. However, the quid pro quo should be that the system will support them to ensure the rest of their training is as stress free as possible.

Already, though, there are signs that this is not the case. The issues are around the entry and exit points to and from specialty training. As I have written about here before, the ability for those who were in the 'old' CMT rotas to get back into training is being limited by the availability of posts and the constraints of certification of experience done outside of the 'new' IMT programme. There was a commitment from the system to create training places in the local 'deanery' (they are not officially called that any more but you know what I mean) for those who have completed CMT but it appears that there may be large numbers of posts short for the expected demand this coming year. This, to me, is an absolute disaster. These posts are medical registrars in waiting that the NHS desperately needs now, let alone in the coming years. It is an English problem – Scotland has committed to finding places for these trainees, and NI and Wales have enough capacity.

At the other end of training the lack of specialty experience during the pandemic is leading to thoughts about extending training. This is more relevant for craft specialties where procedural experience has been extremely limited in the past year. In the surgical specialties this has caused considerable worry and it seems that large numbers of their trainees will need another year. Extension of training then stops people entering training as the budgets and numbers are fixed. This exacerbates the problem of there not being enough places at the entry point.

Trainees (and social media) will understandably blame the RCP in part for this situation but it has been pretty much out of our control. Most believe we are responsible for recruitment and the distribution of training places. I wish we were and thus could do something about it directly, but for England this all rests with Health Education England (HEE). HEE are in a difficult situation themselves having had 30% of their budget cut in recent years. The solutions will need the support of the NHS to fund and create posts which, let's face it, will provide much service to those trusts.

You don't need to be a genius to realise that this will all lead to added anxiety for trainees, worsening of the retention problem we have seen over recent years, and battles between the profession and those funding and running training rotations. I have raised this issue at the highest level in government and it is understood. I have likened it to that seen with medical school places and A-level results. The short-term costs of finding a solution are small compared with the damage that will result if it isn't sorted. Furthermore, the additional workforce is just what we will need in the next few years as we try to recover from the pandemic.

It's alright – tackling the psychological impact

Given all I have said above, the psychological impact on staff is substantial. Our most recent survey suggests that many physicians have had to seek formal psychological support as well as relying on peer support. I have been worried to hear that the additional clinical psychology support of staff that was put in place in the first wave has not been reinstated in all hospitals.

Peer support should not be understated as a very useful way to help doctors cope with the traumatic situations we are witnessing. There is much understanding about what works and doesn't work in such clinical situations. It may surprise some but the immediate debriefing by others outside the team after an adverse clinical incident is probably not as useful as peer support. As doctors we relate much more easily to each other (the correct term is 'social bonding') and thus talking things through with people who have been there, done that, is as useful as anything. Two experts in this area, Neil Greenberg and Derek Tracy, have written about this and recommend the PIES approach (proximity, immediacy, expectancy and simplicity) in such situations. It is worth a read.

Given the thin spreading of the workforce at the moment it may be that such peer support is not immediately available. The NHS is piloting a helpline supported by Relate in London and the Midlands to offer support for staff who need it. This is good to see as talking to a person often beats any online resource. The irony of the NHS using Relate to support its staff isn't lost on me (and I don't know why they have chosen London and the Midlands).

I was also heartened by the comments of Prerana Issar, the NHS chief people officer, at our conference 10 days ago. Prerana used to work for the UN and made the observation that UN workers in disaster zones have timetabled downtime in view of the toll on them as humans. While it may slow recovery by a week or so (and it would be nice to be able to travel somewhere to relax), wouldn't it be good if downtime was timetabled for those frontline workers once this wave is on the wane?

OK, I can't hold off any longer.

Liberation – vaccines

First up if you want a really sensible overview of the issues related to vaccines it is worth listening to Greg Poland's talk at Medicine 2021. Greg works at the Mayo Clinic and is editor-in-chief of Vaccine so knows his beans on this topic. He is also a lover of Pink Floyd, so is alright by me. His thoughts on the risks of an 'S-only' strategy are rather sobering and he explains the immunology of the different vaccine types really clearly.

Our survey suggests that many physicians have had their first dose of vaccine which is reassuring, but I know that many remain concerned about the delay in second dose for the Pfizer/BioNTech vaccine. I have continued to seek reassurance on this and the immunologists carry on debating this between

themselves but I remain convinced that it is the best policy to delay the second dose to up to 12 weeks when supplies are limited. It also seems reasonably likely that this will provide longer protection for those of us who have only had one dose so far. The SIREN study (see later) will allow us to monitor the incidence of COVID-19 in vaccinated healthcare workers between the first and second doses and there is also heightened surveillance for healthcare worker infections to ensure that there is no significant 'vaccine escape' by adopting this strategy.

I have also noted that there have been some unhelpful communications that a second dose may not be available for particular vaccines and that in such a situation another vaccine will be used. This is a non-negotiable point for me. While there are data to support a delayed dosing schedule there are no data to support a two types of vaccine approach. Thankfully this is the view of those advising the government. It may well come to be, though, that in future years there will be evidence for such an approach (studies are underway). There is also no evidence for a single dose-only approach with the currently available vaccines (but see Greg's talk for news about others which may be single shot).

Over the past week there have been reports of 'unused' vials of the Pfizer vaccine being thrown away rather than given to staff and that this has been as a result of formal policy by trusts. As yet I've not seen hard evidence of this (and if you have seen such a policy please let me know) but I can't believe any trust will be hauled in for questioning by senior NHS staff if they are able to use up any such vaccine for those healthcare workers who need it rather than throw it in the bin. As to who needs it I would respectfully suggest this should be those who have not had a first dose and those who are at higher risk and thus may benefit from an earlier booster. I have taken this up with the top brass of the NHS and they are looking to clarify this point.

Sadly, commercial interests have come to play and the short-lasting publication of their vaccine strategy by the Scottish government last week means that all the vaccine manufacturers now know exactly when the UK will be needing more of their vaccine (anybody with a calculator, an understanding of how the Barnett formula works and access to the ONS website can do this). In a seller's market supplies may be more expensive as a result.

The opening up of mass vaccination sites is good to see although I'm a little sceptical of these being 'easy to access' as advertised. Anyone trying to get to ExCeL London will attest that 'accessibility' is an issue. Epsom Racecourse is also not easy to get to except during Derby week when additional buses are put on by the … er… busload. One plus side to using such large venues is that they allow a lot of space between the vaccinees and minimise any risk of infection. Fear of catching COVID-19 at vaccination sites is causing some vaccine hesitancy and is something that other vaccine programmes have not really had to consider before.

Over the past couple of weeks I've come to understand more about the use of NNV (number needed to vaccinate) in defining the priority groups (cohorts) we are using in the UK. The Institute and Faculty of Actuaries (IFoA) has produced a fascinating paper on these figures for the different cohorts.

The IFoA's numbers are based on the first wave. We need to vaccinate 20 care home residents to save one life, and 160 people over the age of 80 to do the same. Once you get beyond the nine priority cohorts the number increases to 47,000. However, these figures don't cover the impact of long-COVID and the costs thereof, nor take into consideration the major health implications of lockdown for non-COVID conditions. In short, even the money-folk think vaccination is a good thing.

Se a vida é (that's the way life is) – SIREN

The much-anticipated first cut of results from the SIREN study came out last week in pre-publication version. There are a lot of data in this paper and there are some caveats to the certainty of previous infection but in essence it demonstrates that reinfection does occur. There were (and are as the study continues) 20,787 staff included and 6,614 of

these had evidence of previous infection. Between June and November 2020 re-infection occurred in (at most) 0.67% of healthcare workers who had had COVID-19 previously. Only a third of these were symptomatic infections.

This 0.67% compares to 2.89% in the cohort that had no evidence of previous infection showing an OR of 0.17 or 83% 'protection' gained from previous infection. Given 19% of physicians were off with COVID-19 in the first wave this might explain, in part, why we are seeing fewer physicians with infection this wave.

The median length of time to reinfection was 190 days and has been used in the press to claim how long infection lasts, but given the way the background prevalence of infection has changed over the time period of the study, I'm not sure how relevant it is. The next set of data after November when the new variant has come into play and background prevalence of infection is much higher will be telling.

You choose – saliva versus nasopharyngeal swabs

Another paper that caught my eye last week was a systematic review and meta-analysis looking at the sensitivity of saliva samples compared with nasopharyngeal samples for RT-PCR testing. The bottom line is that saliva samples are only slightly less sensitive (8%) in those who had not had infection previously and a lot seems to depend on the collection method. The fine nuances of the drooling technique versus the posterior pharyngeal spitting technique are perhaps a bit too much for this bulletin.

Because saliva is cheaper to collect this saves money when large numbers of people are being tested and obviously is more attractive to the general population. The paper estimates it would save around £5 per patient, although that sounds like a very expensive swab to me.

Left to my own devices – and finally, bedtime reading

Like many I suspect, my sleeping patterns in the past year have not been great and I often struggle to get to sleep. The upside of this is I have been consuming books at quite a rate. A couple of weeks ago I finished *The book about getting older* by Lucy Pollock, a geriatrician based in Taunton. It is excellent and I would recommend it to all medical students and doctors (of any age), although it is primarily aimed at the general public. The chapters on falls, incontinence and faltering cognition gave me new insights and also made me smile as I empathised with many of the stories.

I've now moved on to Lefèvre's *History of Troy* as I'm told by a couple of Oxford scholars that it is a classic medical text. I must confess I'm finding it heavy going and it is not quite as helpful as Lucy's. I am falling asleep faster though.

25 January 2021

It took a chilly presidential inauguration to knock the pandemic off the headlines last week but after the razzamatazz of welcoming in a new era of US politics had passed, the colder hard facts of the pandemic brought us all back to earth.

In a week where we have had to take notice of what is happening elsewhere in the world, 'beyond the neighbourhood' if you like, understanding how physicians here in the UK are doing is important. We published the results of our eighth survey last Thursday and as in previous bulletins I will try to weave them into this week's athletic sprint through what is happening.

Best not to think about it – where is this pandemic going?

The hospitalisation rates in the UK do seem to be plateauing or even falling in most parts of the country, although there is large variability in the impact on individual hospitals in those regions, and many are seeing cases continue to climb while their neighbours are feeling a relaxation of pressure. You can see how your trust is doing in this helpful HSJ table.

Our survey showed starkly that the medical wards are much busier in the second wave with 75% of respondents saying they are busier than at the peak of the first wave. 56% are very worried about their organisation's capacity to deliver safe and effective care. We remain more worried about the impact of this on our ability to deliver care for our non-COVID patients than for those with COVID-19, which has been the case throughout the pandemic.

Predicting what happens next is not easy, to which many with PhDs in the subject will attest. I will never forget being interviewed by a group of MPs in the summer who asked if I thought there would be a second wave. I said 'yes, but no-one knows how big it will be' (ever the hedger of bets). Two people more qualified than me (one a member of iSAGE) being interviewed in the session said 'no'. Those days feel like a different world. It is clear, though, that this wave will be much harder to control using the methods we employed first time around and there will be many more deaths.

The evidence that the UK new variant (B.1.1.7 as it is now known) is 'more deadly' is based on a rather bewildering mathematical manipulation of data but it also slightly misses the important point. As Greg Poland so clearly explained in his talk at Medicine 2021 a couple of weeks ago, it is the 'exponentiality' of the virus that defines its 'deadliness'. Even if a virus mutates such that it increases the case fatality rate by 50%, this is dwarfed into relative insignificance if it mutates to become 50% more transmissible instead. The compound interest created in the latter situation results in many times more deaths (over 10x in Greg's example). A more transmissible virus (as this new variant is) is always going to be 'more deadly'.

Tourist – new variants elsewhere in the world

While the B.1.1.7 variant took the headlines this weekend we should keep our beady eyes on what is happening elsewhere in the world. The P.1 variant in Brazil is causing some concern based on what is happening in Manaus.

Manaus is the seventh biggest city in Brazil and can be found where the Rio Negro joins the Amazon. The city's population took a big hit earlier in the pandemic with an estimated 75% showing antibodies indicating previous infection. There is now a second wave of infections occurring and in one study 42% showed a new genotype called P.1 which was not seen previously. This has raised the potential that P.1 is evading the acquired immunity from previous infection.

The mutations in P.1 include N501Y (which will be familiar to readers of this bulletin) but it is another mutation in the receptor binding domain that is vexing people, E484K. This mutation is also seen in the South African variant and we are now seeing variants with this mutation in the UK. This might suggest that there is more 'viral tourism' going on

than we know about but probably just means that these mutations confer advantages to the virus and therefore will occur wherever the virus is replicating at scale in populations. We still don't know the relevance of these mutations to the effectiveness of our current vaccines.

Chances – vaccination

The survey showed that 85% of physicians had been 'vaccinated' by last weekend (by which I mean received at least one dose of a vaccine) with another 11% having a date scheduled. This is good news and will be critical in protecting both the individual doctor but also their families – I have been struck by the worry most of us have about bringing COVID-19 home from our workplace. This is reflected in the fact that many of us now say 'hello' to the washing machine and shower before the family when we get home. I met one of my geriatrician colleagues in the corridor on Friday evening with a cloth bag (like an old gym bag if you are of that generation) – I didn't have to ask what was in it.

Back to vaccinations. The delay of second doses remains a source of worry for many according to our survey. 16% are very worried about it and 17% not at all worried. Everyone else is slightly worried or 'not very' worried. I fit into the latter group although still think it is the right (and ethical) thing to do with a limited supply of vaccine (distribution of limited resources seems to be the recurrent theme of this pandemic – PPE, ITU beds, vaccines, staff etc). The evidence from most other vaccines that delaying the second dose might be advantageous in the long run also helps me sleep a bit easier. The 'news' from Israel last week that the Pfizer/BioNTech vaccine doesn't work as well as it did in the trial will have increased these anxieties, so I've been trying to find out more.

First though, are we really that surprised that a 'drug' may not work as well in the real world as it did in the trials? Even if the efficacy turns out to be 80% rather than 95% it is still much better than was expected when vaccines were first being developed for SARS-CoV-2 and remains the only way to control the pandemic. The lack of any actual data from Israel should also temper our interpretation of the implications of this news. It appears that the lack of efficacy relates to a delay in protection afforded in the over-60s and that hospitalisations only fell by 33%. Again, this isn't really a huge surprise. We know the immunogenicity of most vaccines is less and takes longer in older patients and thus it is still too early to judge how effective the vaccine is in this age group. The vaccine effect will be most noticeable on mortality, then hospitalisations and then symptomatic disease.

There is also reassurance from the data on 1,800 doctors in a hospital in Rambam, also in Israel. 91% had high levels of antibodies after 3 weeks. In the UK we should soon have data from the SIREN study on how the vaccines are performing in healthcare workers here. The fact that there is a cohort of us who have had two jabs will allow any relevant effect to be seen (accepting that those vaccinated earlier and thus more likely to have had two doses will have been from more at-risk groups – older, BAME, pre-existing health conditions – all of which will be confounders).

In case you were not aware, if you diagnose a healthcare worker with COVID-19 who has been vaccinated at least 10 days ago there is a special reporting mechanism. This too will allow us to monitor the effectiveness of vaccines.

It's not your fault – infection rates in physicians

One of the findings from the survey that slightly surprised me was the rate of sickness absence. 4.3% were off work related to COVID-19, 2% either with confirmed or suspected COVID-19, 0.5% with long COVID and the rest self-isolating due to contacts or being in the CEV group. The 4.3% figure compares with 17% in early April in the first wave and the 2% figure is pretty close to that seen in the wider population by the most recent ONS data.

There are lots of reasons why the infection rates should be lower this time around. Firstly, at least 17% of physicians got COVID-19 in the first wave so will have a degree of protection from that (83%

according to SIREN). The supply of PPE is better this time around and case identification in hospitals has improved though widespread testing. Some may have been infected in November and December and are now back at work. Lastly, a proportion of physicians will already be benefiting from vaccination before Christmas (and this should only increase).

While supply is better, concerns around PPE remain and only 70% said they had the PPE they felt they needed to manage patients with COVID-19. There is strong debate at the moment about where and when to use FFP3 masks and we must be slightly wary not to turn this into a reductionist FFP3 v surgical mask debate. 16% of physicians reported they were unable to get fit-tested for their PPE and we know that FFP3 masks that fit cannot be found for a similar proportion. We must continue to explore all ways to reduce the environmental risk on COVID-19 wards, including air conditioning, personalised (and reusable) respirators and the need for full PPE versus any particular type of mask.

I would like to see a renewed focus on the risks of individual areas in the hospital based on staff infection rates as well as ongoing individualised risk assessment. This needs to be consistent across the NHS or else it will set doctors against each other and other healthcare professionals.

Yesterday threw everything at me – how valued are we feeling?

All of the above issues have impacted on how physicians are currently feeling. Our survey showed that 65% of us feel tired/exhausted, 48% worried and 29% demoralised. 14% are angry but 37% feel determined and 6% are energised (can I have some of what they are having please?).

As I mentioned last week, large numbers have sought psychological support with 9% doing so through formal services via their employer or GP. This is a remarkable figure and would have seemed unthinkable before the pandemic. This number will only increase with time and I've started to push strongly for a planned programme by the NHS to mitigate the psychological impact of the pandemic. This is going to have to include time away from the frontline for some staff.

Trainees have had a particularly torrid time and 88% are concerned about the impact on their training. The training pathways have been slowed down considerably by COVID-19 with fewer jobs being advertised at the end as well as delays in the chances to get craft competencies. One unforeseen negative effect of the vaccination programme is that some venues we had planned to use for the next diet of PACES are now unavailable as they have become vaccination sites.

For trainees we are able to drill down in much more depth into the impact of the past year through the census of higher specialty trainees. Anyone in such posts should have received a direct email with a link to the census (if you haven't please contact MedicalWorkforce.Unit@rcplondon.ac.uk).

In short, many of the responses to the survey I've talked about come down to how valued people feel. In those trusts where they feel they are supported, listened to and concerns over vaccination, PPE, workload and staffing levels are being addressed, people are in a much better place psychologically. Where this feeling of value is lost, though, demoralisation and anger predominate.

Wires – Donal's funeral

The loss of colleagues and friends has affected many and when the number of cases drop to more manageable levels this may be the longest lasting legacy of this pandemic for me.

Professor Donal O'Donoghue's funeral will be tomorrow at 11:30am at St Paul's Roman Catholic Church in Poynton. In other times I know the church would be full to the rafters and not big enough to hold all who would want to go. Due to the current restrictions Donal's family have arranged for anyone who wants to attend 'down the wire' to be able to watch on live stream. It will be streamed on YouTube and available to watch afterwards.

New project – old treasures

On a less sombre note, while it may surprise some, I am fascinated by some of the treasures hidden in the RCP's collections and the lockdown has given us the chance to think about how we can get such things seen more widely. Our new online exhibition RCP Unseen offers a fantastic opportunity to explore some rare items from our collections and is well worth a look. There are a few things in there that may surprise you.

…and finally

I never cease to be amazed by both the way medicine seems to weave connections between people's lives and the impact we can have on each other. Following my review of Lucy Pollock's book last week, I was contacted by a consultant (who is herself a star) who remembered fondly how Lucy had inspired and supported her to apply for medical school when they were a few years apart at the same school.

We may not always feel valued by the health services we work for, but we can value each other.

1 February 2021

This week has seen the official death toll from COVID-19 in the UK pass 100,000, more promising vaccine trial results published, worrying news from Myanmar, escalation of border conflicts over what vaccine we do have and much talk about 'influencers'. Meanwhile hospitals and the NHS continue to wilt under the unrelenting pressure.

The hardest part – 100,000 deaths

The passing of the 100,000 milestone (millstone?) last week captured the public's imagination and it still surprises me that, given this figure, there remain many whose lives have not been touched personally by a COVID-19-related death such that the pandemic remains either a hoax or something that only affects others.

It is worth putting this figure in context. In all of 2019, 530,841 deaths were registered in England and Wales. Of these, the leading causes of death were dementia and Alzheimer's disease at 66,424 deaths, ischaemic heart disease at 55,064 and chronic respiratory diseases at 31,221. It seems highly likely that these figures will fall significantly when the 2020 data are published, given that many deaths in care homes are usually attributed to these causes (in the peak of the first wave, COVID-19 was the cause of death for up to 50% of care home residents).

These data from the Office for National Statistics also confirm that death has always focused on the poorest in our society and the large differences seen during COVID-19 have always been there. In 2019, the death rate for males was three times higher in Blackpool and Merthyr Tydfil than it was in the City of London. For females Blackburn & Darwen and Denbighshire had the highest rates, double those seen in the lowest region. This never seems to make it to the front pages of the papers. Patient groups understand that it is important, though, and National Voices is hosting a conference on health

inequity with the Health Foundation over four Thursdays in March.

A cold statistic doesn't tell the human cost of each of these deaths and at Donal's funeral last week, I reflected that at the moment there will be around 7,000 similar gatherings each week to mourn the death of someone close.

I was very upset to hear this week about the death from COVID-19 of Prof James Hakim FRCP, who was one of the most influential physicians in Zimbabwe and more widely in Africa, and whom I had the honour of knowing. Not only was he an inspirational cardiologist, he was also key in developing research networks, work on HIV and the development of medical training. Rest in peace James.

A message – the situation in Myanmar

Everyone in the RCP has watched the news emerging from Myanmar this morning with concern. There are many members and fellows currently living and working in Myanmar as well as among the Myanmar diaspora in the UK and around the world and we would like all of them to know that our thoughts are with them at this difficult time. This is already a hugely challenging time for the medical community in Myanmar as they tackle the COVID-19 pandemic and we hope that the current political turmoil does not compromise the provision of healthcare in the country and particularly the recently begun vaccination programme. The RCP remains available to offer support and guidance to all of our members and fellows in Myanmar and across the globe.

Fix you – vaccines

The rapidity of release of new data on vaccines and the cross-border disputes about vaccine supply have been hard to keep up with this week, so I will try to summarise them here (as much for my own mental filing as anything). I will focus on those making the news in the UK, as the number of vaccines in clinical development throughout the world is a staggering 63 (and there are 174 in preclinical development) according to the World Health Organization's vaccine tracker.

The UK has ordered 367 million doses of vaccines from seven different suppliers. I will take each vaccine in turn and in no particular order to save being accused of playing 'vaccine Top Trumps' (I claim intellectual property rights if this becomes a real thing). If you spot any errors, please let me know – accepting that things may change from the time of writing to publishing to reading.

Pfizer/BioNTech mRNA vaccine. 40 million doses ordered, approved by the Medicines and Healthcare products Regulatory Agency (MHRA), in use. Declaration of interest – I have one dose of this in my left arm.

No new data this week, but the border debates within the EU have set alarm bells ringing about the supply to the UK. Unlike for the AstraZeneca/Oxford vaccine, there is no UK-based manufacture and thus if the export ban that has been debated occurs, then there will be a lot of very angry/worried healthcare workers.

AstraZeneca/Oxford adenovirus vector vaccine (AZ). 100 million doses ordered, approved, in use.

There was much debate this week about the efficacy in over-65s, precipitated by claims in Germany that the vaccine may only have an efficacy of 6.3% in a table used by STIKO, Germany's equivalent of the Joint Committee on Vaccination and Immunisation (JCVI). These data were in the original Lancet paper but have been used to try and come up with an estimate of efficacy, despite there being only one case of COVID-19 in the placebo group and one in the vaccine group aged over 65. Poor science all round. The European Medicines Agency (EMA) has followed the MHRA and approved this vaccine for use for everyone over the age of 18 on Friday. They were very open, accepting that the data for over-55s are limited but that 'protection is expected, given that an immune response is seen in this age group and based on experience with other vaccines; as there is reliable information on safety in this

population, EMA's scientific experts considered that the vaccine can be used in older adults'.

A very public spat between AstraZeneca and the European Commission about the wording of the contract between them resulted in the border rules between Ireland and Northern Ireland being briefly unilaterally threatened. The frailty of the 'Brexit deal' was shown in worrying clarity, but as I write this, pragmatism has won over brinkmanship.

Moderna mRNA vaccine (mRNA-1273). 17 million doses ordered, approved, supplies expected April 2021.

Not much news on this one except for the publication of safety data from the US vaccine adverse event reporting system (VAERS), looking at the data on the 21.8m people vaccinated with the Moderna and Pfizer/BioNTech vaccines. It makes for reassuring reading as it shows that, at present, there are no worrying signals in the adverse events seen and that the deaths following vaccination are the same as would be expected in the population vaccinated thus far.

Novavax protein subunit vaccine (NVX-CoV2373). 60 million doses ordered, not yet approved, expected late summer.

Preliminary data were announced this week in a company press release from a phase 3 trial of 15,000 people in the UK, showing an efficacy of 89.3% in all, 95.6% against 'old' strains of the virus and 85.6% against the 'UK variant'. The company also released results from a phase 2b study of 4,400 people in South Africa, showing 60% effectiveness in HIV-negative individuals (the majority). 93% of those genotyped (only 44) were the 'South African escape variant'. We will be seeing more and more data comparing different variants, although I am slightly concerned by the stigmatisation of naming variants by country.

Valneva inactivated adjuvant whole virus (VLA2001). 60 million doses ordered, not approved, expected late 2021 if effective.

The prime minister visited the Valneva manufacturing site in Livingstone last week, but that seemed more about stretching the definition of what is essential travel rather than there being any new data on the vaccine, which is still in phase 1 and 2 trials.

Sanofi/GlaxoSmithKline adjuvanted protein vaccine. 60 million doses ordered, not approved, expected 2022 if at all.

This vaccine programme hit a significant snag in mid-December when disappointing results were released from phase 1/2 trials, showing that neutralising antibodies were only sufficient in those under the age of 50 (thus creating concerns about its effectiveness in those most at risk). While their vaccine development programme continues, the news last week that Sanofi will be supporting the production of the Pfizer/BioNTech mRNA vaccine, possibly under pressure from the French government, suggests we should not hold out much hope for a vaccine this year. Will we see it in 2022? Peut-être, peut-être pas.

Johnson & Johnson (Janssen) adenovirus vector vaccine (Ad26.COV2.S). 30 million doses ordered, not approved.

Janssen is the pharmaceutical arm of Johnson & Johnson, which can be a bit confusing as the two names are used interchangeably around this vaccine. Phase 3 results were announced at the end of last week, which were promising as much because this is a single-shot vaccine, even though the results seem a little unimpressive compared with some.

The ENSEMBLE study included almost 44,000 people across eight countries and three continents (34% over 60) and showed a reduction in severe COVID-19 of 85% and in moderate/severe disease of 66% (57% in South Africa). Single-shot vaccines will be useful in hard-to-reach populations and may be part of the global solution to the pandemic, especially as many countries have limited experience with adult vaccination programmes, let alone a vaccine requiring two doses.

How do you summarise this morass of information? We have ordered lots of vaccines and there is growing evidence that the newer vaccines are active against new variants. It seems very likely that we will need many of the 367 million doses we have ordered and that we will all be getting another set of jabs in the autumn/early winter to manage emerging variants. My history O-level taught me that wars were generally about obtaining control of limited resources. We need to be careful.

Twisted logic – falling COVID-negative results

Most of us in hospitals in England now do twice-weekly lateral flow tests (LFTs) and report the results via text or online. I'm told by those watching these results in the NHS that the number of negative results is falling, which suggests either that people are forgetting to log them, they are getting LFT fatigue (which us gastroenterologists had long before COVID-19), or now that people are being vaccinated they feel that the tests are no longer needed as much. Obviously it is still too soon to conclude the latter and LFTs remain a very useful tool for detecting asymptomatic infections.

As an aside, I had an LFT that didn't flow laterally this week. It just seemed to flow a little bit then gave up (I did use two drops so it wasn't 'user error'). I then thought I would take a used one apart and see why that might have happened. I'm none the wiser – it is just a long thin strip of paper with some felty bits at either end.

Square one – February rotations

This week sees many trainees rotating posts, but not all. For those moving to another hospital site there is an additional concern this year, which is where they can get their second dose of vaccine. There doesn't seem to be a robust policy yet, with some regions saying they need to go back to the site of original vaccination and others that they can get it locally.

This affects trainees in all specialties, so we have been trying to get a uniform policy sorted via the Academy of Medical Royal Colleges. The expectation is that people should be able to get the second dose wherever they are working, but until I see this in writing I will continue to press on it.

Low – the 20/21 flu season

This season continues to have the lowest rates of flu in living memory, as shown by the Public Health England flu surveillance data with hardly any cases being diagnosed. Some have been perplexed by this, but to me it is highly predictable.

The R0 value which so obsesses the media for flu is only 1.3 for most seasons, increasing to 1.5 or slightly higher when there is a pandemic. All the measures we've taken for SARS-CoV-2 to reduce R0 for that virus will do the same for other respiratory viruses and by about 0.4–0.5. Thus, flu will have an R0 of about 0.8–0.9 and remain unable to gain a foothold in the UK this winter.

What if – other routes of transmission

As discussed above, it seems that the aerosolised/droplet route remains the most likely mode of infection for the virus, but there are some interesting thoughts about other routes such as the faecal–oral one. Professor Ashley Woodcock, a recent RCP councillor and highly respected respiratory physician, has written about this possibility which makes one stop and think. He notes the high levels of infection in certain occupations associated with food production and distribution, as well as evidence of virus on many surfaces. To me, this reinforces that we should wash our hands as much as possible and being a bit paranoid when you go food shopping is probably a good thing.

Speed of sound – ambulance care

The impact of large numbers of COVID-19 cases on the ability of hospitals to admit patients has been one of the more visible features to the outside world, with large numbers of ambulances waiting to offload patients in the hardest-hit hospitals. I was made aware of acute physicians being asked to assess patients in ambulances and the concerns around the ethics of this. Alexis Paton, chair of our committee for ethical issues in medicine, together

with colleagues of that committee and the Society for Acute Medicine (SAM), have come up with some additional guidance in this area for the ethical framework we published, which will be available later this week. I hope this is some help to those faced with this extreme situation. There is also some helpful guidance from the Royal College of Emergency Medicine and the College of Paramedics.

When this issue came up, it reminded me of the vital role that our paramedic colleagues play and that they have been an overlooked vital part of our pandemic response. Not many paramedics will read this bulletin, but the next time you see any paramedics please say thank you.

In collaboration with SAM, we have also published some updated guidance on end-of-life (EOL) care today, which will help us identify patients in the acute setting who are in their last days or weeks of life and ensure that their choices are heard and supported, in a holistic and sensitive way. It provides guidance on starting the often-difficult conversation about EOL care with patients and their families or carers, recognising that every patient will have different needs and priorities.

and finally …

I suspect that I have neither the looks nor the 'youth vote' to make it in the big time as an 'influencer' in the outside world, but will continue to try to do what I can in the much smaller sphere of health. I couldn't make it to Dubai to bring you this bulletin from the back of a camel or the side of a pool, but if you try saying Derby with a mouth full of coffee it sounds much the same. There is also a large puddle outside my window from the recent rain.

8 February 2021

The number of COVID-19 cases in our hospitals is definitely declining although it still feels extraordinarily busy (winter is hitting us hard). Safari ward rounds remain common for many of us and the 'pleasure' of learning about patients in far-flung places in the hospital on a Friday evening hasn't lost its ability to fill me with dread. This week has seen a number of interesting developments and publications which I will try and summarise, although I've been on call this weekend and up during the night so the usual apology stands if the bulletin feels less refined than usual.

Signal to noise – vaccine safety

I'll start with vaccine safety. The Medicines and Healthcare products Regulatory Agency (MHRA) is now publishing regular updates on the Yellow Card reports for adverse reactions to the vaccines. As of 24 January there were almost 17,000 reports for the Pfizer/BioNTech vaccine and 6,000 for the AstraZeneca/Oxford one. These reports describe 49,000 possible reactions as each card can be used to report more than one adverse reaction. This looks alarming but the detail provided is reassuring even once it is remembered that this is for over 7.5 million doses. It is worth noting that the MHRA team has done an enormous amount of work looking into the worrying reports. Medicines regulation is all about patient safety and the MHRA folk are showing their value.

Almost all the reports were what would be expected with any immunisation (and what was seen in the trials), including pain at the injection site and flu-like symptoms. There have been 101 anaphylaxis/anaphylactoid reactions described for the Pfizer/BioNTech jab and 13 for the AstraZeneca/Oxford one. This gives a rate of 1–2 per 100,000 doses. We should therefore continue to warn people it may happen.

A number of cases of Bell's palsy have been reported (69 and 6 respectively for the two vaccines) but this is probably normal incidence for that condition in the age group vaccinated. Previous

research looking at Bell's palsy and flu vaccination showed no association but is helpful as it shows the normal incidence of Bell's palsy in the UK is 39 cases per 100,000 patient years. Thus, if we estimate that the 7.5 million have been followed up for 4 weeks on average, we would expect 84 cases to occur 'normally'.

107/34 patients (respectively for the two vaccines) have died shortly after receiving a vaccine dose. Each of these cases has been investigated at length and there is no evidence they are related to the vaccine. Again, death is not that uncommon in the groups of patients we are prioritising for vaccination. Over the age of 85 your chance of dying per day is around 1 in 2,000 (slightly lower for women).

Don't give up – second doses and variants

Concerns about the timing and availability of second doses persist, although the data published last week around the increased effectiveness of the AstraZeneca/Oxford vaccine when given at 12 weeks is reassuring. The noise about vaccine export from the EU also seems to have calmed down but discussion around trials that mix vaccine types has reignited concerns for those awaiting the second dose that they will get a different vaccine. Some of the statements coming out from government have been a little vague as to the policy for this.

This was raised by college presidents with Prof Chris Whitty last week and he was very clear (and happy to be quoted) that people should receive the same make of vaccine for their second dose and there is no plan to change this. There are data from other immunisation programmes that show mixing vaccines is advantageous but the trials for mixing COVID-19 vaccines are only just starting and for the current round different vaccines should not be substituted between doses.

The news from the AstraZeneca/Oxford vaccine trials in South Africa over the weekend is a little concerning as it shows that it is much less effective for the new SA variant (B.1.351 – which accounts for most cases in S Africa currently). I haven't seen the full data but the NY Times reported that there were 19/748 cases of the B.1.351 variant in vaccinated people compared with 20/714 in those getting placebo. Small numbers but concerning all the same. This 'vaccine escape' isn't altogether surprising though and confirms what I said last week that we will almost certainly need a booster to protect against variants later in the year.

Red rain – anticoagulation in COVID-19

Fairly early on in the pandemic the impact of COVID-19 on the clotting system became clear with evidence of thrombosis in both large and small vessels as well as in external circuits (such as those used for dialysis) despite prophylactic anticoagulation. COVID-19 results in a hypercoagulable state though systemic and localised factors. As in any acute inflammatory state fibrinogen, factor VIII, D-dimer and VWF levels are all raised. There is also direct viral infection of the endothelium via ACE2 with resulting activation, damage and local vascular inflammation.

Various anticoagulation approaches have been tried but a consistent message and evidence base as to best practice has been absent. To try and get some clarity three research trials (REMAP-CAP, ATTACC and ACTIV-4a) have been collaborating through harmonised protocols and have now published their interim report.

There are four key messages from these results. Firstly, therapeutic dose heparin worsens outcomes, compared to standard of care, if initiated when patients are severely ill with COVID-19 (ie in ICU receiving organ support). Secondly, for moderately ill patients therapeutic dose heparin is beneficial and results in fewer days of organ support and a lower mortality. Thirdly, D-dimer results are not useful to guide anticoagulation dosing strategies. Lastly, in both moderate and severe COVID-19 patient cohorts, overall risk of major bleeding was low compared with previous large observational studies of hospitalised non-COVID-19 patients receiving conventional thromboprophylaxis or therapeutic anticoagulation.

We've published a useful explainer on this from Charlotte Bradbury and Cheng-Hock Toh on our website as part of our research hub. We should remember that these are interim results and (as often these days) not peer-reviewed. The optimal dosing requirements and the role of antiplatelets are still being defined in studies and it looks like the timing of anticoagulation is critical. However, these rather unheralded results suggest to me that we will be seeing much more therapeutic anticoagulation for COVID-19 patients not on ITU.

The drop – understanding how COVID-19 is spread

As I said last week, we are still not entirely certain of the main routes of COVID-19 transmission, although the aerosol route seems critical. Four papers this week increase our understanding, although they raise as many questions as they answer.

In the early days of the pandemic we were not sure about the role of asymptomatic spread and based on the experience with SARS, initial responses were guided by the (false) assumption that asymptomatic spread was unlikely. We now have data from over 19 million international travellers entering China between April and October last year to understand this. The size of the study population is testimony to the ability of China to carry out PCR testing on large numbers of people and is in itself quite mind-boggling.

From those 19.4 million travellers (mostly male and between 20–49 years of age) there were 3,103 positive tests of which 43.6% had symptoms at entry, 4.4% developed symptoms and 51.9% never developed symptoms. I am slightly surprised that the number of positives was so low, but this is good evidence that for every symptomatic person next to us there is an asymptomatic one. Trust no one.

Two papers from Michael Marks (who deserves congratulations both for the work and for getting a consultant post recently) show that community spread within certain populations can be very high and that viral load is possibly more important than symptoms. The first study showed that the seroprevalence for SARS-CoV-2 was 64% in a large population of strictly Orthodox Jewish families. This is one of the highest seroprevalence rates that has been recorded for any community and shows that we must tailor our thoughts about how to manage COVID-19 at the local community level as much as the national one.

The other study, based in Spain, followed up contacts from 314 cases to look at onwards transmission. The 'secondary attack rate' was 17% but varied from 12% to 24% depending on the viral load of the index patient. Half of contacts who became positive remained asymptomatic (confirming the China data above) and the attack rate was highest for household contacts (not surprising). One interesting finding was that there was no association between coughing and risk of transmission and that it was viral load not symptoms that was the main driver to ongoing transmission. Viral load also predicted whether a contact would become symptomatic.

The last study looked at the aerosol production in healthy volunteers on air, high-flow nasal oxygen (HFNO) or CPAP. The current wisdom is that HFNO and CPAP generate a large aerosol and thus create a high risk but this study challenges that. It showed that CPAP produced negligible aerosol and that HFNO aerosol was almost all from the machine rather than the patient. Coughing was by far the largest source of aerosols (although wearing face masks reduced this substantially).

Putting all of this together means that we should not drop our guard at any point soon and, sadly, it is close contact with people that carries the greatest risk. The debate about the risks associated with coughing is unresolved and urgently needs clarification. Coughing patients should be strongly encouraged to wear masks.

In your eyes – ivermectin

I've had a few emails this week about ivermectin and asking why I was not acting as a strong proponent for its use as an anti-viral. I can't worm my way out of this debate it seems. Ivermectin is a widely used antiparasitic especially in countries where such diseases are common. In the UK and US it is used most commonly for scabies, although it is used much more frequently in pets (which makes it fairly accessible to the public). There is some rationale for its use in COVID-19 patients as it is known to inhibit viral replication in cell lines.

In South America the vogue for using ivermectin has gathered momentum and some trials are promising with regard to impact on viral load and some symptoms. However, the evidence for an effect on hospitalisation rates and mortality is currently lacking as described well in a systematic review from Peru of studies including over 7,000 patients. I therefore think we should keep an open mind as to the place of this drug but I agree with the US National Institutes of Health's statement that the evidence base is too poor to recommend its use currently. I note that Merck, the manufacturer of ivermectin, has also distanced itself this weekend from its use in COVID-19.

Even in the era of vaccinations it is likely that we will struggle to control the virus on a wider scale and will need antivirals as a further part of our treatment options. Big pharma certainly has this view and is investing hugely in this area. However, Tamiflu taught us that we should ensure we have good evidence for a drug before recommending widescale use.

More than this – IMT issues

IMT stands for internal medicine training and has replaced core medical training and higher specialty training in general (internal) medicine (which itself replaced general professional training). I continue to work with my fellow presidents in Scotland on the issue of standalone IMT year 3 placements, alternative certification and future specialty training posts. If those phrases don't mean anything to you, I can assure you that for trainees who are affected the current time is one of considerable angst. It feels like we are making some headway but there is a long way to go.

There are a few new resources on the JRCPTB website that may help explain the landscape, allay some concerns as to the impact of COVID-19 and allow new ways of training to be recorded. The former include a guide to transition to the new curricula, recruitment during the period of introduction to these curricula and a guide to all the organisations involved.

The outpatient care assessment tool (OPCAT – you can always rely on the education system to produce a new acronym) is a way to record outpatient activity be it face-to-face or virtual. It isn't mandatory but should be helpful to anyone trying to show evidence of outpatient experience.

This is the picture – MTI

MTI is not IMT mistyped but the Medical Training Initiative which is a UK-wide scheme for international medical graduates to enter UK training posts for a 2-year period. The scheme is mutually beneficial and allows these international doctors to develop their skills over 2 years, support the NHS while they are here, and on return to their home country benefit the local community with their increased clinical knowledge and skills.

The RCP MTI team has recently published a list of the doctors who have been interviewed as part of 'Route B' of the scheme, and are available to be placed in UK trusts in a variety of specialties and grades. The MTI scheme has been very successful in those hospitals which have embraced it and I encourage everyone to think if it might be something that they could both help with and be helped by. You can view the full list on our website (this will be regularly updated throughout the year).

Sledgehammer – the new NHS white paper

Last Friday the impending White Paper on new legislation for health and social care was leaked. I haven't had a chance to read it in full yet but if you want a good summary (and a slightly cynical view)

Andy Cowper's editorial on the Health Policy Insight website does this well. He has had a bit longer to read it and understands NHS policy better than most.

I will cover this in more depth next week but the headlines are that this signals a formal end to 'the Lansley Act', gives the secretary of state for health and social care (SoS) more power, enshrines integrated care systems (ICSs) in law and reduces the powers of foundation trusts. It gives the SoS more say in the planning of workforce which may be a good thing or a bad thing.

The timescale for most legislation like this is that it takes about a year before it becomes law. There will be much debate in that time but judging from comments so far Mr Hancock's bill will be better received than its predecessor.

Growing up – modern ward rounds

Having spent the weekend wandering around various wards I was struck by how ward rounds have changed since I started as a physician – in some ways quite a lot (electronic patient records, automated observations, many more tests available to consider and PPE) and in other ways not much (missing patients, overstretched staff, the importance of good communication between medical and nursing staff to mention just three).

We have just released new guidance on ward rounds together with the RCN, RPS, Chartered Society of Physiotherapy and NHS England/Improvement which is centred on improving the last of these 'not much' changes. The guidance focuses on a standardised multidisciplinary approach to inpatient care which involves patients, carers and families. It aims to be as practical as possible with templates, checklists and advice.

Big time – COVID-19: 1 year on seminar

A year ago the pandemic was changing from something happening elsewhere to something that seemed likely to impact all of us. We held an evening 'teach-in' at the RCP attended by over 400 people to hear Chris Whitty, Susan Hopkins, John Edmunds and others update us on what might be in store. Gosh, how much has happened in that year?

We thought we should try and get some of the band back together for another gig and COVID-19: 1 year on is planned for next Thursday evening (18 February) to allow everyone to review the year and assess what the future holds for us. The audience will be virtual this time but the issues will be all too live.

That voice again – fellowship offers

When I became registrar the fellowship process was a once-a-year affair which dominated my Christmas holidays. Now it is spread out over the year and the next group of fellows approved at Council in November were notified electronically yesterday. Congratulations to all 138 of them. These individuals have all shown themselves to have gone above and beyond in their roles and are a credit to medicine. I am looking forward to meeting many of them in the coming years.

… and finally

I heard an inspiring story last week about a fourth-year medical student (called Theo and who probably won't read this) who volunteered to help on his local ICU. He wrote about his experiences in a blog which was picked up by the CEO and forwarded to me. After describing his experiences and saying that the camaraderie he felt would stay with him always, he concluded:

'I will carry this experience with me into my future clinical career. When I feel outside of my comfort zone whether that be on my first day as a foundation doctor or maybe one day as a consultant, I will think back to a cold, wintery day in January 2021, when I suited up in full PPE and entered into a room full of a virus which I had spent the last 8 months doing everything possible to avoid, driven by a deep desire to do my part. It is an honour to know I have been able to help in some way.'

We all go outside our comfort zone sometimes. It is often uncomfortable, scary even, but there is always something to learn, something to gain and something to give. All of us can make a difference.

15 February 2021

I would describe this week as a very mixed bag. The government white paper on the future of the NHS was released, and the positive news from the RECOVERY trial about tocilizumab was balanced with the tragic news this week of the death of two trainees in the Midlands.

Open your heart – sad news about two colleagues

I learned of the death of Rolland Iriarte early in the week from our Trainees Committee. A gastroenterology SpR in the West Midlands, Rolland was loved by all those he worked with and those I have spoken to since hearing the news have said how hard working he was, and dedicated to both medicine and his family.

I heard about the death of Anna Lewis on Friday evening in an email from my own hospital. Anna was an SpR in geriatric medicine, popular and always willing to go the extra mile for her colleagues.

The details behind their deaths are unclear at the moment but my heart goes out to their families, friends and their fellow trainees. Their untimely deaths prove once again that we must value and support each other more than ever.

Mirror man – RECOVERY part 1

The results from the tocilizumab arm of the RECOVERY trial were announced at the end of the week and thankfully they have mirrored those from the REMAP-CAP trial on which I commented at the end of November.

Since November the REMAP-CAP investigators have released more data – 353 patients received tocilizumab with 402 receiving standard care (control). Those getting tocilizumab had a mortality of 28% compared with 36% of the control group. Due to the timing of standardised use of dexamethasone, 93% of those recruited after 17 June received dexamethasone and before that about 51% received hydrocortisone. Some also received remdesivir. 29% of patients were mechanically ventilated at randomisation.

The RECOVERY trial had a much larger study population, with 2,022 receiving tocilizumab and 2,094 assigned to 'usual care'. 82% received concomitant 'systemic steroid' and 14% were on mechanical ventilation at randomisation. Mortality in the tocilizumab group was 29% compared with 33% in the usual care group (which is convincingly similar to REMAP-CAP). The study also showed that tocilizumab reduced the chances for non-invasively ventilated patients progressing to ventilation or death from 38% to 33%.

To put this another way, the number needed to treat (NNT) for tocilizumab is 25 to prevent one death. Most would say an NNT of less than 5–10 shows a treatment works but there are very few NNTs calculated for drugs to prevent death (the trial of antibiotics v placebo for bacterial pneumonia is unlikely to get past even the most relaxed ethics committee). There are lots of NNTs calculated for preventative treatments (eg warfarin in non-valvular atrial fibrillation has an NNT of 60 to prevent death). NNTs have their own website if you want to lose yourself for an hour or so.

Both the RECOVERY and REMAP-CAP trials should be seen as major successes for the NHS and reiterate the value of coordinated clinical research. Martin Landray, one of the joint chief investigators of RECOVERY, has asked me to thank all RCP members who have contributed to this research. Thank you to all.

Based on these results from both trials it strongly suggests that tocilizumab and steroids combined should become first-line treatment for around 50% of hospitalised patients with COVID-19. This creates a possible problem. Not cost (the savings in reduced need for ventilation alone make it cost-effective), but supply. Tocilizumab is used as a second-line agent in the management of rheumatoid arthritis and juvenile idiopathic arthritis and it is unclear if there is enough supply globally to meet both the rheumatological and the COVID-19 demand.

Tell me when – velocity, variants and vaccines

Thankfully this demand is dropping. As COVID-19 hospitalisation rates fall in most countries across the world, more and more noise is being created about when lockdowns will be relaxed and what the implications are for those vaccinated.

In terms of half-life decay, hospitalisations are halving in the UK every 3 weeks or so but ITU numbers are falling at half that rate. Thus ITU capacity will remain at risk for some time yet and a rapid relaxing of lockdown should not be on the cards. It needs to be remembered that descents can be dangerous (most of the 1 in 8 Everest summiteers who die on their climb do so as they come down the mountain). We must remain wary.

Already people are not talking about if there will be a third wave but when it will be. Variants will have a big say in the timing of a third wave and may still have something to say even in the tail of the second wave. Operation Eagle has been industriously tracking outbreaks of variants in the UK and has managed to get PCR tests on over 85% of households in the relevant areas. But, like a more worrying version of Springwatch, 'Variantwatch' has become a weekly obsession for me. There was a press release by PHE last Wednesday which you might have missed that gives more information about two new variants of concern. The first has centred around Liverpool and includes our old friend the E484K mutation. The other, which centres around Bristol is another E484K mutation but this one is on top of the first UK variant of concern, B.1.1.7.

As more countries try to catch up with genomic testing of viral isolates we will see more and more variants. One announced this week was from California where they have seen a recent surge in cases. CAL.20C has five mutations including a new one on me – L452R. Time will tell if this is a mutation to worry about but there is a useful review in *JAMA* of what it might mean. The confusing nomenclature that is being used – you have to know your PANGOs from your Nextstrains – really has to get sorted soon.

Variants only come to the fore if there is selective evolutionary pressure on them to succeed and vaccinations will, of course, lead to this. Thus, even seemingly no more transmissible variants may still have their day if they are not covered by immunisation. Us variant 'twitchers' will continue to watch with interest.

The sound of the crowd – recovery part 2

Planning for the recovery after this wave continues to build apace. My article in the Times last week had a lot of positive feedback, and in meetings whenever I mention the need for recuperation and planning of how to support staff recovery as well as service recovery there are rarely any dissenting voices. This includes at the highest levels of the DHSC and NHS which fills me with some hope. However, the louder the noise about this from all of us the more likely it will be that the needs of the workforce are not drowned out by a desire to get waiting lists down.

Two recent articles have given me some different thinking on the next steps. The first of these was published by The King's Fund and relates to experiences about recovery from other disasters. This shows us that recovery takes many years and needs to be focused on individuals and communities. The phases of a disaster – pre-impact, heroic, honeymoon, disillusionment and reconstruction – all sound familiar to where we are at. Worth a read.

Not forgetting where we were 'pre-impact' is important when thinking about reconstruction. The other article shows where health services in the UK were at before COVID-19 and is rather a wake-up call of the enormity of what lies ahead. As part of the Nuffield Trust's regular Quality Watch updates, the article displays graphically several public health measures over time. The graphs allow you to compare with other countries (including many in the EU) and show that we don't do too badly. However, the disparities between the most deprived and least deprived are stark. Health inequalities must be addressed in whatever restructuring of health services occurs next.

Don't you want me – NHS reform

The UK government white paper Integration and innovation: working together to improve health and social care for all was published on Thursday. That this was the third-ranked news story of the day says much about the time at which it was launched and the lack of major contention within it.

I've only had time to sit down with the white paper and go through it this weekend (admittedly with the rugby on in the background) and often found myself thinking 'that's interesting' rather than 'that's terrible'. The paper shows a lot of intent and will remove some of the anachronistic governance systems. The detail of the legislation will be interesting but there is an undoubted intent to give power to systems rather than individual trusts, focus on wellbeing and prevention, and more control going to the centre.

Integrated care systems (ICSs) will become statutory bodies and have most of the power. For example, foundation trusts will have limits put on their capital spending to ensure that the ICS is not destabilised. From what I understand, local government welcomes this move to ICSs and the white paper focuses on the importance of bringing social care closer to health care systems.

Around training it looks like LETBs will go (and if you don't know what they are it shows that they have perhaps not had the impact the 2012 Act intended) but given HEE will still pull the training system strings I think deans will stay, so we may go back to the deaneries of old. While the secretary of state will have to produce a 5-yearly workforce plan looking at supply and governance, whether this will be based in reality will be keenly anticipated. If the paper reaches the statutes in 2022 we may not even see such a plan until 2025–26. That is too far away.

Monitor and the Trust Development Authority (TDA) will finally be abolished and there may be a bonfire of regulators. The latter has been on the cards for many years (nine separate regulators always seemed too many) but given it will need to be a four-nation plan there is some wrangling still to be done.

Data sharing is highlighted and this is good to see. Many feel that the relaxations of data sharing legislation during COVID-19 have helped improve patient care, speed up research and innovation and generally been good for the NHS. There will be pushback if the changes are too radical but provided the lessons are learned from previous IT debacles, increased data sharing has to be the way forward.

As with all such legislation we mustn't throw the baby out with the bathwater. Primary care networks have been successful in many places and issues (eg vaccination). We also need to ensure that new systems adequately address the challenges of an ageing population with multiple health conditions.

These are my thoughts and you can read more in the formal RCP response. Whilst not bad, the white paper could go further and I am pleased that the shadow health secretary agrees with us that a funded workforce plan and a cross-government strategy on health inequalities are needed as well.

Human – ethically complex care

Ethically complex care is a term used to describe many difficult decision-making situations, which have been a source of much concern during the pandemic when thinking about escalation and de-escalation. There is often no clear right or wrong in these situations and it is impossible to take the human and the humane out of such decisions. Ensuring that all necessary steps have been taken and recording them is vital. Many organisations have been working on ways to document such decision-making processes and having seen these we felt it would be best to try and produce one way of recording them. Working with the GMC we have today launched an 'Ethical Care Decision-Making Record' (ECDMR).

You can download the guidance, a quick guide and the ECDMR itself. This tool was something that Donal O'Donoghue worked hard on over the latter part of 2020 with support from the RCP Committee on Ethical Issues in Medicine and two trusts which had piloted such documentation. It stands as yet another legacy to Donal on the benefits of

collaboration, hard work and doing something that improves patient care.

While talking about Donal we need to find someone to fill his shoes long term. Pete Belfield has been doing a stellar job as 'interim registrar' but was called in at short notice and would like to enjoy his retirement a bit more. The job of registrar is one of the most important in the RCP and is both busy and rewarding. If you think you might be interested do look at the job description. You will have to work closely with me I'm afraid (but only for another year and a half).

A doorway – Samaritans

I've had several meetings this week about how we support staff moving forwards and a glance at the early results from our survey this weekend (which I will cover in depth next week) shows that many are still under tremendous pressure. As doctors we often 'carry on regardless' and are the last to ask for help. This is not good for us.

If you are in need of support don't forget the Samaritans. Last April, concern over the acute and long-term impact of the pandemic on health and care workers' mental health led the Samaritans to launch a confidential, emotional support line dedicated to NHS and social care staff . You can call it free on 0300 131 7000. It's open 7am to 11pm, 7 days a week. The line is independently run by Samaritans so their trained volunteers are on hand to support you when you've had a tough day, are feeling worried or overwhelmed, or just have a lot on your mind. Samaritans is there for everyone, not only those in crisis or feeling suicidal.

Together in electric dreams – writing the COVID-19 physician history

The past year has been like few others in our 502-year history as a college and we want to ensure that the stories and experiences of physicians are told in the RCP's collections, preserving them for future generations. If you would like to be part of this historical record please share your experiences.

… and finally

In a week where a US lawyer appeared as a cat on a Zoom call and the recent use of muting committee members on parish councils became a topic of national debate, I have become very aware of needing to be on my best behaviour when on Teams or Zoom calls.

As chair I often find myself saying 'we can't hear you – I think you are still on mute' and this happened again this week. I was starting to get frustrated when the individual failed to unmute and I had to repeat myself until it was pointed out that I myself was on mute. Sometimes I hate virtual meetings. At least I am not a cat.

22 February 2021

By the time you read this the UK 'roadmap' to the steps out of lockdown will be known. As I write this bulletin, we still have more ITU admissions than in the peak of the first wave and only slightly fewer hospital admissions. Let's also not forget that it is still winter. Whatever the roadmap, we need to drive very carefully as it will be easy to lose control.

We published the results of our ninth survey of physicians on Friday morning. I'll cover the highlights throughout this bulletin but the full results are available on the RCP website.

I'm thinking about reducing the frequency of bulletins down to fortnightly after this week. But that's for next week and we need to be here now.

Don't go away – COVID-19: 1 year on

On Thursday evening we held a webinar on COVID-19 almost exactly a year since the day that COVID-19 was named and we held a seminar in the RCP building in Regent's Park attended by over 500 people. On that day the UK had recorded its ninth case and worldwide there had been 45,000 cases and 1,100 deaths. Much has happened in the year since (the understatement of the bulletin) and the meeting on Thursday gave us an opportunity to reflect on events. You can catch up with the webinar but here are some highlights:

Maria Zambon, head of the Respiratory Virology Reference Service at PHE, reviewed what we know now about the virus and our immune response to it. From obscurity it has become one of the most studied biological organisms (what are viruses? – a separate debate) ever. I was reassured that while some assays show a tailing off of immune response over 6 months there is good evidence of immunity persisting well beyond this.

Wei Shen Lim, chair of COVID-19 immunisation at the JCVI, walked us through the vaccination programme and how we are faring as we move into its next phase. We still have much to do to ensure we are reaching some ethnic minority groups but seem to be doing a bit better with reaching the most deprived groups in society. He provided ongoing reassurance around the delaying of second dosing.

Susan Hopkins, strategic response director for the pandemic at PHE, gave an open and frank view of the UK response to the pandemic and what went well and what went wrong. Any use of a retrospectoscope can be subjective but what caught my eye was the objective data from SIREN on healthcare worker infection. This showed that the number of healthcare workers getting infected in the second wave has been much lower than in the first, despite the number of infections in both the community and in hospitals being double with the more transmissible variant.

This reflects what our own surveys have shown over the past year with much lower levels of sickness in physicians in the second wave. A total of 21% of physicians had positive antibodies after the first wave, and our latest survey shows this has increased to 27% in the second. For comparison, ONS data show that community antibody prevalence was 7% after the first wave and is now 19%. At the peak of the first wave, 7% of physicians were off with acute COVID-19 and at the peak of the second wave it was 2%. The weekend before last it was 0.65%. The reasons for this were debated and while I will talk about PPE later I do wonder if the vaccination of many staff in December has contributed. Although the SIREN data are not yet published there is a good graph of staff sickness rates due to COVID-19 on the Spectator website which clearly shows the differences between the waves.

I had the chance to quiz Chris Whitty and the other panel members, including asking them about the one thing we should have done differently. There were some interesting responses but the role of asymptomatic infection struck home. We thought this SARS would be like the one before and that there would be virtually no asymptomatic transmission. How wrong we were.

Stand by me – PPE

Throughout our surveys over the year we have asked about PPE. I have had some flak on Twitter for the way we have phrased the questions but we have consistently used two questions to differentiate between having the PPE that the PHE guidelines recommend and the PPE that physicians feel they need.

On the former, things are much better than in the first wave but still not perfect – 4% of people still cannot get the PPE that PHE recommend. Given that this figure was 39% in April (which in itself was a big reason why infection rates in healthcare and social workers were so high in the first wave), we are in a better place but I have been clear with the NHS that there are still shortages.

Throughout the pandemic a significant number of physicians have felt that the PHE guidance is not adequate. In April, 22% said they didn't have the PPE they needed, and this figure was still 21% in January and is now 18%. Confidence in infection prevention and control (IPC) processes aligns with this as 16% are not at all confident in their trust's IPC processes and only 60% are fairly or completely confident.

The data on infection rates for healthcare workers in the second wave being very similar to community rates may change our perception of risk and I suspect vaccination may also change this once we understand how effective it is in the hospital setting. However, the loss of confidence in PPE created in the first wave will be almost impossible to regain and fear and doubt remains. It needs to be addressed.

On PPE the RCP position is that risks should be assessed on an individual and workplace setting basis. Where a higher level of PPE is needed it should be used (and not just masks). The outcomes for healthcare workers from COVID-19 infection follow the pattern in other parts of society. Being male, older, from particular ethnic backgrounds and having multiple conditions are the determinants of severe disease. Individual risk assessment is vital – 24% of physicians have not had one.

We have also publicly stated that ventilation must be improved, especially in older hospital wards. That one of my local trusts has just bought 250 standalone air-cleaning systems for their wards based on evidence from local trials is reassuring.

I hope, I think, I know – vaccines

As of a week ago 97% of physicians had received at least one dose of vaccine, with 95% of us getting the Pfizer/BioNTech one. Another 1.5% had definite plans to get vaccinated and less than 0.2% are not planning to get vaccinated (and there may be many reasons for this). This is all good news and shows the confidence we as a group have in vaccines. The dominance of the Pfizer/BioNTech vaccine, though, means I am watching supplies for the second dose very carefully. All seems on track at the moment…

The timing of the second dose remains a contentious issue, although the early signals for those groups vaccinated suggest that the single dose is having the impact as predicted. People seem less worried about the delay in second dose now than in January with only 12% being very worried about it compared with 17% back then. The sooner we have data on the effectiveness of the strategy for healthcare workers the better.

As the majority of us will all be (hopefully) heading for a second dose soon we should expect some significant flu-like symptoms. There has been some debate about using paracetamol with some media doctors saying avoid paracetamol prophylactically as it may 'blunt the immune response'. The AstraZeneca/Oxford trials specifically looked at this and showed that taking paracetamol prophylactically helps reduce side effects and has no impact on immunogenicity. I will be taking some paracetamol pre-jab.

As per the Green Book guidance on immunisation, NHS England has also recommended this week that the small number of patients about to receive planned immunosuppressive therapy should be considered for full vaccination prior to commencing therapy (ideally at least 2 weeks before), to make the vaccine more effective. The guidance says that

where possible patients should receive the two doses 3–4 weeks apart to provide the maximum benefit. Any decision to defer immunosuppressive therapy or to delay possible benefit from vaccination until after therapy should of course balance the risk from COVID-19 against the risks from their underlying condition. Clinical staff responsible for patient care are advised to liaise with local hospital vaccination hubs (preferred) or the patient's GP regarding accessing vaccination.

My big mouth – it's OK to be honest with people about how we feel

Our latest survey reinforced the effect of the pandemic on us all. Almost half are not getting sufficient sleep and 69% said they felt tired and exhausted. This should mean planning how to recover but 63% said there were no discussions in their trusts about time off to recuperate. We therefore decided this should be the main focus of the press release and I ended up being interviewed a few times on it. I did a few TV interviews but the story was bounced by a couple of channels once the news about Harry and Meghan being 'relieved' of their royal duties came out. This says much about what is seen as important to our society.

In one interview I was asked how I had personally felt during the pandemic. I was honest about the emotional impact of seeing so many patients dying, colleagues struggling and friends and colleagues dying. As I said, I have cried more this year than ever before in my career (including during the worst job of my life – being an eminent surgical professor's SHO on a sleepless 1:3 rota). I didn't think too much about what I had said but it was front-page news (with a big photo of me in scrubs) in our local paper. I then worried about how it would be perceived. Medical leaders need to be strong, don't they? Colleagues in Derby have told me, though, how much me going public with how I felt has helped them. If I can't admit my frailty and say it's OK to do so I'm not setting much of a lead.

It's gettin' better – COVID-19 infection in physicians

Testing was a big problem in the first wave and many physicians will have had COVID-19 without a positive PCR test (as shown by the antibody prevalence). In this survey we wanted to drill down a bit more into the disease course.

Lateral flow tests (LFTs) are being used by most and we are now able to give some information on their sensitivity and specificity in our population. Of those who had a positive PCR test, and an LFT in the preceding 2 days, 66% of the LFTs were positive. There is a slight bias here as the positive LFT may have resulted in a PCR test being done. Of those who had a positive LFT (4% of the 817 survey respondents doing regular LFTs) only one person reported then having a negative PCR. In short, LFTs perform in real life as expected in trials.

A total of 180 physicians gave us data on disease course following a positive PCR test. 7% of physicians who had a positive COVID-19 PCR ended up being admitted, which is higher than we would expect from other studies and has to be a concern. 76% of us were off work with symptoms for less than 2 weeks, 20% for 2–6 weeks and 4% for more than 6 weeks. 48% had symptoms for less than 2 weeks, 25% for 2–6 weeks, 9% for 6–13 weeks and 18% still had symptoms after 3 months. Strikingly, more physicians are currently off work with long COVID than acute COVID.

The impact of long COVID continues to be a worry both with respect to increased demand on the medical specialties, mental health services and primary care but also directly on those healthcare workers who have it.

Fade in-out – QCovid and shielding

After a very long gestation the QCovid risk calculator was launched last week. It is a tool which has been constructed by the Oxford team that came up with the QRISK tool and allows individual risk of outcomes from COVID-19 to be estimated. This has allowed the 'shielded patient list' (called SPL by those in the know) to be updated to ensure it

includes those most at risk. Clinicians will be able to work with their patients to decide whether that patient should be on the SPL. This list has advantages and disadvantages for the patient but at least with QCovid we can have a more rational approach as to who should be shielded.

The tool mostly uses data from the outcomes in the first wave so it will adapt with time as more understanding develops and data become available. The impact of vaccination on risk is perhaps the biggest new variable so the tool will need to be used with a bit of old-fashioned clinical common sense.

Patients should have been notified that they are now on the SPL and while this is good from the point of view of patient safety I wonder how much work it will create for GPs and consultants. Expect some telephone calls this week. GPs can add and take people off the SPL and hospital doctors can ask their 'COVID-19 trust lead' to do this. I have been asking for clarity about what threshold has been used to put people on the SPL as this would be helpful when we are having discussions with patients. This was published over the weekend and it is an absolute risk of mortality of 0.5% or a relative risk of 10x baseline.

D'you know what I mean? – vitamin D

I have had more emails on vitamin D than any other potential intervention during the pandemic so we thought we should see what physicians are doing (actions speak louder than words sometimes). Interestingly, 51% of us are taking supplements of which 58% were doing so before the pandemic. The most commonly taken dose (41%) is 800–1000 IU a day with most (64%) taking it for perceived benefits to health and immunity. 30% are taking supplements to improve COVID-19 outcomes.

The evidence that vitamin D supplements prevent an individual contracting COVID-19 is scanty at best and the survey backs that up. The prevalence of antibodies (27%) was the same in those taking supplements as those who were not. Whether vitamin D prevents severe disease, hospitalisation and death is perhaps more important and our survey was really too small to look at this. However, 9 out of the 13 physicians who were admitted to hospital were taking supplements which rather refutes the notion some have put about saying supplementation is better than vaccination.

Vitamin D supplementation hit the headlines last week when David Davis MP tweeted that it reduces mortality by 60% following a preprint of a study from Spain. He has previously spoken in parliament on the topic a couple of times citing the experience in Andalucia where supplements have been introduced to 'halve the death rate'.

The study that he cited by Nogues *et al* from Barcelona has now been removed from the Lancet preprint site due to concerns raised about its methodology (a bit worrying). Thankfully I managed to read it before it was withdrawn and although it was large (930 patients) and claimed to be randomised and controlled it was unclear how randomisation (of wards not patients) had occurred. Patients were able to swap into the treatment arm and the admission criteria for supplemented wards versus non-supplemented wards was not described.

To pour further water on the fire, a smaller (240 patients) RCT from Brazil published this week on using high-dose vitamin D in hospitalised patients showed no benefit. Lastly, since I heard about the supplementation in Andalucia I have been watching death rates regularly. After a fall, they have risen again significantly over recent weeks and as of yesterday were the third highest in the 19 regions of Spain.

I have to say all this frustrates me. There is a reasonable hypothesis why vitamin D supplementation should work, it is not overly expensive and should be amenable to testing in large RCTs. That we still have no published RCT evidence of benefit, and preprints of studies with potential serious methodological flaws keep appearing helps no one and means the debate continues to go round and round.

… and finally

I was very upset to hear about the death of Cliff Mann on Saturday from cancer. Cliff was a former president of the Royal College of Emergency Medicine and a fellow of the RCP. I knew Cliff for over 10 years and he was instrumental in the development of emergency medicine and the college. His drive, humour and an ability to get people alongside him made him special.

Cliff was always self-deprecating and full of great stories. My favourite was one about his interview for a registrar post. He realised he wasn't going to get the job fairly early on in the interview but all doubt was removed by the chairman's final question:

Chairman: 'I see your primary postgraduate qualification is the Membership of the Royal Colleges of Physicians. Did you pass that first time?'

Cliff: 'Yes.'

Chairman: 'So you haven't got a lot of experience of that either.'

The last time I saw him in person was a year ago in an empty café just up the road from the NHS building at the Elephant and Castle. We chewed the cud as well as some slightly ropey sandwiches and wondered when we would next meet in person.

Once again, the death of a friend has shown me that we must cherish the time we spend with people. Life, especially at the moment, may not always turn out the way we expect.

8 March 2021

After a brief fling a week ago, spring has put itself on hold in the UK but there are green shoots appearing from the ground and the occasional flower to promise better months ahead. The world of medicine is much the same, although not everything pushing itself into view is particularly pretty or welcome.

COVID-19 still features in most people's lives but it seems that its partnership with winter has come to an end. Unlike some other recent ends of partnerships, no one is too sad about this.

Get lucky – vaccine efficacy

In my last bulletin I said we needed evidence of the efficacy of the UK vaccination programme as soon as possible. Just as we hit the 'send' button for the bulletin, two papers were published with such data (Mondays and Fridays seem busy days for releases of this type). Since then we have had even more data to pick through so I will try and summarise the state of play.

The report from the four UK nations' public health bodies and NIHR on vaccine efficacy included 7.5 million people, covering a period when the 'Kent variant' predominated. The relatively small number vaccinated before 4 January mostly had two doses of the Pfizer/BioNTech vaccine. After that date almost all had a single dose of either the AstraZeneca/Oxford vaccine or the Pfizer/BioNTech one. A single dose of the Pfizer/BioNTech vaccine reduced symptomatic disease in the over 70s by 60–70% and two doses by 85–90%. A single dose of the AstraZeneca/Oxford vaccine reduced symptomatic disease by 60–75%. Importantly, in those with symptoms a single dose of the Pfizer/BioNTech vaccine reduced hospitalisations by 44% and deaths by 51%. The EAVE II study in Scotland confirmed this, showing a single dose of either vaccine reduced hospitalisations by 81% in the over 80s.

PHE is monitoring vaccine effectiveness on a regular basis using nationally collected data and has produced its first report. Infections were found in 12,000 people over the age of 80 and fell by 57% in those who had been vaccinated with one dose and 88% with two doses. This document also shows a much faster fall in admissions for the over 80s (who have been vaccinated) compared with other age groups.

Israel is the furthest ahead in its vaccination programme of any country in the world and most people have had two doses of the Pfizer/BioNTech vaccine. Data on the first 600,000 showed two doses reduced infection by 92%, symptomatic disease by 94%, and hospitalisation by 87%. While this makes it clear that a single dose is not as effective as two doses they also estimated that a single dose reduced mortality by 72%.

Given the much larger numbers of death and severe disease in the over 70s we can be reassured that the UK single dose strategy has saved more lives and resulted in fewer hospitalisations than a 3-week second dose strategy would have done, given our supply restraints (which have been a bit worse in the past week). But what about for (younger) healthcare workers? Given 95% of us have had the Pfizer/BioNTech vaccine the above data may make some feel slightly uneasy.

One more time – vaccine efficacy in healthcare workers

Firstly, for the 27% of physicians who have already had COVID-19 there is now good data from the US that a single dose of the Pfizer/BioNTech vaccine produces higher levels of neutralising antibodies than in those who have not had infection. If you haven't had COVID-19 you can be reassured somewhat that neutralising antibody levels after a single dose were similar to those seen after COVID-19 infection.

The SIREN study of healthcare workers showed a single dose of Pfizer/BioNTech vaccine was 72% effective at reducing infection, detected using the regular PCR testing undertaken by SIREN cohort members. This increased to 86% after two doses. The study did not report hospitalisations (the sample is probably too small) but vaccination increased the proportion of asymptomatic infections from 6% to 18% in those who were PCR positive, strongly suggesting it does reduce severity. It must be remembered that the SIREN cohort is 85% female and 89% White healthcare workers so not totally representative of physicians.

Putting this all together, the vaccines we are using work and while two doses are undoubtedly better than one, delaying the second dose has not been the calamity some predicted. We also still don't know if delaying the second dose of the Pfizer/BioNTech vaccine to 12 weeks will result in better or worse long-term protection than dosing at 3 weeks but data is now accumulating (I'm due my second dose this week). There is little to choose between the two vaccines and thus we can advocate strongly for both.

Incidentally, from an RCP perspective, this advocacy stops short of supporting mandatory vaccination for all healthcare workers given the discussions that are now happening on this topic.

Human after all – vaccine hesitancy

When it comes to the vaccine rollout many have been surprised by the large uptake in those over 70. The NHS weekly data on vaccines show 95% of the population over 70 has had at least one dose. This is much better than was expected although the figure for 75–79 year olds is 100% which suggests the data may not wholly reliable … However, the data do show a drop in uptake in certain parts of the country (London for example) and in the most deprived areas and in those from ethnic minority backgrounds.

This is also seen in the SIREN data with vaccination coverage of 89% overall falling if participants had previous infection, were female, younger than 35, from the most deprived communities or from a BAME background. The details are a little worrying as vaccine uptake in Black healthcare workers was a quarter of that expected and certain occupations (portering and midwifery) also had much lower rates. Understanding the reasons for this are important and it will need local and relevant advocacy to resolve.

This also has implications for the rollout as a whole. We should expect a reduction in uptake in younger age groups who view the risks of COVID-19 as minimal and we may well see people not turning up for second doses.

Face to face – what's next?

As the restraints of the lockdown relax in the UK we will almost surely see many wanting to stretch those restraints further and vaccination will give people the feeling of increased freedom.

We should expect infection rates to increase with such behaviours as this is likely to happen to some degree even if the 'roadmap' is followed to the letter. It is probably a good thing that Easter holidays are only 3 weeks after pupils return to school today. Some parts of the country are already seeing stubbornly slow rates of reduction in case numbers (especially in my neck of the woods). We will need to remain vigilant but how we manage endemic COVID-19 over the next year or so is a significant challenge.

The Lancet COVID-19 commission taskforce on safe work, safe school and safe travel produced a document last week which looked at this (the document is as long as the name of the group). The report makes good sense promoting a risk reduction framework, layered approach to protection, prioritising protection for the most at-risk workers, the reopening of schools, a more strategic approach to reopening businesses and focusing on air travel as an important mode of transmission of infection. Reading the latter has rather put me off air travel in the immediate future.

Doin' it right – COVID-19 treatments

As always, my postbag has been bulging with enquiries about why I am not advocating for particular treatments. Keeping on top of all the treatments being proposed for COVID-19 is no easy task and ensuring they are reviewed objectively and fairly is harder still. Thankfully the NHS has a specific team doing this called the RAPID-C19 initiative. RAPID stands for 'research to access pathway for investigational drugs' and is a collaborative between different parts of the NHS including NICE, the MHRA and NIHR as well as the NHS bodies in the devolved nations.

At the moment they have a staggering 742 treatments under consideration/observation, from those looking at community prevention, through management of symptoms, hospitalisation, and rehabilitation after infection. It seems unlikely that we will have any drugs that have such a dramatic effect on mortality as steroids and tocilizumab but I await the news around inhaled budesonide and aspirin with interest. The former is being looked at in the PRINCIPLE study. Hats off to the 4,000 or so patients who have volunteered to take part in the study.

Contact – letter from the PM (not)

My postbag also contained a much-awaited letter this week. In October I wrote to the prime minister on behalf of the Inequalities in Health Alliance asking for a cross-governmental strategy to tackle health inequality, particularly important now in the light of the pandemic. I had to write again as the letter apparently got lost in the post (it was an unlucky day as both the electronic and paper post systems seemed to fail at the same time).

The PM has been a bit busy so I can understand a slight delay, but 5 months is quite a while. He passed it to Jo Churchill MP (parliamentary under-secretary of state for prevention, public health and primary care) as 'it was a health issue'. The irony of this was not lost on me as I had specifically made the point that the drivers of health inequality are system wide (education, housing, food, environment etc). To give her credit, the minister agreed with this in her letter. However, despite that there was no commitment to such a strategy. The glimmer of acknowledgement, though, is a start. We will keep pushing on this.

The UK chancellor produced his budget last week which did not go down at all well with most of us in the NHS. I have written a blog on this, but the failure to tackle the social care funding issue will do little to improve health inequality and the needs of the most vulnerable parts of our population.

Around the world – thank you international NHS colleagues

The chancellor and rest of government have also been hauled over the coals over the weekend by the media once it became clear they only propose a 1% increase in pay for NHS workers. The 'thank you message' this sends is an interesting one.

It looks like we will have to use other ways to ensure that NHS staff know that they are valued. One such way was aimed specifically at internationally trained staff last Friday. Overseas NHS Workers Day was an initiative established by the Doctors' Association UK. This was something that we wanted to support as the NHS would not be able to exist without the large numbers of internationally trained staff. The medical specialties in particular are reliant on international medical graduates. Thank you to you all.

Today is International Women's Day and we should celebrate that as well. Alongside the social media we have been doing throughout the day promoting our series of blogs on the subject, our vice president Global, Mumtaz Patel, has been hard at work organising a webinar to highlight the inspirational role of our international female medical leaders. Although the webinar will have taken place by the time you read this, it will continue to be available through RCP Player.

The new wave – elections

It is that time of year again and we are looking for people to stand for election to Council as well as someone to replace Cheng-Hock Toh as academic vice president. Nominations are open until 1 April and details can be found on our website. The next few years will be exciting as we build on the transformation in the way the RCP has influenced the health agenda (and research in particular). Council remains a diverse and energetic body and we are keen that it continues in that vein.

If those roles are not quite up your street we need two RCP reps on the Intercollegiate Committee in Haematology and a new RCP member of the Inflammatory Bowel Disease Registry board. If you're not up for these yourself, please draw them to the attention of your haematological and gastroenterological colleagues (which reminds me, I must do that too). If you want to know more about the IBD Registry role please contact John Dean, RCP clinical director for quality improvement and patient safety at John.Dean@rcplondon.ac.uk

As an aside, as I type that email address we are in the process of switching over addresses to @rcp.ac.uk (mine changed last week) as we gear up for the opening of RCP at The Spine in Liverpool. I am keen that the RCP is not seen as a London-centric organisation and having a domain name that reflects this is important.

On 29 March I too must face the electorate for the last time. The nature of RCP presidential elections is that they are usually uncontested except when the incumbent reaches the end of the accepted 4-year term. Even though it is uncontested this year I will still need some people to vote for me and while the date is not easy (it is enshrined in law), it would be great if you can join us for College Day. I will be the warm-up act for two stellar neurologists (Professors Alan Lees and Mary Reilly) giving the FitzPatrick and Samuel Gee lectures.

Lastly on RCP governance topics, the AGM this year will be on 6 September. We are moving to having the AGM in September more regularly having done this last year.

Our sister college in Edinburgh has also been having elections and I was very pleased to see that Professor Andy Elder has been elected as the next president and will take up his post in June. This was mixed with some sadness as one of his co-candidates for presidency was Angela Thomas who has been acting as interim president for much of the past year. I have tremendously enjoyed working with Angela over her tenure and she has guided the RCPE through some very tricky waters. Well done Andy and many thanks to Angela.

Digital love – opportunity for Wales physicians to speak up

The RCP members in Wales are a very active part of our membership and to ensure we know about the issues and experiences that concern them the RCP Wales office has set up the first RCP Connect in Wales on Wednesday 10 March for those in Swansea Bay and the Hywel Dda Health Board. Members will be able to join Olwen Williams, vice president for Wales and the RCP regional advisers.

…and finally

The positive effects of the vaccination programme are already clear to see but the 'freedom' vaccination instils has its downsides. One of my friends told me about his elderly parents showing up on his doorstep unannounced last weekend as they 'had had their vaccination so thought it was OK'. Initially flummoxed he then did the right (but difficult) thing. After a brief (behind a mask) chat he lovingly and gently closed the door on them.

It must be so difficult for those grandparents and others who have been unable to see families and loved ones face to face for such a long time. Many of us will be faced with such dilemmas over the next few weeks.

Beware wandering parents.

22 March 2021

In the 2 weeks since my last bulletin we have had the first major hiccup with the vaccine programme since the anaphylactoid reactions seen on the first day. I will cover this in some depth. The third surge of the pandemic in the EU also needs some thought and I will focus on variants. As always, much else has happened (with some good news among it) and I will try and ensure my aim is true as I run through it all.

Accidents will happen – CVT and COVID-19 vaccination

Since the rollout of the AstraZeneca/Oxford vaccine in the EU there have now been 18 cases of cerebral sinus venous thrombosis (CVT) reported to the European Medicines Agency among the 20 million recipients of the vaccine (or roughly five cases per annum per million). This rate of incidence is similar to the normal incidence of CVT. What makes the cases more likely to be related to the vaccine is that all were associated with thrombocytopenia, occurred 4–16 days after vaccination, and of the six cases identified in Germany, three patients died. This is unusual in CVT which has a mortality of around 3%. That the cases were in young people is worrying but CVT is normally more common in younger women (partly related to pregnancy and the oral contraceptive pill).

The growing consensus among thrombosis experts is that the mechanism behind these cases is probably not dissimilar to that seen in heparin-induced thrombocytopenia (HIT). While I'm sure most of you will remember the mechanism of HIT, here is a quick reminder for those of us who have haematological amnesia. In HIT, heparin binds to platelet factor 4 (PF4) inducing conformational change that allows IgG antibodies to bind and the resulting complex activates platelets and other parts of the thrombotic cascade to create a prothrombotic condition with thrombocytopenia. HIT tends to occur between 4–16 days of starting heparin. How the vaccine might induce such an effect is unclear (and as you can imagine there is a

lot of frenzied activity looking into this – PF4 stocks have become highly valued). It seems that the effect is limited to the AstraZeneca/Oxford vaccine at the moment.

The Paul Ehrlich Institute in Germany has been looking at the cases occurring in those under 55 and gives some helpful advice. My reading of this is that in the cases referred to them the incidence is higher (around 1 in 100,000) and if someone has severe headache persisting more than a few days beyond the first 2–3, or a headache associated with epileptic seizures, speech disturbance, hemiplegia or other significant neurological symptoms, this should be investigated (although I struggle to understand why you would not investigate a headache with such symptoms urgently anyway).

Given all the above it is not surprising these cases have caused significant disquiet, but the stopping of the vaccination programme in the EU will have resulted in many preventable deaths and even with an incidence of 1:100,000 the risks of the vaccine are far outweighed by the benefits. David Spiegelhalter, one of my favourite statisticians (and an Hon FRCP), put this into context on Twitter, estimating that two–three deaths per million occur in those in their 50s (and it will be much higher in older age groups) for every week the vaccine programme is delayed.

Thus, the challenge here is communicating to all populations the risk/benefit of vaccination. When the news of 'increased thromboembolic events' first appeared a week ago I was surprised no one pointed out that 21% of hospitalised patients with COVID-19 have such events, and that mortality is almost double for those patients with thromboembolic events compared to those without (23% v 13%), let alone that COVID-19 doesn't just cause thromboembolism.

I'm not convinced that having images of politicians having the AstraZeneca/Oxford vaccine to show it is safe will work (I vividly recall the image of John Selwyn Gummer's daughter being made to eat beefburgers in public during the days of BSE). After advertising executives, politicians are the least-trusted professionals by the public (the Ipsos Mori 'Veracity Index is worth a look). We need to show the public that the vaccine works and prevents deaths and perhaps give a figure for this. Enabling someone to compare the risks of having the vaccine with the chance of dying or having life-changing symptoms if they don't have it is critical. As we have seen with the MMR vaccine public confidence is a fragile thing. That the EU has taken a different course from the UK, though, may actually increase uptake in some parts of the UK population ('Brexit' emotions continue to run high).

Watching the detectives – variant watch

Talking of the EU brings me on to variants. Regular readers will know this has become a slight obsession and I am delighted to report that I have found the perfect website to feed my addiction. The fact that it is called 'Pangolin' only adds to the joy. The website allows you to look for emerging variants and assess how known variants are doing. Given the differing effectiveness of vaccines (see later) this is important.

The B.1.351 variant (the so-called South African variant) seems under control in the UK, being found in only 0.17% of 158,452 sequenced viruses since it was identified being of this lineage. In parts of the EU the pattern is more worrying with figures showing 4.26% of 6,314 in France, 1.31% of 24,609 in Germany and 0.21% of 5,628 in Italy. The lack of sequencing in the EU has to be a concern – if countries are not monitoring variants as closely as we are how can they hope to control them?

The P.1 variant (the so-called Brazil variant although there are others that have been identified from in that population) also seems under control in the UK with only six (0.01%) cases in 42,481 sequences. It is much more prevalent in the EU with 2.58% of sequences in Italy, 0.25% in France and 0.19% in Germany. This makes the rising number of cases in the EU a real concern and we should expect to see increased numbers of cases in the UK as the third wave surges in the EU.

The evidence of effectiveness of available vaccines against these variants is accumulating, although limited, as many of the initial trials were done before the variants emerged and so we will need to see 'real-world' effects which will depend on sequencing numbers. For the AstraZeneca/Oxford vaccine, though, a trial was carried out in South Africa where 93% of cases were the B.1.351 variant. The results of this study were published in the *NEJM* last week. The number of cases was small and thus the confidence intervals wide but a vaccine efficacy of 10.6% (compared with 75.4% for non-B.1.351 strains) was found. This is a big worry and shows that my obsession with variant watching is probably warranted (confirmation bias I know).

Other vaccines may hold the key. Summary data have now been published by the FDA on the Janssen vaccine Ad26.COV2.S, which is a human adenovirus vaccine (the AstraZeneca/Oxford one uses a chimpanzee adenovirus, hence its abbreviation ChAdOx1). It is important as it is a single dose vaccine and so may be useful in situations where follow-up second dosing is difficult or as a booster for populations where variants are emerging. The Ad26.COV2.S studies included many populations and showed that globally at 28 days vaccine efficacy for moderate/severe COVID-19 was 66.1% and for severe/critical COVID-19 it was 85.4%. In South Africa these figures were 64.0% and 81.7% respectively and over 90% of strains tested in that country were of the B.1.351 lineage.

I can't stand up for falling down – Act FAST

All the discussion around CVT reminds me to highlight stroke medicine. Having many specialties within the RCP means that it is always hard to pick any single one out for a mention when I know there is activity going on in all. However, I've been at lots of meetings recently where stroke medicine has been discussed and given how common stroke is and the impact it has on so many people I'm happy to give a shout-out to one particular campaign that is being relaunched – Act FAST. Raising awareness of the symptoms of stroke is important as well as the need for a 999 call.

Even among the medical profession there is some underplaying of the importance of these symptoms and the ongoing risk of further events in those who have had strokes or TIAs.

Pump it up – other vaccine news

Given the focus on CVT the issue of anaphylaxis with the vaccine has been rather forgotten of late. It remains an important issue and the incidence of significant anaphylaxis in a group of US health workers getting mRNA vaccines was found to be 2.5 per 10,000 doses, of which over half were given adrenaline.

There has, however, been a fair bit of discussion about mRNA vaccine efficacy in some groups of patients, including those with cancer and those on immunosuppressants. In a pre-print release (which was really hard to track down) of the SOAP-2 study Monin-Aldama and colleagues from the Francis Crick Institute and others showed that a single dose of Pfizer/BioNTech vaccine produced an antibody response in 100% of healthy controls at 5 weeks but only in 43% of those with solid cancers and in 8% of those with haematological cancer. Giving the second dose at 3 weeks increased this to 95% and 60%. The numbers of patients were really small and thus the findings should be viewed carefully.

In a separate group of patients with renal transplants only 63% developed neutralising antibodies after a single dose of mRNA vaccines (including the Pfizer/BioNTech vaccine) and this fell to 37% in those receiving antimetabolites. This doesn't come as much of a surprise to those of us who use azathioprine to reduce the immunogenicity of biologics in our patients but does make one worry a bit more about those patients.

How do we take this forward? I think we need to think urgently about earlier second dosing for mRNA vaccines in immunosuppressed patients and look for any evidence around other vaccines. As the vaccine programme rolls out and we move into less at-risk cohorts, the issue of best use of supply to prevent mortality may need a more subtle approach than one based on just age and all getting a 12-week second dose.

The breaking news today that the trials of the AstraZeneca/Oxford vaccine in the US had 100% efficacy in preventing serious illness is further evidence that vaccination will continue to be the main weapon in our defence against COVID-19. I just hope that vaccine supply doesn't become weaponised by different EU countries over the next few days.

Good year for the roses – a day of reflection

Tomorrow is the anniversary of the first UK lockdown and the date has become a totem in many people's minds for reflecting on the pandemic so far. The charity Marie Curie has led the calls for this to be a national day of reflection and the British government has backed this with a minute's silence being held at midday for those who have died in the pandemic so far. The RCP will also be supporting this and we will be reflecting in a number of other ways.

Firstly, we will publish the final version of our tribute to members and fellows who died of COVID-19 in 2020. This expands on the version we published at the end of 2020 as we have collected more obituaries and thus are able to celebrate those lives more fully.

Secondly, we will publish the March edition of *Commentary* which will include my reflection on the impact of the pandemic on training, and an interview between Phil Gothard and Professor Chris Whitty. That interview pulls few punches and Chris gives his (typically) honest and straightforward answers. As 'one of our own' I think Chris appreciates the work and sacrifice of physicians in the past year better than anyone else leading the pandemic response. His final words of the interview say it all (but you'll have to read the article to find out what they are!).

Thirdly, we will publish a separate reflective piece on the past year written by me. It will be a bit more sober than these bulletins as it may get wider readership than you valued readers (not everyone enjoys my 'bulletin tone').

Lastly, we will be asking everyone to use social media and the #RCPRemembers to reflect on colleagues who have died during the pandemic. For me that will include my old mate Donal.

Senior service – appointment of a new registrar

On which note it is probably the right time to announce that last week (after a very gruelling and competitive interview process) we appointed a new RCP registrar, Dr Cathryn Edwards. Cathryn was president of the British Society of Gastroenterology from 2018–20 and has been involved in various RCP activities for the past 5 years. She will be the first-ever woman to be appointed as registrar and it will mean five of the eight RCP senior clinician positions are filled by women. I am really excited about Cathryn starting and it will allow continuity of 'RCP memory' as my successor takes the reins in 2022.

Some may worry that there is a takeover of gastroenterologists at the RCP but you will only have to put up with me for another 18 months, and Chuka Nwokolo will be stepping down as treasurer at the beginning of 2022.

Also, please don't forget College Day in a week's time. I will (hopefully) be voted in for my last year and will also be giving a summary of the past 12 months. It has not been a quiet one. By now all fellows should have received their registration email with log in information for the virtual College Day on Monday 29 March 2021. If you have not received this and would like to attend, please contact conferences@rcp.ac.uk

Everyday I write the book – cannabis registry

When I was registrar one of the tasks I was given by the then president was to draw together some evidence on the use of medicinal cannabis. This was as 'hot' a potato as you can be handed but given the paucity of evidence for positive effects it was not as impossible as I first feared and when NICE published its guidance in 2019 it agreed with our recommendations (although being interviewed on

the Today programme on the topic with a mother who had mortgaged her house to pay for her child's medicinal cannabis was one of the hardest things I have done). What was clear when we were drawing the guidance together was that we needed a national registry for patients on such drugs to ensure we could assess benefits and risks.

I am pleased to see that this is now going to be available and it is an important development for neurologists in particular. From Thursday 1 April, providers of specialised services prescribing cannabis-based products for patients should submit data to the registry. A lead clinician needs to be identified and registered at Arden and GEM CSU for training and technical support by contacting agem.apps@nhs.net

Ollivon's army – Wales news

My Saturday evening this weekend was made much more exciting by the France v Wales rugby match. I know rugby is not everyone's cup of tea but it was one remarkable match with France snatching victory in the final minute. It was a good example of the adage that nothing is over until it's over and that keeping going even when things seem against you can bring rewards. Unlike England (don't get me started), Wales have played great rugby this year so like most of the Wales population, Olwen Williams, our vice president for Wales, will have been gutted and probably threw a baguette at the television. It has not all been bad news, though, for the RCP Cymru/Wales team this week.

Wales will be having national Senedd elections in a few weeks (6 May) and the team brought together a brilliant paper looking at how services and health should be delivered in Wales in the brave new world of the pandemic. Recover, rebuild, renew calls on the next Welsh Government to recruit and train more doctors, invest in community and social care, and tackle health inequalities which have been exposed and exacerbated by the COVID-19 pandemic. It got a huge amount of press coverage with multiple television interviews for Olwen, trainees and others which really waved the RCP flag. Well done to all involved.

Shipbuilding – generalism v specialism

It is not only in Wales where the future of the NHS is being thought about. As many discussions move towards restarting services, the white paper and what hospital services might look like in the future in the UK, it was perhaps timely that a piece of NIHR-funded work was finally published a couple of weeks ago to help understand the relationship between specialism and generalism in smaller hospitals. It was conducted by the Nuffield Trust under the leadership of Louella Vaughan.

The publication itself is long but full of fascinating detail (conflict of interest – I was one of the investigators so may be a bit biased). In short, what comes into hospitals under medicine is very predictable but among the 50 hospitals studied the way services were set up varied tremendously with 25 different designs of service. These were determined by the workforce available, historical service design, the geography of the area and level of engagement with clinicians. No particular model was more cost-effective. In other words, one size doesn't fit all and there are many ways to crack a nut. It does mean that imposition of one type of model of care across hospitals in the NHS is unlikely to succeed.

Service design is likely to come up as a discussion point at the next RCP Book Club which is tomorrow evening at 7pm. Lord Nigel Crisp will be joining us to discuss his book *Health is made at home*. His work highlights that health inequalities have been exacerbated by the COVID-19 pandemic, and talks about our responsibility as individuals and as a community to create a healthy society. Lord Crisp will read a short excerpt from his book before the discussion is opened up. The event is free so do register to attend if you are interested.

… and finally

My hospital has been a bit thin on the ground medical staffing-wise over the past week or so as people desperately try and get some (much-needed) leave in before the end of the month. Indeed, I am among their number this week.

I hope that if you have a chance to get some downtime that it is restful and that the weather allows some outside activity. We all need to recharge our batteries at the moment – they are going to be needed for the next year.

29 March 2021

This bulletin is a week early and bit shorter to allow the Easter weekend to be bulletin-free. This may not improve your Easter much but it will make the Goddard household a much less conflicted space.

Musing on the past week, it has been one of developments and politics rather than too much major breaking news. I will start by building on the issues covered in last week's bulletin.

Map of the problematique – HIT-like syndrome and vaccines

The potential association of a HIT-like reaction in people having the AstraZeneca/Oxford vaccine continues to be investigated, particularly by the MHRA. The British Society for Haematology (BSH) has produced helpful guidance for the diagnosis and the management of the haematological aspects. The triad of thrombosis, low platelets and raised D-dimers (>4,000) should raise suspicions and critically, platelet infusions should be avoided as should heparin (consider non-heparin anticoagulation including DOACs). This is a rapidly developing area and the BSH website is a good place to keep updated as understanding improves.

Survival – vaccination rates and policies

It has been hard to keep track of the comings and goings in the EU over vaccine exportation and there is much 'vaccine nationalism' at play globally. For a good take on the challenges of the COVAX programme to facilitate global vaccination and the 'race' between countries I would recommend an article by the international editor of the *New Statesman*, which in turn was recommended to me by the current RCP registrar (thanks Pete). It is a quick and easy read.

If visual representation is more your thing, the Spectator vaccine tracker provides a grandstand view of the situation in the UK, EU and the rest of the world. The stockpiles in the EU are particularly interesting as are those countries doing well (eg Serbia is doing much better than any of the established EU states).

Invincible – reinfection rates

Debates continue to rage about rates of reinfection with COVID-19 and this is a complex topic. Any measure will be dependent on the community prevalence of the virus, the infectiousness of the predominating strains, the effectiveness of vaccines against those strains, exposure risk and the NPI measures in place. A recent Lancet article on a Danish population-level study gives further insight. The infection rate in those who had evidence of previous infection was 0.65% compared with 3.27% in those without, an 80.5% 'protection'.

These data mirror the SIREN study which showed 83% protection from previous infection in NHS healthcare workers in the second wave. The Danish study also showed, though, that protection was much lower (47%) in those over 65 which stresses the need for vaccination as well as keeping a very sceptical and close eye on the older population as lockdown in the UK relaxes. Many may not be as 'bulletproof' as they feel.

Aftermath – restarting and resetting health services (and training!)

The NHS in England has now published its planning guidance for 2021/22. There are six priorities (unusual for an NHS document as they normally have five): supporting the health and wellbeing of staff; vaccination and management of COVID-19; transformation of services, especially the backlog and mental health; primary care, focusing on health inequalities; transforming urgent and emergency care; and using a system wide approach (ie integrated care systems). It all seems appropriate and reasonable.

The BMA has also published its take on getting services back on track, *Rest, recover, restore.* This includes a good figure which makes the size of the backlog plain and rather frightening. It also includes some practical steps that employers can make to support their staff.

The two documents look at the same issues from different perspectives but are not a million miles apart, which is good. One disappointment for me was that they both only mention training in passing (but at least they mention it). The training recovery is to me as big an issue as the service recovery and ongoing management of COVID-19. Unless it is prioritised by employers from the point of view of both trainees' and trainers' time, it will fail, and the long-term consequences will be devastating. I've written more about this in the latest edition of *Commentary* published last week.

Also, neither document mentions research, which is a shame given the obvious impact clinical research has had on our ability to deal with the pandemic. However, the UK government published its vision for clinical research last week and this shows a clear commitment moving forwards. Cheng-Hock Toh, our academic vice president (the election for his replacement is still open for nominations), has responded from an RCP perspective.

The key date for all of us, though, is 6 May (only 6 weeks away) when system plans have to be submitted based on the NHS guidance. This is quite a tall order and I suspect most clinicians will have neither the time nor the connections to input into local plans. If you do, please make sure training and research are thought about.

Undisclosed desires – the white paper

Thank you to everyone (over 700 of you) who responded to our calls for views on the NHS white paper 'Integration and innovation: working together to improve health and social care for all' which we have used to respond to the Health and Social Care Select Committee's inquiry. From all of those responses we were able to produce quite a detailed submission, a stark contrast perhaps to

our responses to previous NHS bill proposals. We have been mostly supportive and have made a few statements, summarised below.

Firstly, we want to see the bill place clear legal responsibility on a designated body for publishing workforce projections, and place a duty on the secretary of state to respond to those projections with a plan for government action. Secondly, we would welcome greater clarity on the relationship between the ICS health and care partnership and the ICS body to ensure that all stakeholders are meaningfully involved and that voices outside the NHS are heard. Thirdly, we believe the better health and wellbeing element of the triple aim should include an ambition to reduce health inequalities. Different levels of responsibility for reducing health inequalities should be made clear in guidance: what must be done at place, trust, ICS and NHS England level. This goes alongside our call with the Inequalities in Health Alliance for a cross-government strategy to address health inequality.

We also commented on the role of the National Institute for Health Protection (NIHP) but almost immediately (as is the way), the goalposts moved …

Exo-politics – the NIHP is dead, long live the UKHSA

On Thursday came the rather surprising news that the NIHP was going to be called the UK Health Security Agency (UKHSA) instead and would be led by Jenny Harries, one of the deputy CMOs for England.

Detail on the UKHSA was rather limited and we should expect a more detailed announcement from the PM in the coming weeks. The move from an England-focused body to a UK-wide one is both surprising and welcome. Surprising as it suggests there has been shared four-nation thinking on the issue (unlike NHS pay rewards), and welcome as a whole UK approach is needed when dealing with public health threats. Anyone who has heard me talk about 'what we have learned from COVID-19' will know that the lack of unity across the four nations over the past year is a real bugbear of mine.

According to the government policy paper the UKHSA will have five functions (back to a usual number, phew) to prevent, detect, analyse, respond and lead. The detail beyond that is rather superficial.

I also see this morning that the 'prevention' aspects of public health in England will be covered by the Office for Health Promotion which will report to the secretary of state and the CMO. Again, detail is very light at the moment and understanding the powers of that body and its funding will be critical to predicting its effectiveness. At the RCP we are, however, delighted to see acknowledgement that cross-government attention is needed to push forward action on the wider determinants of health. Perhaps the messaging from our Inequalities in Health Alliance is finally getting through.

Unnatural selection – Liverpool

Anyone living in Liverpool or interested in the progress of The Spine will have been taking keen notice of the statement by Robert Jenrick, secretary of state for housing, communities and local government, last week about the need for commissioner support of Liverpool City Council for the next 3 years. This is the result of a 'Best Value' investigation by Max Caller on behalf of the government. It makes for grim reading especially around the historical awarding of building contracts.

We have known about the investigation for several weeks and have been ensuring that there are no implications for our building in Liverpool. From the building contracting side of things there are no concerns, as the issues identified by Caller were related to building projects outside of the Knowledge Quarter. We have also been working with the new regime in Liverpool City Council (including the CEO Tony Reeves) which was praised by Mr Jenrick for trying to overcome the historical issues.

As for The Spine building itself, it looks like it will be practically completed in 2 weeks and we will take occupation soon afterwards.

I do worry slightly about the impact all of this negative press will have on the city itself, which has already had a hard hit from the pandemic. However,

one of the reasons for going to Liverpool was to put ourselves in the heart of communities that most needed health and social care support. This will be needed more than ever and it seems likely that government support for the city will, if anything, improve its future prospects.

Micro cuts – surgery for hyperparathyroidism

In a bulletin that includes much health politics and policy it is nice to be able to touch on a clinical topic. The NHS has asked me to raise the profile of the NICE guidance on the management of hyperparathyroidism, as it has become clear there are still instances where patients are not being referred for surgery when it is indicated.

Previously a level of corrected calcium has been used as the main determinant of surgery, and while any level greater than 2.85 mmol/L still allows referral, any level of hypercalcaemia if associated with relevant symptoms is appropriate. The Society for Endocrinology fully endorses this approach. The guidance around this issue has changed a few times over the past decade but the NICE guidance has been stable since 2019.

….and finally

As you read this I will (hopefully, depending on today's College Day proceedings) have been elected for a fourth year of office. Where has the time gone? It's been so quiet too …

I was forwarded a fascinating essay written by the late (and great) Sir Christopher Booth in 1988 on the behaviours of presidents past called 'Smoking and the gold headed cane'. It focuses on the need for presidents to grapple with the health issues of the day and to not stay for any longer than needed. I certainly feel like I've been doing some grappling of late and have no desire to try and prolong my time at the helm. However, it also reminds me there is much to be done in the next year. It will not, I suspect, be a quiet one.

12 April 2021

It has been a rather eventful couple of weeks since my last bulletin in matters both COVID and non-COVID. Some of the issues have created heated debate and I will try and address these. Regarding COVID-19 in the UK, the general direction of travel is that the clouds are lifting, allowing a ray of light through. I'm not sure how long this will last and will start with the potential for a third wave.

Into the groove – the third wave

I think we are all agreed that in the UK the second wave is petering out and that even with a slight uptick in R0 since the schools went back, the 'roadmaps to normality' across the four nations are on schedule. Lots of modelling has been done on if/when a third wave will happen (accepting that some places in the UK have seen three waves already) and the group of modellers who advise the UK government goes under the catchy name of SPI-M (Scientific Pandemic Influenza Group on Modelling). This group has a further 'operational' subgroup (code?) named SPI-M-O. Although openness was not a feature of governmental decision making early in the pandemic and the names of these groups seem to come from an episode of Line of Duty, we can now get early access to papers from them. The latest from SPI-M-O makes for rather depressing reading.

'It is highly likely there will be a further resurgence of hospitalisations and deaths' it says in its sixth statement (and in bold print just to make it really clear). It also says this is likely to be in the summer or late summer/autumn and in a worst-case scenario could be as big as the second wave. All models show a third wave and the height and timing depends on seasonality, effects of vaccine on transmissibility (still a relative unknown), variants which might evade vaccine protection and, of course, vaccine uptake. The seasonal variability is an interesting one as we don't know how much good weather (eg more sunshine) and warmer temperatures reduce transmission. Vaccine uptake will depend on two

main variables: supply and public confidence. The latter has taken a slight hit recently.

Reading through the SPI-M-O document I was struck by a few things, not just the impressive graphs and detail provided. The predictions from the three main groups of modellers (Imperial College London, University of Warwick and the London School of Hygiene and Tropical Medicine) make very different assumptions in their models. For example, the first two assume the AstraZeneca/Oxford and Pfizer/BioNTech vaccines have the same impact on transmission whereas LSHTM assume the Pfizer/BioNTech one is twice as effective. I am also aware that the modellers overpredicted numbers of hospitalisations and deaths in the second wave and that already models have been downsized due to increased vaccine uptake in vulnerable groups. Pandemic forecasting is not an exact science.

Causing a commotion – HIT-like adverse events

Last week the MHRA, EMA, CHM and JCVI (sorry for all the acronyms but they are now part of public consciousness so I feel less guilty about using them) made announcements about the HIT-like events observed in people receiving the AstraZeneca/Oxford vaccine as I have talked about in the previous two bulletins. The roles and responsibilities for these different organisations has resulted in some confusion as to who has said what and the British Society for Haematology has expressed concern about the formal MHRA announcement given that there is no evidence that those with prior thrombosis are at increased risk of the syndrome.

The JCVI has made the recommendation that anyone under 30 should be offered an alternative vaccine given the balance of risks. This seems a sensible course of action to me and the slides presented at the news briefing on 7 April (mid-afternoon when most clinicians are busy being clinicians – no other comment needed) put this risk into a useful visual representation of risk/benefit. I think the public will have slight difficulty putting risk rates per 100,000 into context and understanding that the COVID-19 risks change as the prevalence of infection changes. The latter is shown really well in the heatmap of death rates on another GOV.UK webpage (I should be on a commission from them today). The risks given on the slides also only use data for a 16-week period when arguably the risk from COVID-related events should be doubled as the vaccines work for at least 6 months.

Since the announcement there has been an unsurprising increase in GP contacts, 111 calls and ED attendances by people concerned their symptoms are related to this syndrome. The fact that the MHRA is independent from the NHS is good but it did mean the system had very little heads up that the announcement was coming and thus advice for professionals was limited. There is now very helpful guidance from PHE.

In short, the time frame of concern is 4–28 days after vaccination and the following symptoms should raise concerns:

- new onset severe headache, which is getting worse and does not respond to simple painkillers
- headache worse on lying flat or bending over, accompanied by blurred vision, nausea or vomiting or other neurological symptoms
- new unexplained pinprick bruising or bleeding
- new symptoms that would fit with thrombosis in a major vessel (shortness of breath, chest pain, leg swelling, abdominal pain).

The Royal College of Emergency Medicine produced some helpful advice for ED staff over the weekend and although there was briefly some guidance from the neuroradiology community which can be best described as 'thorough', we now have guidance that all are agreed on which the RCP has supported.

There are also a few other issues to leave you thinking about before I move on. There have been some cases across the globe in patients who received vaccines other than the AstraZeneca/Oxford one and the exact mechanism by which HIT-like antibodies and immune complexes are established is unknown. Is it related only to chimp adenovirus vaccines (the AstraZeneca/Oxford one), all adenovirus vaccines (Johnson & Johnson, Sputnik V) or all the spike protein (all vaccines)? We still

don't know for sure if this is related to the vaccine and thus the terminology used by some, ie 'vaccine-induced' or 'vaccine-associated' thrombosis and thrombocytopenia syndrome (VITT and VATT respectively) cannot yet be used with impunity. I personally think the circumstantial evidence is pretty convincing and look forward to being able to use an agreed shorthand name soon.

Incredible – Commission on Race and Ethnic Disparities (CRED) report

Most government-commissioned reports create a bit of news or are released in a way to minimise awareness of them. The report from CRED, which came out 10 days ago, is still creating much noise and recriminations abound (including at the RCP for not roundly condemning it).

At 258 pages the report is long and it is therefore perhaps understandable that many have not read it in full and relied on media interpretation of its contents. As someone who enjoys data as much as anecdote I found it fascinating reading and I would strongly recommend everyone reads the section on health (pages 199–232). The data make it clear that ethnicity is a critical determinant of health outcomes but there are large differences between different diseases and different ethnicities and that other factors, especially social deprivation, are key. It also makes it clear that use of the term 'BAME' to refer to a population when it comes to health is massively flawed. I had already stopped using it and we understand that the NHS Workforce Race Equality (WRES) team is currently considering new language.

We (the RCP) gave evidence to the Commission and have welcomed their recommendation that an Office for Health Disparities should be established. This chimes completely with our calls for a cross-governmental approach to inequalities in health. However, such a Commission should have given hope to those of us concerned at the impact of structural racism in society. Instead it has left many feeling short-changed by some of the conclusions, and most profoundly by the conclusion that institutional racism doesn't exist.

There is no denying the existence of discrimination in our own environment, evidenced just recently with publication of progress on the NHS's WRES. The latest edition of our own *Future Healthcare Journal* includes a few articles that show we have a long way to go in medicine.

We have been open with our findings that doctors from many ethnic backgrounds not only find it more difficult to secure interviews for first consultant posts, but they are then less likely to be appointed. This is a standard the new WRES will measure, and we must all pull together to root out these issues and act on discrimination wherever we see it. For me, the independent Summerskill report on diversity and inclusion at the RCP was a difficult read, but hearing the first-hand experiences of colleagues who feel they are treated differently and have fewer opportunities to engage with the RCP made me understand their viewpoint much better. That report (as opposed to the CRED report) united all in the RCP to committing to and doing something about the racism and disparities it highlighted.

So in summary, there is some good in the CRED report but the fact that it has left many of us feeling let down by not acknowledging the reality most people from ethnic minorities experience in their everyday lives, is a deep disappointment and missed opportunity.

Miles away – Myanmar

The situation in Myanmar continues to deteriorate and the treatment by members of the military of many healthcare workers over the past few weeks as they have tried to do what they were trained for has been abhorrent. I wish to reiterate the RCP's support for those members in Myanmar who are affected by the crisis in the country.

We stand squarely behind the statement that THET has produced since my last bulletin and are looking at ways we can support any members in the UK who may be affected. One such way is extension of visas for Myanmar doctors currently working in the UK under the Medical Training Initiative.

Vogue – Advanced medicine conference

The RCP has four main educational conferences each year and it is the turn of Advanced medicine to take centre stage. Once again it will need to be virtual (although we are planning hybrid conferences for next year) and we are using some of the things that worked for Medicine 2021 to ensure delegates can get some rest and breaks from full-on streamed talks.

Advanced medicine always has a more scientific and future-focused theme than our other conferences and is less political. It will have 'hints of COVID-19' but even those speakers who have high public profiles in the media talking about COVID-19 have been given a non-COVID brief.

I'll remember – Sir Paul Cosford

The past week has seen two deaths that have made me pause to reflect. The first was of Sir Paul Cosford who was a leading figure in the world of public health and had key roles in Public Health England and before that the Health Protection Agency. For a snapshot of why he was so well-liked, I recommend his blog about having to shield a year ago due to lung cancer.

I only knew him to say hello to (the last time being at the RCP early one morning a couple of years ago) but if you ask anyone in public health what they thought of him you will only get positives. He is a great loss to the profession.

Separately, as work in Liverpool on RCP at The Spine enters its final phase, we have commissioned a recognition wall to thank those generous enough to help us see the project to completion. As with the Linacre Wall at the RCP in London, donors will be able to have their name, or that of a loved one or colleague, inscribed on an individual brick. The wall itself will be named in honour of Donal O'Donoghue and his steadfast commitment to the project. Full details will be included in the May edition of *Commentary*.

… and finally

The other death that made me reflect this week was that of HRH Prince Philip. While we don't have a patron like many other colleges, HM The Queen is the RCP's 'visitor' – an ancient role that relates to our origins and more recently our charitable purpose. We have tended to underplay our royal connections and when I started as president I was surprised we had no photo of the Queen displayed anywhere in the building. Keen-eyed folk will have noticed this is no longer the case.

I know that not all readers of this bulletin are fans of the monarchy and/or our particular royal family. However, when Her Majesty came to the RCP in 2018 for the celebration of our 500th anniversary, her skill and ease at talking to large numbers of people and making them feel special was impressive (and melted a few republican hearts). Both she and Prince Philip have been unwavering public servants over their married lives. Prince Philip was, as she said, 'her strength and stay' and very few reading this will know what it is like to lose a partner of 73 years, although many of us will have some understanding.

It has made me reflect that those who support us at home (such as Nicky, the long-suffering Mrs Goddard) often don't get the thanks or billing they deserve. So, for all those strengths and stays – thank you!

26 April 2021

The pandemic is proving very good at challenging different countries in different ways. As life in the UK moves from managing acute COVID-19 to service recovery and the vaccination programme, it is wreaking renewed carnage as infections surge once more in other countries. I will try and cover all these aspects.

For the first time in many years Mrs G and I have been invited to a wedding, so I have been thinking about matrimony and the like. The bulletin will therefore include something old (VITT), something new (B.1.617), something borrowed (training numbers) and something blue (dismay). I would hate to limit the content to just four topics so will have other 'somethings' as well.

Why, oh why, oh why – VITT

There have been a couple of developments around vaccine-induced immune thrombosis and thrombocytopenia (VITT) since my last bulletin. Estimates of the incidence remain the same as I cited 4 weeks ago at around 1 in 100,000 but we now know a bit more about the pathogenesis and the implications this has for the course of the disease.

The German group who first described the syndrome have published a pre-print suggesting a plausible mechanism whereby vaccine constituents act as haptens and create an acute inflammatory state, as well as potentially increasing microvascular permeability, although it is still unclear which bit of the vaccine does this. The resulting complexes as well as activating platelets stimulate NETosis, which is in itself a pro-coagulant process.

Experience from haematologists in the UK suggests that the level of anti-PF4 antibodies is probably proportional to the extent of thrombosis seen. Given the anti-PF4 antibodies generated remain around for several weeks and intravenous immunoglobulin has a shorter half-life we should be wary of discharging patients with proven VITT without follow-up. The UK Expert Haematology Panel is now seeing occasional cases of recurrent VITT.

Monitoring of platelet levels after discharge and keeping a high index of suspicion seems important. The British Society for Haematology (BSH) guidance (which is brilliant) includes guidance for discharge. There was also guidance published last week on the neurosurgical management of central venous sinus thrombosis (CVST).

At one meeting I attended last week it became apparent that not everyone in the medical world was aware VITT isn't just related to CVST and 30% of cases have splanchnic vessel involvement. As a gastroenterologist I am used to seeing portal and/or superior mesenteric vein thrombosis (PVT/SMVT) and the symptoms are not easy to distinguish from much more benign causes. Acute PVT usually results in abdominal pain, fever and diarrhoea caused by venous congestion of the gut. GI bleeding and ascites are more common with chronic PVT. However, in the non-VITT situation PVT is most commonly an incidental finding when investigating or managing other conditions such as cirrhosis, hepatobiliary malignancy or pancreatitis and has no obvious symptomatology. In the non-VITT situation anticoagulation is the management of choice (not thrombolysis as I was asked to consider for a patient last weekend when on call).

For PVT in the VITT situation the first step is to ask the haematologists for help (they will want to know) and avoid heparin. Direct thrombin inhibitors such as argatroban have been the mainstay of anticoagulation in VITT patients so far but UK stocks are getting low so there is a push to increase manufacture. I'm told IVIg stocks remain OK but the BSH is watching the situation for both of these carefully.

There does seem to be some evidence emerging in the US that VITT can occur with mRNA vaccines, although as yet we haven't seen any confirmed cases in the UK. If it does, it is much less frequent.

Lastly on this, the success of daily national case discussions in the UK led by the expert panel has resulted in a much lower mortality rate for VITT than seen elsewhere in the world. Currently the rate is 19% and we should all take our hats off to the

haematology community for pulling together so effectively. I had a chance to thank them publicly yesterday at their annual scientific meeting, but it is worth saying again today.

Too much attention – variant watch

The new kid on the block is B.1.617 or the Indian variant for those who prefer, but as we don't know for sure that is where it arose I think such terms only increase xenophobia. This variant is causing a frisson due to its high prevalence in India and consequently the chance of transmission by air passengers arriving from there. First identified in the UK in late February, as of Saturday there had been 185 sequences identified in the UK compared with 297 in India (where it was first detected in October). Not much difference you would think, but the denominator is staggeringly different. For example, since the B.1.351 (South African) variant was first sequenced, India has only sequenced 1,167 cases compared with the UK's 234,887. Only a handful of the 185 sequences in the UK have been detected in community swabs, the rest in those arriving from amber and red countries. Much as I don't like the idea of shutting our borders (the impact on many people of not seeing loved ones is huge), unless we screen international travellers very carefully moving forwards we will continue to feed the pandemic fire.

B.1.617 has been, rather excitedly and inappropriately, termed a 'double mutant' by the press due to its mutations E484Q and L452R. There are in fact 13 mutations in this variant that result in amino acid changes… so maybe it should be called the 'unlucky mutant'. Other variant twitchers will know that the E484K is a mutation present in the three main variants of concern we currently have and is associated with a reduction in antibody neutralisation. Whether having a Q rather than a K changes transmissibility or severity of disease is unknown and although L452R has been seen in several other variants, again, its importance is unknown. As such, officially B.1.617 remains a 'variant under investigation' (VUI) rather than a 'variant of concern' (VOC).

The variant is likely to be the predominant strain in the current surge in India at the moment. Cause and effect are unproven, and I suspect that most physicians in that beautiful country are far more concerned with the basics of providing healthcare to a terrifying number of critically ill patients. The lack of oxygen supplies is a massive concern and the pictures we are seeing from hospitals in India are heart-wrenching. Our thoughts go out to all our members and fellows in India as well as to those in the UK with family and loved ones there.

We will – recruitment

Training recovery from the pandemic continues to keep me awake at night and I have been to several meetings over the past couple of weeks set up to identify the key issues and solutions. The data suggest that there is tremendous variability between specialties and regions as to what proportion of trainees will need extensions to training to get their CCT. Because of this it becomes very hard to plan recruitment as we won't have an exact idea of numbers until after the annual review of competence progression (ARCP) season has finished (and ARCPs happen at different times in different specialties). Therefore, the decision has been made by Health Education England (HEE) not to hold any training numbers back for extension and recruit as normal. This is very good news as it will keep the training programme flow going and reduce the additional number of IMY3 places that will be needed. However, there are some noises to suggest that not all parts of the system have heard this decision and continue to hold back (borrow) recruitment numbers. I have been asked by HEE to make it very clear this should not happen.

Regarding IMY3 places, it still looks like there will be a shortfall but again this seems to vary by region and is less than first feared. We are still waiting to see what posts trainees will confirm offers on to get an exact number. Until that point, I will sleep less well.

Should extension of training be needed for an individual it is important that we don't just extend the training without considering the particular skills that need to be developed. Extensions and remaining training time will need to be tailored to trainees' needs. For example, if more outpatient experience is needed, extra clinics should be arranged rather than continuing to just do more of the same.

You never listen to me – selective hearing

My postbag this week has had a couple of (understandably) irate comments about the mention of the RCP made in a recent debate in the House of Commons about the Commission on Race and Ethnic Disparities (CRED) report. I made my feelings on that report pretty clear in my last bulletin and was dismayed to see our support of the potential for an Office for Health Disparities being interpreted by the government as having 'welcomed the report'. Politics is a messy game and by having an opinion we always risk others using it to support their own view.

As it happens, I am due to meet the particular minister who has misquoted our position in a couple of weeks. I will politely but very firmly make clear that we haven't welcomed the report and its main conclusions, but see it as a missed opportunity to address the racism that exists in our society and point out that it is a report that has greatly upset many in the NHS.

The latest NHS Assembly meeting focused on health inequalities and I sense a strong appetite to come up with meaningful measures and improvements. Given the long-standing and societal problems that result in health inequality this will not be easy. The first piece of work on this is looking at the post-COVID care backlog and how we can ensure that management of this doesn't worsen health inequalities, and if possible, find approaches that reduce them. For medicine this is not easy and I am joining a short-life working party to give a physicianly perspective. If you have any good examples of how your unit has addressed this issue, please let me know so I can share them.

What can I do? – sustainability

One of the success stories of the past year has been the increase in visibility of our journals. Combined submissions to *Clinical Medicine* and *Future Healthcare Journal* have almost tripled in the past year and article downloads from our journals website increased twofold. There were a staggering 3.2 million downloads for *ClinMed* and over 0.5 million downloads for *FHJ* in 2020.

This success creates its own problems as finding the capacity to publish all the great submissions we get is challenging. Readers of the journals will have noticed that well over half of the articles are now published online only. This is part of a journey towards a fully online offering as other colleges have done. Many trainees, members and fellows have been exhorting us to do this for some time, as much from a sustainability perspective as an access one. Therefore, as of next month we will be producing both main journals online only.

I do appreciate a hard copy of certain journals and therefore know this won't go down well with all. To mitigate the loss of printed copies for those who await the doormat thud from the RCP with anticipation, we will continue to produce a paper copy of our membership magazine *Commentary* three times a year which will highlight key content from our journals. We will assess the impact of this change over the next few months.

The 'onlining' of journals does have the additional benefit of savings which will help the RCP financial position for 2021 and beyond. The negative impact of the pandemic on our finances is the gift that keeps on giving.

Rightfully, climate change is moving back to the top of the agenda and as advocates for recognising climate change as a danger to public health, the reduction in paper journals is a positive move. Together with the fact that we have now met the objectives we made in our 2020 Climate Policy 2 years earlier than planned, I am proud of what the RCP is achieving in this area, especially as we have now completely divested from any fossil fuels in our fuel-related funds (well done treasurer!). There is still much, much more to do though.

My mind has been on the role of treasurer a lot in the past few days as I heard the sad news that Norman Fielding Jones has died. Older fellows will remember him well and he held many posts at the RCP including censor, senior censor and treasurer – the Council Chamber was built on his watch. He had a full and varied clinical and college life and he recorded his reflections for the RCP oral history in 2015. A lot has changed in his long and remarkable life.

Alone again (naturally) – latest RCP survey results

We published the results from the latest (tenth) COVID-19 member survey 10 days ago and you may have seen this in the media. The majority of the coverage focused on the long time most of us think it will take to get the NHS back on an even keel.

Two of the findings that struck me were that 21 % of us want to work fewer PAs following the pandemic, and the impact of the two waves on team working. The latter showed that in the first wave there was in general an improvement in team working, mostly due to more people being available and a sense of shared purpose. This disappeared in the second wave (to be replaced by a feeling of being alone for some). Both findings show how the pandemic has taken a big toll on us all, that this toll can be reduced by having more of us around and that the shortage in workforce we already have is likely to worsen.

Get down – enjoying the data

I get sent a lot of links and papers by members and fellows (thank you) and try to read and respond to everything (with variable success). In the past couple of weeks the relentless pressure of the previous 6 months has eased a bit and allowed me to look at some of these in detail and lose myself a bit in the data. Here is the pick of the past week.

During the pandemic the amount of research and related work conducted has been enormous and for some institutions forms a major body of work. A summary of such a corpus came across my desk this week from the Nuffield Department for Public Health and includes bits that have had national prominence and others, equally important perhaps, that have escaped the spotlight. It is worth a peruse.

Early on in the pandemic a group from South Wales noticed a fall in admissions from several conditions and have proposed that the improvement in air quality and changes in behaviour have had directly positive impacts on some diseases. Their paper has just been published in ClinMed and makes one think.

There has been much debate in the medical press about the aerosol spread of SARS-CoV-2. The benefits of improved air flow and filtration are, to me, a no-brainer and there was a very useful review of the practicalities of this from a US perspective (hence the regulations are different). When we are building the 40 new hospitals (with bids for another eight pending) we have to think about this.

Nothing rhymed – 'til death us do part

I was sent a fantastic reflective piece from the Guardian last week and would strongly recommend it (you'll need a good 10 minutes but it may the best use of 10 minutes this week). I also think it should be required reading for all medical students. It shows how even when careful advance decision planning has occurred and everybody tries their hardest to avoid a hospital admission and arrange for a good death, the system manages to defeat them time and time again. It also gives an upsetting picture what it is like to be a relative in the time of a pandemic. It may make you look at your patients in a different way on the ward round tomorrow.

… and finally

Even those who do not follow football will have been aware of the failed bid for six of the bigger English clubs to break away to form a super league with clubs from Spain and Italy. This led to a frenzy of noise from grassroots supporters and commentators. One by one the clubs reversed their decision and 'common sense' was victorious over 'greed'.

One sharp physician made the quip on social media that three of the big medical specialties had broken away to set up their own medical league and I was looking to step in to 'protect the medical take'. I smiled at this but it is a little too close to the truth for some hospitals. We are better together.

10 May 2021

My RCP diary is now full of non-COVID related meetings and we have dipped below 1,000 hospitalised COVID-19 patients in England. The public is also moving on and border conflicts have been the headline news of the past week. My inbox, though, still bulges with pandemic post and the news continues to change thick and fast so I will major on this.

Tears are not enough – India

The situation in India shows no sign of abating and is a cause of great concern, especially for those with friends and family in that magnificent country. Official case numbers are now greater than 22 million and deaths over 246,000. Reasonable estimates due to under reporting and lack of testing put these figures at three times higher. One well-respected group, the Institute for Health Metrics (IHME) in Washington, projects that total deaths in India may reach a staggering 1.7m by September 2021. (As an aside, the IHME website contains lots of useful ways to compare different country projections for the pandemic, including such things as mask use).

It is clear that the situation is bad in the main cities, but also that it is worse in the poorer and rural areas where lack of healthcare resources and the availability of the vaccination programme have made those populations most vulnerable to the disease. As in many countries, politics has played and continues to play a big part in the spread of the virus but it is a situation that needs a global approach and we in the UK and the rest of the world must do our part.

Many of my colleagues with friends and family in India have been really affected by this evolving tragedy and others have asked me what we can do. Lots. Firstly, if you have any colleagues who may be affected ask them how they are and if there is anything they are doing that needs support. For example, I learned that one of my radiology colleagues is fundraising specifically for oxygen supplies. Another way is to support the BAPIO India Covid Fund which is supporting not just oxygen delivery, but virtual consultations and testing. Several groups are offering help with virtual consultations, but it is important this is facilitated through BAPIO (the British Association of Physicians of Indian Origin) as the language needs are specific for different parts of the country.

Some have asked why India should be treated as a special case. This suggests a rather unobservant or even racist view of our cultural heritage and society in the UK. The links between the UK and India are familial as much as business, trade or political and many of our NHS staff have friends and family there or are from India themselves. From an RCP perspective we have more international members and fellows in India than in any other country and we wrote to them directly this week in support. This included links to useful guidance on relevant issues and is, of course, useful for any country having to manage COVID-19 cases. Lastly, the emergence of variants in countries where the virus is circulating in large numbers threatens the whole world, not just one country. We need to think globally.

That was then but this is now – B.1.617.2

Two weeks is a long time in politics as well as in the world of COVID-19 variants. In my last bulletin I introduced readers to B.1.617 which is now being seen as three variants of interest, B.1.617.1, B.1.617.2 and B.1.617.3, the middle one of which officially became a variant of concern (VOC) on Thursday of last week. Being a VOC puts a variant on the 'most (un)wanted list' and the focus of attention for Public Health England (PHE) and those tracking the pandemic in the UK. Regular updates on VOCs are published by PHE and the tenth edition included much (slightly scary) data on B.1.617.2.

This variant seems more transmissible than 'wild-type' SARS-CoV-2 but as yet there are no data to suggest it outcompetes B.1.1.7 (the 'Kent' variant). Figure 3 in the PHE document (p13) is the most striking. The purple band is the new VOC and it has clearly been vying to become top dog.

Figure 12 is also worrying as it shows that the majority of cases with this variant are now not related to travel. Importantly though, there is no evidence that this variant is more deadly, and therefore provided we can control local outbreaks it should not become too much of a problem. The report also shows that we are now sequencing 50% of all PCR swabs in the UK so identifying outbreaks of variants becomes much easier. As I have said before, this is a staggering achievement for the testing services.

As always, the ability to control local outbreaks will be down to the hard work of those in PHE and local public health teams. These teams are working hard throughout the country. The modellers and academic pandemic commentators get all the media glory but the real heroes are those door-knockers and lab workers. Let's raise a glass to them (albeit in a thick coat and under an umbrella).

Be near me – vaccine effectiveness in patient groups

As someone who has many patients on toxic but effective immunomodulator and biologic therapies, I have spent much of the pandemic worrying about the impact of the drugs I prescribe on the outcomes of COVID-19 and more recently vaccination, especially now that shielding has been dropped. For patients with IBD the recently published CLARITY study is helpful and showed that seroprevalence of antibodies to the virus were lower in those on anti-TNF treatments and immunomodulators (such as azathioprine and mercaptopurine) than in those on another biologic, vedolizumab. It is possible that the control group had different behaviours so were less exposed but it is far more likely that this is a real effect and that the ability to mount a lasting immune response to the virus in those patients on such drugs is impaired. The fact that the seroprevalence was 6% in the control group at the end of 2020 also showed that these patients are still at significant risk of contracting the virus even with precautionary measures.

For many of these patients the question of whether vaccination will give them as much protection as others has real importance, as it affects their ability to work as well as socialise. We know that vaccine responses to other vaccines such as influenza, are blunted in such patients but more evidence is now emerging about the effectiveness of COVID-19 vaccines in patients on immunosuppressive drugs. Two papers from the USA were 'published' last week on this topic. The first, an article in *JAMA*, showed that 46% of 658 solid organ transplant patients had no antibody response even after two doses of mRNA vaccine and this was commonest in those taking antimetabolites. 15% had a response after one dose and 39% needed both doses. A preprint in medRxiv looked at antibody responses in 133 patients with chronic inflammatory disease (roughly a third with IBD, a third with rheumatoid arthritis and the rest with other arthritides or connective tissue diseases) and showed that those on steroids and B-cell depleting drugs had a significantly blunted response. Those on antimetabolites had a moderately blunted response and those on biologics including anti-TNF, anti-integrin and anti-IL-12/23 had only a very mildly blunted response.

I'm hoping we will get some data for the AstraZeneca/Oxford vaccine soon but these studies have important implications when talking to such patients and may influence choice of treatments in the immediate future. Difficult conversations when starting new drugs will be even more so.

Poison arrow – VITT

I have said much about VITT in the past couple of months but the news that those under 40 will be offered an alternative vaccine to the AstraZeneca/Oxford one does need some comment.

I think this is the right decision at the moment as the incidence of infection is low and the supply chain for non-AstraZeneca/Oxford vaccines is robust enough to not hold up the vaccine programme. These are the two variables that can change at relatively short notice and thus are the determinants

of vaccine policy. The risk of VITT remains at around 1 in 100,000 so should a third wave kick off or alternative vaccine supplies dry up, the decision will need review. This is hard for the public to understand but, again, it is the greater public health benefit that needs to be kept at the centre of our thinking.

The clinical guidance for diagnosing and managing VITT continues to mature and we were happy to add our name to the recent joint guidance coordinated by the Royal College of Surgeons of England for those patients who may present outside of the AMU. The British Society for Haematology (BSH) guidance remains a key resource and is in its seventh iteration. It is also worth pointing out that, as for respiratory medicine, the pandemic will continue to create significant work for our haematological colleagues. The thrombosis burden from the second wave was large and those patients continue to need follow-up.

All of my heart – heart failure

BSH is also an abbreviation for the British Society for Heart Failure, and heart failure is another condition which is seeing a resurgence following the first two waves of COVID-19, partly due to the effect of the virus on the cardiovascular system but also due to delayed presentation. This week is Heart Failure Awareness Week and it is something that is worth highlighting. I was amazed to learn that 80% of cases of heart failure are diagnosed in secondary care.

The BSH is running a 'Freedom from failure – the F word' campaign to inform and educate. Brian Blessed is acting as the public face of the campaign so it is unlikely to be a quiet one. I heard a very good presentation on heart failure at the East Midlands regional update in 2017 by Dr Brian Gordon which is available in the RCP video archive and brings the topic to life. 'Gordon's alive' as the other Brian would say.

One better world – public views of the NHS

I was surprised by the recent Ipsos MORI poll which looked at the public's top priorities for the NHS. It showed that improving waiting times was the biggest priority – more so than increasing staffing numbers or COVID-19 vaccination. Therefore, we should all be prepared that government policy will prioritise waiting times in the near future. Given the lack of money there will be for all public services because of the pandemic, this will have a direct impact on other parts of the NHS. Sobering thoughts.

I contributed to a roundtable discussion led by Policy Exchange, one of the non-health specific think tanks a couple of weeks ago on the management of waiting lists which is summarised in a very readable blog. The blog also gives a helpful background to how waiting times were prioritised and reduced in the 2000s. This is shown most graphically with other helpful insights on the Nuffield Trust's Quality Watch webpage. Think tanks make you think.

By the way, if you have wondered why Ipsos MORI has such an unusual name, it is because it was the result of a merger between the two companies. In 1991, Ipsos took over a market research company called Research Services Ltd set up just after World War II, and then they took over Market and Opinion Research International in 2005. So now you know.

The real thing – workforce

Even though the public may be less concerned about staffing in the NHS than some other aspects, to me it remains the core issue that needs resolving to allow the best outcomes for patients (it is hard to do additional waiting list activity if you have no staff). I have a busy week ahead with lots of meetings on the issue and its related impact on public health, health inequalities and wellbeing of staff.

The first of these is an RCP member-only digital event happening soon after this bulletin goes out. If you can't make it, it will be available afterwards on the RCP Player for all members to watch. What is the pandemic teaching us about workforce planning? will be live from 6pm today and feature reflections from different parts of the physician workforce. It will be followed by a discussion and Q&A session with our panel of Anita Charlesworth, director of research at the Health Foundation's REAL centre; Jeremy Hunt MP, chair of the Health and Social Care Select Committee; Prerana Issar, NHS England's chief people officer and Wendy Reid, HEE medical director. Having seen the reflections from our members who are speaking, it will be a fairly frank and honest 90 minutes.

Later in the week I will be presenting evidence to the All Party Parliamentary Health Group (APHG) on workforce and the rationale behind our calls to double the number of medical students.

The look of love – The Spine

We now have the 'keys' to our stunning new building in Liverpool, The Spine, having signed an interim occupancy agreement. This is good news, as although we will not officially be open for business for a little while, we were able to host our first exam there last Thursday with more to come from next week.

It has been a tough ride to get finished on schedule given the pandemic, but it has been achieved and on budget (there aren't many builds that can be said about these days). Once we have an official opening date we will advertise it widely and look forward to welcoming members and fellows through the doors. We are already planning to hold some of our traditional big events in the building and, if I'm honest, I'm quite excited by that.

It was good to see that a new city mayor has been elected for Liverpool, Joanne Anderson (no relation to the previous mayor Joe Anderson). The city has been through a turbulent few months, but the collaboration between the RCP and the city and region is strong and holds much promise for the future.

Show me – censors and elections

Any fellows reading this bulletin who are keen to get more involved with the RCP at a senior level should think about applying to be a censor. The role of censor has been around for as long as the RCP but has seen a resurgence in recent years and the censors form an important part of our educational and governance processes. If you are interested, more details are available on our website but you will need to be quick as the closing date is Friday.

Next Monday the voting papers for academic vice president and councillor posts will be emailed to fellows. Please do vote as these are all important roles – as elected posts they represent you.

…and finally

My bedtime reading this week has been A listening doctor by Jeremy Bending, FRCP, a diabetologist and endocrinologist. The theme of his book is the importance of listening to patients and relatives and is illustrated with several case vignettes which we can all relate to, as well as some which we would all very much like to avoid.

I was struck by how much of listening needs to be an active, planned process and the impact that rushed virtual consultations can have on the effectiveness of this. Not all that needs to be listened to makes a noise.

24 May 2021

Last week was quite an eventful one for the RCP with an appearance on Panorama, release of a major report on smoking and health, and the opening of The Spine by Liverpool City Council. As usual it hasn't been a quiet week for COVID-19 and other news stories either. I tried to get all the COVID-related news into one section this week but failed – I'm hoping that it won't be too long before that will be possible.

Change of the guard – UK COVID-19 news

On Monday last week further relaxation of lockdown rules in most parts of the UK came into effect. The ability to see people from different households indoors has been especially welcome as heavy weather has lashed the country (as an aside, there was a severe hailstorm on Wednesday which literally slashed young leaves and shoots in the RCP Medicinal Garden – thankfully not too much lasting damage has been done).

The main concern in the UK has been around the B.1.617.2 variant and its surge in several regions. B.1.1.7 remains in the top spot as the predominant variant of concern in the UK with 7,066 cases in the past week, but B.1.617.2 is climbing up the charts rapidly with 2,111 cases. B.1.617.2 is almost certainly more transmissible than B.1.1.7 and, as I've said before, compound interest of cases makes increase in transmissibility more important than increase in case fatality.

Over the weekend Public Health England (PHE) released a pre-print looking at vaccine efficacy against B.1.617.2. This showed a 20% drop in efficacy for single doses of both AstraZeneca/Oxford and Pfizer/BioNTech vaccines and only a 6% and 5% drop respectively for two doses. This is reassuring but confirms that acceleration of the second dosing schedule for those most at risk is the right thing to do.

However, vaccination isn't the whole answer to the variant, and effective contact tracing will be needed for us to have a good chance of controlling outbreaks. If the wonderful folk of PHE and local public health teams succeed and the surge dies down, I hope they get all the praise they deserve rather than the comment 'what was all the fuss about?'. PHE continues to publish updates on all variants and the latest can be found in its technical briefing 11.

It is important, though, to put this all into context and I have been using the BBC COVID-19 webpage for the past year to track outbreaks in different regions. This allows you to enter a local council area to see its data over the past few months. The map shows you local hot spots and you can click on them for more detail. My local area is South Derbyshire (directly under the middle of the 'ENGLAND' label on the map – my house has a large letter G over it) and case numbers are the lowest I've seen. Put in 'Bolton' and you see the current outbreak is almost all in those under 60 – a very different pattern from before. We must also remember that targeted local tracing will have resulted in much more testing and thus case identification than for previous waves. It is the over-60 graph that we should watch carefully.

We now have good evidence that vaccination with either the AstraZeneca/Oxford or Pfizer/BioNTech vaccines reduces transmission. PHE has published data from its work on almost one million contacts traced during the roll out of vaccines in the early part of the year. 93% of those vaccinated in this study had only had one dose of either vaccine and vaccination reduced transmission by around 45%. This protective effect kicks in at around day 14 after the first dose.

Any major dude will tell you – COVID-19 in context

It seems very likely that SARS-CoV-2 will become endemic as new variants continue to develop and this is the thinking of the WHO as well. I am not sure if there is an official definition of when a pandemic

becomes endemic based on time in circulation or number of countries with 'recurrent' infections. What we don't want is for it to be 'hyperendemic' which applies to a recurring level of high infection. With endemic infection we will need to normalise the response to appearances of variants in the population. Maybe the point at which COVID-19 will be seen as endemic is when someone has a bad cold and describes it as 'mild COVID' rather than 'mild flu'.

I was sent a very interesting paper from 2007 on the emergence of SARS-CoV-1 by a vet who has been reading my bulletins having had them sent on by a friend (it is good to see the bulletin has such a diverse readership). The paper is quite long but also quite fascinating and shows in a very obvious way the close relationship between human and animal coronaviruses. The last paragraph, titled 'Should we be ready for the re-emergence of SARS?', includes the (literally) killer line: 'The presence of a large reservoir of SARS-CoV-like viruses in horseshoe bats, together with the culture of eating exotic mammals in southern China, is a time bomb.' Bang.

Another paper I spotted recently was an observational study from the GIRFT programme looking at in-hospital mortality in England during the first wave. It found there was only modest variation between trusts regarding mortality once adjusted for covariates. Outcomes for larger hospitals with more beds (and almost certainly more staff) especially on ITU were slightly better but I read the paper as saying that everyone did well with the resources they had and in general had outcomes as expected. The funnel plot shows no trusts were outliers in the 'wrong' direction.

Showbiz kids – Panorama

Having praised the BBC earlier I need to add some balance (it is what TV licence payers want after all). Readers of this bulletin from outside the UK may not have heard of Panorama, an investigative news programme that has been broadcast most weeks on the Beeb since 1953. The programme made headlines itself this week following the Dyson report into the episode featuring Martin Bashir's interview with Princess Diana. I'm not going to comment on that particular episode (apart from to say that the brand now looks a little tarnished), but will focus instead on the one that aired last Wednesday, a few hours before the Dyson report went public.

The programme was on royal college invited reviews of services and featured three specific reviews. We were part of the middle one which related to an invited review we did of a vasculitis service in the north west in 2015. The other two were reviews by the RCOG and RCPCH. The thrust of the programme was that patient safety issues were being hidden and covered up.

Having been involved in invited reviews for almost 10 years now I have no doubt that they are an effective way to improve patient safety so was disappointed to see them portrayed in a negative light. The programme did say they were useful and was more critical of hospital trusts for not making the findings and recommendations public, but this was perhaps lost in the powerful and moving patient stories. Knowing the full background to our review and all the information we had shared with the Panorama team, as well as what was said by the chair of the Academy of Medical Royal Colleges, I was disappointed and dismayed at the way that information was redacted and edited to suit the narrative.

I hope this doesn't result in a decline in requests by trusts for invited reviews. We don't make money from them (as the reporters had assumed), but they can have a transformative effect on services and are a core part of what we do.

Do it again – Smoking and health 2021

In 1962 the RCP made its first major public health intervention with the publication of Smoking and health and has been building on this ever since. On Thursday we released our latest report on smoking and health which landed well. It clearly shows that we still have a long way to go when it comes to tobacco control. Smoking, especially in young people, has increased during the pandemic as

shown by the latest data from the Smoking Toolkit Study, so we will definitely miss the 2030 targets on smoking the government has set unless we act now, and act big.

The report is 150 pages long so I would not expect most bulletin readers to read it all but there are separate downloadable infographics produced by the RCP publications team which bring it to life immediately and contain some key facts and figures. The ones that hit me are: deaths due to tobacco were still greater than from COVID-19 in the past year; tobacco costs us £12.5bn a year in the UK; quit attempts have dropped alongside reductions in public messaging about the harms of smoking; and only 10% of smokers attending GP surgeries are offered referral to stop smoking services.

66% of smokers visit their GP each year so we have to find ways to support our primary care colleagues to help smokers to quit. One of the barriers to this is their workload.

Rikki don't lose that number – primary care 'versus' secondary care

The news and social media in the past week have been full of evidence of the pressures currently facing primary care in the UK. Hospitals are also seeing levels of ED attendance and hospital admission well above what we would normally see this time of year and it appears to be getting steadily worse.

The whole system is buckling and I sense this pressure is forcing a wedge between primary care and secondary care, which the media, in all its forms, adds weight to. The fact that some doctors prominent on social media (from both parts of the system) have had to take a break from it because of the volume of abuse they have been getting is evidence of this.

We can't let this wedge go any further and need to support each other to face the pressure we are all seeing. It is only through closer working to create joint solutions that we will get through this. Part of the problem is public expectation. There is a sense that everyone is now 'war weary' of the pandemic and that the de-escalation of lockdown is a sign that it is all over. B.1.617.2 should remind us it is not and there is a balance to be had between the NHS being 'open for normal business' and stressing that the system is still under real strain. It may not be a popular political message but it needs to be made by our politicians.

The arguments about virtual and face-to-face consultations have predominated and cause much heated debate. Face-to-face can have many meanings and, as one of my patients commented, for colonoscopy it is perhaps an inappropriate term. The bottom line (sorry) is that, as with all access issues, it is a rapid and personal response that matters most to the public rather than the form that takes.

Reelin' in the years – The Spine

Last week saw the culmination of 5 years of hard work – on Friday we celebrated the official opening of The Spine, the building in Liverpool containing our new northern home. Built by Liverpool City Council it looks truly spectacular and has the RCP logo shining brightly from the top for all to see. The two Liverpool mayors, Joanne Anderson (mayor) and Steve Rotherham (city region metro mayor) were there to open the building and, as one of the major partners and residents, I represented the RCP. We met some of the apprentices who had helped with the building work and it is already obvious that The Spine and us being there is contributing to the local community.

The internal layout is just what we wanted with a very 'green' feel, both because of the plants that are everywhere but also the sustainability and air quality standards that the building meets. It is the 'healthiest' building of its size in the UK. As some examiners and physician associates will attest, the exam spaces work really well and will get much use moving forwards. The top floor, while giving amazing views, also has a brilliant meeting space that will get its first major airing with the Harveian Oration later in the year.

The Boston rag – RCP-ACP webinar on health inequality and justice

I know you are already looking forward to my next bulletin in 2 weeks' time, but around an hour or so after that is sent to you there will be a webinar that should take priority in your diaries – it is the first webinar in a series we are doing in partnership with our friends and colleagues at the American College of Physicians.

At 6pm on Monday 7 June, Health inequalities and justice – during COVID-19 and beyond will include talks by Professor Sir Michael Marmot and Dr Eileen Barrett with reflections on health inequality around the world.

Talking of health inequalities, I was lucky enough to be on a question panel for an upcoming BBC World Service programme on Dr Paul Farmer, a global pioneer in the area. I was slightly overawed to follow Melinda Gates who asked the question before me, but others were less affected. The prize for show stealer went to the young son of another questioner who appeared mid question behind her to ask his own questions of his mother. The adage about working with young children (in the house) remains true.

…and finally

I've always said that the membership and fellowship ceremonies are the best bit of my job. We've been doing virtual MRCP ceremonies throughout the pandemic, which although small have given a lovely opportunity to spend a bit more time than we usually do talking to each of the candidates. The registrar and I did one last week and the array of diplomates was moving. Two were based in India and very much involved in the current crisis there and another was calling from a quarantine hotel near Heathrow, having been to India to support his mother who had been critically ill.

It was one of the diplomates who was calling from Truro who really choked me up, though. She was wearing a beautiful pink top and commented that her family were watching. I stressed how important I thought family and friends were to us all in our careers. She then explained that the top belonged to her mum who had died recently and she was wearing it in memory of her.

It would have been my late mum's 87th birthday this week and given that I also saw my dad face to face for the first time in almost a year last week, I reflected how none of us would be where we are without the support of family and others when we first embarked on medicine as a career. I said a silent thank you to mum and a not-so-silent one to dad.

7 June 2021

A change in the weather in the UK means that miserable May has given way to joyous June so I'm afraid this bulletin may put a bit of dampener on things. Some difficult decisions will need to be made in the next week or so and the surge of the variant formerly known as the 'Indian variant' will play a big part in those decisions, so let's start there.

Alphabet St. – Variantwatch

Last week the WHO produced a new nomenclature for variants of concern and variants of interest in order to destigmatise countries that detect variants in their population. Regular readers will know that I have called for a different and perhaps more 'user-friendly' naming system for variants. The current location-based system in common use (ie not the official terminology) penalises those countries where most sequencing is done and acts as a political football for shifting the focus away from governments. This was played out in many EU countries as they blamed their recent waves on the UK (variant).

Thus the variant known here as VOC-21APR-02, B.1.617.2 and 'the variant that originated in India' (as the media had taken to calling it in a rather stilted attempt to be politically correct) is now called Delta. I will try to be good and use this terminology from here on in but I think it will take a while for this system to bed down. I also wonder what will happen when the WHO runs out of Greek letters – it is a little optimistic to see the pandemic stopping at 24 variants of concern or interest. Do we go to a 'letter + number' system or 'letter + letter' one? There must be a committee somewhere pondering that vexed question. I am looking forward, though, to seeing some of the lesser-known Greek letters such as omicron, upsilon and xi getting their moment in the spotlight.

The system is already being challenged by what the media and some politicians have called the 'Nepal variant' in the past week. This is a bit harsh on the majestic country of Nepal since it has only detected one sequence (albeit in very few sequences performed) and it has been identified in at least four other countries, including the UK and Portugal. This variant includes the K417N mutation which has been seen in other variants and may be associated with reduced vaccine efficacy. It is too early for the Delta+K417N variant to get its own Greek letter, but anyway, we should be much more concerned about the Delta variant without K417N.

Sign o' the times – the Delta surge in the UK

If you are worried about sleeping well I recommend reading the latest PHE technical briefing on variants of concern published last Thursday. It contains good and bad news and must be viewed with the understanding that many of the cases of the Delta variant have been detected through local surge testing so it is not a UK-wide population snapshot of symptomatic COVID-19 cases.

Delta is now the predominant variant in the UK population but the rate of increase in cases is slowing and the case fatality rate remains low at 0.2%. This reflects the age of those infected and that many cases are being detected in contact tracing of asymptomatic individuals. The 'secondary attack rate' data are now fairly convincing that Delta is more transmissible than Alpha (B.1.1.7 or 'Kent') by 30–40%. At the moment by far the biggest route of transmission is in schools, although links with shopping spaces and workplace are also being seen.

The 'protectiveness' of vaccines against Delta remains unclear. Table 4 in the PHE document is perhaps the most interesting for those working in hospitals wondering what the surge might mean for them. Of the 7,106 cases of Delta detected since February that can be linked to individuals, 77% were unvaccinated or had only had a single dose less than 21 days previously, 19% had had

a single dose of vaccine over 21 days previously and 4% had had two doses. As a percentage of cases, the A&E admission rates for the three groups were 1.1%, 1.3% and 1.1% respectively. There are lots of variables to take into account (eg age of vaccinated populations, numbers of fully vaccinated individuals), but at the very least it should be a signal that vaccination is not the impenetrable shield that some assume it to be. It may also show that the encouraging noises from the system that most hospitalised patients with Delta haven't been vaccinated may simply reflect the overall case distribution in the population rather than the effectiveness of vaccines against this variant.

Take me with U – difficult decisions

Given the above and that cases of COVID-19 in the UK are now inexorably increasing, the main debate is whether we should remove all legal lockdown restrictions on 21 June. This is not a simple right/wrong decision to make given the many variables at play and I do not envy those making it.

Some colleagues will feel strongly that the increasing case numbers and emergence of Delta show that we should stay as we are at the very least and maybe even lockdown further. However, the impact on large parts of the economy of long delays in opening up of hospitality may be the final straw that leads to businesses folding and unemployment soaring. We know this will be bad for the nation's health and once again affect the poorest in our society (it is hard to work from home when your job involves physically doing things with lots of individuals). Anyone who doubts the impact of lockdown on non-COVID diseases isn't working in the NHS at the moment, and, as I noted in my last bulletin, the system is really struggling.

We also don't yet know how the Delta surge will impact on NHS functioning. It is unlikely to have no effect but it is also unlikely to be as damaging as the winter surge was – as shown by the impact on hospitals in Bolton and Blackburn at the moment. If we knew this for certain the decision would be easier, but we just don't know and the effectiveness of vaccination will be critical.

We always knew we would get further surges and it raises the question at what point do we decide that COVID-19 should be seen like seasonal flu? We now have good evidence that flu can be held in almost complete abeyance by lockdown measures but I suspect even in the medical profession few would suggest an annual lockdown over winter to prevent the 10,000 or so deaths we see each year. A difficult decision indeed.

Diamonds and pearls – vaccines

The other difficult decision is around whether we should push ahead and vaccinate children as they are doing in the USA. The MHRA has just approved the Pfizer/BioNTech vaccine for use in 12–15 year olds but that decision rests with the JCVI. I will spend more time on this debate in a future bulletin.

I was interested to see the trial showing that two inactivated virus vaccines were 73–78% effective at preventing symptomatic COVID-19 as we are going to need a wide variety of vaccines and options as variants develop. Spike protein-based vaccines work well but it is a risky strategy only focusing on one target. We will have to wait and see whether whole virus vaccines will help solve this problem. As an aside, I was interested that these two vaccines were designed by a Wuhan-based company. I'm sure some will make more of that than others given the current discussions over other labs in that city.

New power generation – recruitment

The impact of COVID-19 on training has been massive and we are slowly working our way through resolving the problems created. In previous bulletins I have talked about the challenge we have in ensuring those trainees who want to come back into training can do so. Those currently in the second year of internal medicine training (IMT) are guaranteed a place but the issue was about capacity for those previously in core medical training who had stepped out into other posts but wanted to return. Stand-alone posts for the third year (so-called IMY3) were needed and earlier in the year we had a significant over-subscription for these posts of almost two to one and risked having many hundreds

of people wanting to be medical registrars without places for them.

This caused considerable angst and I pushed Health Education England (HEE) to ensure we could get sufficient posts to allow these trainees back in. Many in HEE and in hospital medical education departments worked very hard to achieve this and almost 200 additional posts were created. Unfortunately it now seems that many of these posts have not been accepted by those applying and are left unfilled. This has left many hospitals feeling angry and understandably so.

We need to understand where the 500 or so applicants who did not apply have gone and, if possible, why they elected not to take the posts. While this year has been unique due to the pandemic and the introduction of the new IMT curriculum (and so we always knew getting the numbers right was going to be difficult), there may be long-term repercussions. The challenge of recruitment planning for a curriculum that needs 2 years of training in the first stage for some and 3 for others will need resolving.

Given how things have turned out, I have taken a lot of earbashing by some for pushing for more places. That comes with the job and my ears, like the rest of me, have developed much thicker skin than when I first came into post. However, I stand by the desire to do the best for our trainees who worked at great personal sacrifice during the pandemic. Not having enough training places creates as many, if not more, problems as shown by the recent issues with anaesthetic training.

Cream – chief registrars

Talking about training, we're looking for trainees at ST4 level and above from all specialties to join the fifth cohort of chief registrars as part of our successful programme to develop the clinical leaders of the future. I have been told by many trust CEOs how brilliant chief registrars have been in their hospitals and have no doubt that it is a great way to develop new skills. But I'm biased so it is best to listen to those who have been there and done that.

Therefore, this year, for the first time, we've produced a podcast to allow prospective candidates to hear direct from two of the scheme's alumni. Do have a listen to Will and Lily talk about their experience of taking part in the programme in different parts of the UK, specialising in completely different areas of medicine. There's also lots more information on our website, including a current list of recruiting NHS organisations.

Let's go crazy – long hours and health

Not only does being PRCP come with dermatological side effects it also comes with long hours and as I was looking at the WHO website I found a worrying report on the potential impacts of this. It estimates that working over 55 hours a week leads to a 35% increased risk of stroke and 17% higher risk of dying from ischaemic heart disease compared with working 35–40 hours per week. The risks increase with age and for certain ethnicities. I wonder at what stage I should start taking aspirin and a statin.

Girls and boys – pregnancy

Risk estimation is not easy in many settings. The evidence base as to how safe it is for healthcare workers who are pregnant in the era of COVID-19 is small but growing. Globally the pandemic has resulted in higher maternal mortality and stillbirth rates but it is hard to put that into context for healthcare workers as there are many factors, including access to and fear of healthcare settings, to explain why non-healthcare worker populations may have adverse outcomes.

The Royal College of Obstetricians and Gynaecologists has produced useful guidance for healthcare workers which runs alongside the UK government advice. In short, risk assessment needs to be personalised and take into account workplace, tasks performed, mitigations and perceived risk appetite (for example, some may be happy to work in a higher risk setting with a higher level of PPE). Vaccination with Pfizer/BioNTech or Moderna vaccines is recommended for all but, importantly, does not factor in the risk assessment except from how an individual might perceive their own risk.

Betcha by golly wow! – the human genome

The pandemic and analysis of variants has shown the advantages of understanding genomes and the human genome is steadily revealing more and more of itself.

I had always assumed that when the International Human Genome Sequencing Consortium published the draft human genome sequence in *Nature* in 2001, it was exactly that. It was not, however, and roughly 8% of the genome remained un-sequenced for various technical and methodological reasons in the sequencing process. This is no longer the case and the 'complete human genome' has now been published in pre-print. Some of the science behind this is rather complex and I must confess I struggled with some bits of the paper but it is an impressive feat. Of course it is but one genome and we all have our own variants.

Whole genome sequencing – 'WGS' (or should that be '92% GS'?) – is now available through the NHS and is becoming the default genetic screening test for many conditions. This opens up a raft of issues when it comes to consent and implications for how we handle data and is a hot discussion point in the clinical genetics community. It is something all physicians probably need to get their heads around as it seems that requesting such tests will fall to us all in the future. We will need to roll this out slowly.

…and finally

This weekend we (Mrs G and I) had a couple of our best friends round for the first time since last summer and have enjoyed catching up. Oddly enough some of the conversation was around COVID-19 and the NHS (neither of them are medics or work in the NHS). Hearing a 'user' perspective of the NHS is always useful.

One of our friends was using the NHS App to look at his vaccination status and was filling in the fields to add his details. His second name is Stuart and the app helpfully uses predictive text. Apparently when he put in Stu it came up with 'Stupid'. Who says the NHS doesn't have a sense of humour?

21 June 2021

Today is the summer solstice and the longest day of the year. It feels like a long 2 weeks since my last missive. 'Freedom day' has been postponed, a third surge looms and most emergency departments in England have seen their busiest days ever. To be blunt, 2021 is proving as tough a year as 2020.

I've been on call this weekend (or on duty if you prefer) – 3 weekends in the past 8 weeks says that I must have upset the person who does the rota. This bulletin has therefore been written in between ward rounds, endoscopies, consults and sleeps, so apologies if it is a little less erudite than usual (I struggle with big words when tired).

High – the current surge

In one meeting last week I was challenged as to whether the current surge was really a problem, especially given the success of vaccination and the lack of hospitalisations. This seemingly simple question is full of complexities.

Firstly, is there a significant surge? Yes, but the severity depends on which bit of data you look at. The ONS data released on Friday were for the week up to 12 June and showed that the north west of England has the highest level of infection at around 0.6% of the population (with those aged 17–34 being the main age group affected). The latest data on the government website are a week more up to date and show that cases are currently increasing by 31% a week with (again) marked regional differences. The north west, north east, West Midlands and some parts of London are the early leaders in this dubious race. Importantly, the rate of increase is slower than previous surges and may even be falling, which is reassuring. As things stand the surge is only a ripple and not yet a fully fledged wave.

Secondly, is vaccination successful against the Delta variant? Again, it depends a bit on your definition of success and how wide you like your confidence intervals (true in many aspects of life).

The recent PHE pre-print looking at 14,019 cases of the Delta variant with 166 hospitalised patients showed a 'vaccine efficacy' in preventing hospital admissions of 71% and 92% for one and two doses respectively of the AstraZeneca/Oxford vaccine and 94% and 96% for the Pfizer/BioNTech one. For prevention of symptomatic infection, these figures are 67% and 88% for two doses of AstraZeneca/Oxford and Pfizer/BioNTech respectively. Remembering what I said a fortnight ago though, we have yet to see the older age groups exposed in large numbers and, with some worries about waning of vaccine effect (see later), we must be a bit wary.

Lastly, is there evidence of increased hospitalisations? While it is variable, and hence why some may not be seeing it, nationally admissions were up 40% in the past week. Other data show that ITU admissions are also increasing, although many of these are young patients and not all are needing mechanical ventilation. Until very recently, admissions to hospital of those under 18 outnumbered those over 85 but this position has reversed in the past week.

With all these variables it is unsurprising that the modellers can't agree completely. The most recent models in the SPI-M-O paper for SAGE suggest the surge will grow over the next 6 weeks, plateau and then fall. Delaying the next stage of relaxation of lockdown for 4 weeks made quite a big difference to these models as shown by the graph from Warwick University on page 8 of that document. It explains why 19 July was chosen as the new date for relaxation as longer delays beyond 4 weeks wouldn't have made much more difference.

Best laid plans – what's happening to the world outside health?

While perusing the ONS website I stumbled upon the latest economic activity markers for the UK. I won't spoil it too much for you as some of the detail is fascinating but headline figures show that economic activity is very much on the up. Seated diners (who measures these things?) are at 119% of 2019 levels, traffic levels in the north east and London are higher than before the pandemic and credit card sales and shopping footfall are increasing. One warning sign, though, is that job vacancies are now falling again, and the number of insolvencies is on the way up.

While such data are interesting, they are the other side of the coin that we in health sometimes forget and, for all their faults, politicians have to constantly weigh up when thinking about pandemic management. That doesn't mean that we throw all sensible precautions out of the window if good business opportunities come our way. While I am enjoying the Euros at the moment I do think that letting thousands of match officials, press, and others into the UK without tight quarantine measures is not a wise move as a new surge builds momentum. England's defence has always seemed a bit shaky.

Make me better – vaccination

Vaccination continues to dominate the news. A cynic might say this is because it is something that has gone well in the pandemic. However, the fact that 81.6% of the UK adult population have had one dose and 59.5% two is still pretty remarkable. The acceleration of the date by which first doses to all over the age of 18 will be offered (to 19 July) will be a stretch for the NHS vaccination programme. That is a further 10 million doses, with 62 million having been given so far in England.

Much of the debate this week has been about mandatory vaccination for social care staff and the potential for making jabs mandatory for NHS staff. This is a slippery slope and we (the RCP) have been pretty clear that it is not one we should venture down. Our rationale and position on vaccination for healthcare workers is laid out in the appendix to the ethical guidance that we updated in February. Alexis Paton, the chair of our Committee for Ethical Issues in Medicine, has put the arguments around mandatory vaccination in context in a recent piece in the *Independent* (and blown some of the myths about hepatitis B vaccination).

The Faculty of Occupational Medicine (of which I am a proud fellow) is also against mandatory vaccination for healthcare workers as a condition of employment

for the reasons laid out in their own ethical guidance. Successful vaccination programmes in healthcare settings require good organisational leadership, professional responsibility of staff and individual contact and discussion. A diktat from above is likely to widen health inequalities, disempower staff and result in staff leaving the NHS.

So long Jimmy – waning vaccine efficacy

While the evidence on the effectiveness of vaccination is great, we should not forget that vaccine efficacy, like my sporting prowess, fades with time. Flu vaccine efficacy falls by about 7% per month and it looks like, based on modelling of neutralising antibody levels, SARS-CoV-2 vaccination is not dissimilar. There are also data that show that antibody levels fall after natural infection, although there are different patterns with 'fast waners' and 'slow waners'. It is obvious that the more effective the vaccine at inducing antibodies, the longer protection will last.

According to a relatively recent article in the *Lancet* we shouldn't panic too much, though. The protection against severe infection will be driven by our cellular immune response as much as our humoral one and we still don't know the exact meaning of different antibody levels in vivo. While we are now developing quantitative antibody assays, which will appear in the NHS soon, we should be cautious about overinterpreting these. They may help identify at-risk patients who are unable to mount a meaningful response to vaccination and thus will need to take additional precautions.

One last thing on vaccinations. One reason for vaccine hesitancy in young people is fear about its impact on fertility. The origins of such fear is lost in the mists of hype and social media but if you are faced with such a claim there is now good evidence for men that the mRNA vaccines improve sperm counts and motility. This is probably as a result of the methodology used rather than a real effect, but reassuring nevertheless.

You're beautiful – integrated care systems (ICSs)

Let's move on from COVID-19 (something that we would all love to do in the world outside of this bulletin). This week saw the quiet publication of plans for the structure and working of ICSs. It is not a riveting read but has great importance for anyone working in the NHS, local government or social care in England.

If you want to focus on any one area, page 27 is a good place to start. This talks about the roles of different providers in ICSs. 'The success of individual trusts and foundation trusts will be increasingly judged against their contributions to the objectives of the ICS' suggests that the old-fashioned payment by results will be locally determined but also stresses that engagement with ICSs is critical to ensure all parts of the system agree what is important to measure to assess success.

The document states that funding will be distributed to ICSs linked to 'population need', although it gives no clues as to what this means. ICSs will be statutory bodies from April 2022 and the two types of providers will be 'place-based partnerships' and 'provider collaboratives'. I'm sure we will get used to these new terms as the years go by.

I did notice a typo on page 13. Using the very over-used phrase of the past couple of years it talks about change taking place 'at scale and at pace'. Except it was printed as 'at scale and at **place**'. This might be a Freudian slip as ICSs will need to be place-focused but also perhaps suggests that the phrase should be used less as everyone now just glazes over it.

If time is all I have – training

I promised to keep trainees and trainers up to speed with issues around IMY3 and alternative certification. Following up the news that applications to IMY3 stand-alone places have been lower than expected, it looks like many trainees are looking to use the so-called alternative certificate process to become eligible for higher specialty training in 2022.

This allows more flexibility around posts in the next 14 months but it has become clear that not everyone

has realised that competencies to be signed off for an alternative certificate to be issued need to be achieved by the time of application to ST4. This is likely to be especially important for critical care and geriatric medicine competencies. Trainees may well have acquired the required experience already but they will need supervisors to sign these off by November (when recruitment applications start). Therefore, they should make sure that if they are moving posts in August the relevant supervisors have been contacted to be ready to do this.

If you are a trainee seeking approval by this route or have trainees working for you in this position make sure you have seen the relevant pages on the JRCPTB website.

I really want you – Clean Air Day

Last Thursday was the annual 'Clean Air Day' and it was a good opportunity to renew our push for improved control of air pollution levels in the UK. One key ask by the RCP and others is for the WHO limits on PM2.5 levels to be enshrined in the new Environment Bill. As I'm sure you know, PM2.5 refers to fine particulates in the air of a size less than 2.5 µm which are the main culprits in air pollution-related ill health. The average levels in the UK are 25 mg/m3 compared with the WHO recommended limit of 10 mg/m3. The air we breathe is not as clean as it looks.

On Clean Air Day the government announced that it would 'be informed' by the WHO limits and would have new legal limits on air pollution in place by October 2022. This announcement was in part a response to the Inner South London coroner's report into the death of Ella Adoo-Kissi-Debrah in 2013. Ella's death has provided a focal point for energies around improving our air quality and, while air pollution kills at least 40,000 people a year in the UK, it may well be one death that results in the most change. The coroner's report into Ella's death was unflinching in its assessment of the contribution of air pollution and the RCP was directly asked to respond. Our response confirmed we would do more to ensure that physicians are aware of the health implications of air pollution. If you haven't read it, *Every breath we take*, the report we published in 2016 with the RCPCH, is a very good '101' on the health impacts of air pollution.

The only downside of Clean Air Day was that it shared the day with many other awareness days and the more of these we have, the more the impact is diluted.

Champions – honours

The Queen's Birthday Honours list came out a week ago and I was immensely proud to see so many members and fellows of the RCP recognised. Such was the number I risk upsetting people by singling anyone out, although I was particularly pleased to see recognition of those who have worked so hard to support the RCP or their specialty over the years. I also think it is a fair reflection of the work that has been put in by physicians in response to the pandemic. It has been our toughest but perhaps finest hour.

We have worked very hard over the past few years to improve the way the RCP nominates people for national honours by increasing the diversity of those we submit so it is not just the 'usual suspects'. That the system recognises people who don't grab the newspaper headlines and instead quietly and industriously improve patient care and education (usually on their own time) is reassuring to see. I know not everyone thinks the honours system is a good thing but for those individuals it is just reward.

…and finally

I knew that mandatory vaccination was going to be coming round the corner when early last week I started to receive more emails from activists in the vaccination field. While I fully understand the concerns about this issue, as I've outlined above some of the evidence being cited to warn of the dangers of vaccinating young people was at best 'uncontrolled'.

According to the US system of vaccine adverse event reporting (VAERS) there have been over 5,000 deaths reported to be 'associated' with the vaccine. However, the headline figure masks some of the detail, including deaths from murder and motor vehicle collisions. Association is not causation.

5 July 2021

Today is the 73rd birthday of the NHS and yesterday was national 'Thank You Day' so I will start this week's bulletin with a positive tone to acknowledge all that has been achieved in the past year and say thanks to everyone for all they have done. There have been enormous achievements in that time, not least the response to the second wave of the pandemic and the roll-out of the vaccination programme. I think I will struggle to keep a positive tone going, though, as the current wave builds momentum, the system goes through major churn and the mood on the ground is reflected in our recent survey results.

The past 2 weeks have seen some jaw-dropping events which I may also need to mention. This week's bulletin was always going to have a camera-related theme somewhere.

Ordinary world – the current wave

Much talk in the media in the UK at the moment is about 'getting back to normal' in a fortnight when restrictions are planned to ease on 19 July. If normal is being in the midst of a pandemic wave, then we are on track.

The number of cases in the UK has increased substantially in the 2 weeks since my last bulletin and we now have the fourth largest number of daily cases in the world (accepting that we do a lot of testing compared with some countries). The rate of increase of 67% per week is slower than previous waves but pretty worrying nevertheless. That the number of hospitalisations is only increasing at 24% per week is somewhat reassuring, but when I last wrote this figure was at 10% and thus it is premature to assume (as stated by our PM resplendent in his car manufacturing overalls last week) that the link between cases and hospitalisations has been severed by vaccination. There are torrid days to come and already we are seeing some hospitals redeploying staff again.

The biggest impact at the moment on hospitals, though, is staff absence through self-isolation following contact with (mostly school-aged) infected cases. This is similar to what we saw in the first wave when one in five physicians were off work due to sickness and self-isolation. The impact on small departments in smaller hospitals with little capacity to cross-cover is significant. It is not understating things to say that patient safety is now being put at risk by reduced staffing levels.

This has opened a strong debate at higher levels in the NHS and government about whether the rules for self-isolation should be different for NHS staff who have been double vaccinated and are already wearing PPE, as well as the public debate about self-isolation of large numbers of school-aged children and young adults. While I get that the 'optics' of having differing rules for different groups of people is a difficult one politically, we are beginning to reach a point where the NHS will fall over in places due to staffing numbers. We know the risk of transmission from doubly vaccinated healthcare workers is low and we have the capacity to do daily (monitored) tests and enhance PPE (see later).

I sense that the rule of sending 'bubbles' of school students home will not last the summer holidays and those holidays really cannot come too soon. The impact of lost learning is large and will continue to widen the education gap between rich and poor in our society.

Seven and the ragged tiger – lateral flow tests

As I mention the possibility of daily testing for contacts, most of us continue to do twice-weekly lateral flow tests (LFTs) in our workplaces. This is about to get a little bit more 'testing' as according to a letter to NHS staff last week we will all have to order new tests online rather than pick them up from the hospital or GP practice. No great problem with that, although they will only be delivered in packs of seven. I assume this rather bizarre number is something to do with the number of kits that will fit in a certain size of envelope but not only is

having such large volumes of mail not great for the environment, it makes it highly likely that people will run out of tests frequently and compliance with testing will drop – that is not a good thing.

Notorious – ivermectin

I continue to get emails from proponents for the use of ivermectin as a treatment for COVID-19 and I am trying to keep an open mind. The evidence so far has been conflicting and confusing. The largest randomised clinical trials have no shown benefit.

A recent review and meta-analysis of 15 trials including 2,438 patients showed a mortality drop of 62% with 'moderate certainty' evidence. Reading through the paper, though, doubts begin to creep in as to the relevance to some populations studied. The reviewers worked hard to get the details of the data from individual studies and reviewed the quality of those studies – 'mixed' would be a fair summation of both the quality and the study designs and patient groups. No studies were in the UK or USA and there was no clear evidence of the interactions with other drugs in those patients (and, most importantly, steroids).

However, this is the strongest evidence so far that ivermectin may have a role to play and I am therefore pleased to see that it is now being studied in the UK as part of the PRINCIPLE study so we can try to have a clearer answer on its use.

Is there something I should know? – FFP3 masks

The preprint release of data from a study in my old stomping ground of Addenbrooke's Hospital on the use of FFP3 masks on 'red' wards is also worth a look. The study looked at the impact of a change to FFP3 respirators from fluid resistant surgical masks (FRSMs) in late December 2020. The reduction in infections in healthcare workers on those wards is striking as case rates increased in the community and on 'green' wards.

This is useful evidence for a higher level of PPE on such wards and indeed many hospitals have already moved to this model. Although I think it is a genuine effect, there are some issues with the study as there was a reduction in case rate that started at least 2 weeks before the change of masks was instituted, and more regular routine testing of 'green' areas appears to have started when the change was introduced. The authors state that vaccination didn't start in the relevant healthcare workers until after the intervention (which was slightly unusual as many trusts had vaccinated large numbers of staff by that date) and they don't make much comment on the fact that nationally, infection rates in healthcare workers in the second wave were 25% of those seen in the first wave due to previous infection, general improvement in infection control and vaccination. As I said, though, I think the impact was a real one.

To be fair, the authors themselves tried not to sensationalise their data but I suspect that many infection control teams will have noted the study and (reasonably) will have pressure put on them to act if they have not done so already. Understanding the risks in double-vaccinated staff, ongoing supply chain issues and the fact that at least 20% of FFP3 mask wearers fail a fit test may mean that applying a simple policy to change all to FFP3 will not be without practical challenges.

Save a prayer – vaccination in the autumn

There was a letter from NHS England at the end of last week outlining the plans for COVID-19 booster and flu vaccinations in the autumn. It is a little dry but includes some important messages.

The booster programme will be in two stages with the first (from early September) including immunocompromised and clinically extremely vulnerable adults over 16, frontline health and social care workers, people over 70 and those living in adult residential care homes. Stage 2 will be people over 50, at-risk 16–49 year olds and adult household contacts of immunocompromised individuals.

Flu and COVID-19 boosters will be given simultaneously and a mixed delivery model (ie anywhere and by whoever can be found that is suitable) will be used accepting that pharmacies and vaccination centres will have an increasingly important role. Hospital hubs will be expected to deliver boosters to their staff.

No comment is made about which vaccine to use as the COVID-19 booster but it seems that a different one may be better from previous vaccine studies and there is immunological sense to this. Whether people who have had the Pfizer/BioNTech vaccine will then have the AstraZeneca/Oxford one is doubtful in my mind as the risks of VITT (vaccine-induced thrombosis and thrombocytopenia) will be present as it would be a 'first dose' and the benefit from a booster less than from the initial vaccination, thus reducing the risk/benefit ratio. I am sure the Joint Committee on Vaccination and Immunisation is debating this as supplies will need to be planned asap if we are to start the booster programme on 6 September.

(Reach up for the) Sunrise – a new vine

While we are on vaccinations, the RCP Medicinal Garden is about to gain a new inhabitant. It is a scion from the vine at Edward Jenner's house in Berkeley, Gloucestershire and is a Vitis vinifera or 'Black Hamburg'. That vine is thought to have originated from a cutting Jenner made of the great vine at Hampton Court. The scion we have has been presented to us by Dr John Ashcroft and his son Dr Tom Ashcroft, and will be planted once we have had all the railings of the garden repainted. Anyone visiting St Andrew's Place at the moment will notice large amounts of scaffolding as the terrace houses and metalwork get their regular Crown Estate-approved lick of paint (Crown Paints one assumes).

The vine will represent vaccination in the garden and act as living memorial to the COVID-19 pandemic. As an aside, we have been working with the Jerwood Foundation to create a lasting memorial in the garden to members and fellows who have died in the pandemic. A couple of weeks ago I met with the sculptor we plan to commission and hope the memorial will be in place by next summer.

Girls on film – a new secretary of state

What can I say about the exit of our last secretary of state that hasn't already been said by others? Not much, apart from that the interpretation of hands/face/space was imaginative and his timing could not have been much worse as Sir Simon Stevens steps down as CEO and the NHS tries to navigate one of the most difficult periods in its history.

There is little doubt that the new secretary of state has a very different style but by his own admission in a letter to staff he seems keen to support everyone to 'make it as easy as possible to do (our) jobs'. It was good that he took the first opportunity he could to visit a hospital and the staff there, although he will need to venture a little further than across the Thames to see what life is like in NHS institutions outside of a reasonably well-equipped London teaching hospital.

I have reached out to welcome him and hope to meet him soon. We, as a group of physicians, are keen to help – and he will need as much help as he can get.

Come undone – workforce

As I mentioned at the start of the bulletin, today is the 73rd birthday of the NHS. It is showing signs that it is not ageing well and has already picked up a few long-term conditions. So while it is good to celebrate the birthday, such days should also be about reflecting on how we use the future most effectively.

How we as physicians feel about our futures and the impact of the pandemic has been shown by our most recent survey – the results of which were released today.

I've written a blog to go alongside the survey results but the headlines for me are that 27% of consultants plan to retire in the next 3 years and 56% of trainees would like to work less than full

time. These both have enormous implications for the workforce and Mr Javid will need to think hard about how to retain staff and meet the need for expansion of training places.

The survey showed that 57% of us now work from home at least some of the time and that this has been seen as a good thing by most, with 67% saying it has improved their work–life balance. Most, though, think that any increase in flexibility beyond this is going to be very hard with workforce shortages the main limitation.

The reflex – Brexit

Remember Brexit? I read a fascinating (and relatively short) blog/analysis by the Nuffield Trust of the promises and warnings about health that were made before the referendum and what has happened since in reality. The blog shows that both sides overstated things and got their predictions wrong.

What I found most interesting and has relevance moving forwards was that it was seen by strategists (and, in particular, one Mr Cummings) that all the debate about the £350m a week for the NHS figure was helpful, even if it wasn't correct. Thus, by challenging the claim, opponents of Brexit may have helped sway public opinion towards favouring Brexit – ie any press is good press.

My own way – SAS physicians week

Next week (12–16 July) we will be highlighting the crucial role of specialty, specialist and associate specialist (SAS) doctors and will be celebrating the role they play in the NHS. Throughout the week we will publish blogs written by SAS physicians on four different themes: leaders, researchers, educators and SAS as a viable career. Look out for them in *Commentary* magazine and on our website.

We will also be using our social media channels to share myth-busting facts and figures about SAS careers. In the meantime, do have a look at our current SAS regional representative vacancies.

… and finally

Last Thursday was my 1000th day as PRCP so I briefly reflected on the quiet time I've had since taking office. At least I haven't had to navigate through a doctors' strike like Dame Jane, I thought. Day 1001 started with the alarm clock radio going off with the news about potential industrial action.

As my mum used to say (obviously quoting), 'Events, dear Andrew, events'. You never know what is around the corner.

12 July 2021

This week I will be sending out two bulletins, which may seem a bit excessive. However, there are important things to say today and then there will be an IT-determined 3-week break to bulletins from the end of this week so we will send another one on Thursday.

Coming up – the current state of play

The weekend has been one of disappointment for England fans, especially the youngest who haven't had the pleasure of watching a penalty shootout before. Later today the PM will be making an announcement about the final stage of lockdown easing on 19 July. I'm not psychic but it seems that all legal enforcements will be removed as was signposted 4 weeks ago.

The current wave is marching on, although the increase in cases per week has slowed to 27%, which is slightly encouraging. The impact of mixing in bars and stadiums over the past week will not be without consequence, though. Football may not be coming home but COVID-19 will be – in Wembley last night there will have been around 500 infected people based on the latest ONS data. That slightly annoying shouty bloke in a stained '86 top to your left may well have given you more than a knowing shrug at the end of the game.

The rise in hospital cases is increasing more rapidly at 57% per week, compared with 24% this time last week. We just have to hope we don't reach the situation that the Netherlands have had with a doubling of infections every 2 days. All of this means that the relaxing of lockdown planned for 19 July is fraught with risk and something needed to be said.

We all stand together – go slowly

On Friday the Academy of Medical Royal Colleges (AoMRC) released a statement about the 19 July 'unlocking' following a number of meetings of the presidents of AoMRC members over the past couple of weeks. I suspect that some readers may not have heard of the AoMRC and will be asking why the RCP could not produce the statement. I'll come on to that but first here is what we said:

The COVID-19 pandemic is not over and it will not be over on 19 July

While getting back to normal life is what everyone wants, it is essential that we all take a responsible approach when restrictions are formally lifted.

Medical royal colleges, as the professional voice of doctors, believe that continuing to be cautious is the right thing to do for both individuals and organisations. There is little doubt that things will get worse before they get better.

We are already in the turmoil of a third wave of the virus and cases are rising dramatically. Thankfully, due to the success of the vaccination campaign, that is not translating into the previous levels of hospital admissions and deaths, although numbers of both are rising steadily. There are reports of routine care having to be postponed again due to healthcare professionals having to isolate as well as the rising caseload which risks increasing the pressures on the NHS.

For a combination of reasons, not all of which are yet clear, the NHS is currently under unprecedented pressure. People who stayed away from the NHS during the pandemic are now coming forward, some of them with more serious health problems because of the delay in seeking help.

The numbers of people attending GP surgeries and emergency departments has rocketed to levels which are causing real problems for the NHS and are difficult to manage. In addition the growth of Long-COVID, particularly in younger adults presents additional pressures and challenges to the service. At the same time hospitals are trying to tackle the huge backlog in elective work which has built up over the pandemic. It is like the worst of a bad winter in July.

As restrictions are lifted we will see increases in other respiratory infections as well as COVID cases further adding to the pressures. We have already seen this in children, although COVID itself is very

unlikely to cause severe illness or death in children or teenagers.

The Academy of Medical Royal Colleges and its member organisations would ask the public to continue to show caution in their approach. As medical leaders have repeatedly said, it really is sensible for the protection of other people to continue to wear face masks in crowded indoor spaces.

We would also expect all health and care organisations to continue to require staff, patients and the public to take appropriate precautionary measures and would urge everyone to follow local guidance. Retaining this cautious approach will enable the NHS to continue the task of treating the backlog of patients.

There is no doubt that we will get to a position when this dangerous and erratic disease is largely under control for the population as a whole and we can 'learn to live with' COVID-19.

However, we are not in that position yet and, sadly, we have to expect things to get worse again. Doctors are therefore urging people, organisations and governments to continue to act with care. Only in that way will we fully and finally emerge from this pandemic.

Like all statements written on behalf of lots of people, you will never please everyone (eg I know that for many we are in the fourth wave). However, we felt that on this issue we needed to speak 'as one' so it was clear what the colleges think. It got a lot of coverage in the press on Saturday, but such messages need to be repeated for them to land (especially given last night).

The AoMRC represents 23 colleges and faculties and is often used as a single point of coordination by government and the NHS when trying to get a broader view or engagement on issues. Sometimes it is better to work in partnership with one or two other colleges such as on urgent and emergency care as we did last week but on this we were happy for the AoMRC to speak on our behalf.

Tug of war – other viewpoints

Some will think we should have been bolder in our statement. The members of Independent SAGE have called for a 'delay in relaxation of guidance until everyone, including adolescents, have been offered vaccination and uptake is high, and until mitigation measures, especially adequate ventilation (through investment in CO2 monitors and air filtration devices) and spacing (eg by reducing class sizes), are in place in schools'. Independent SAGE is a self-appointed group of experts many of whom have good credentials to offer advice, although there are few practising clinicians in their group.

While implementation of this call would undoubtedly slow transmission, the reduction in uptake of vaccination in the younger population seen in the past week suggests that waiting until uptake 'is high' may be a long wait. As winter approaches (with other respiratory infections including flu waiting for their time on the stage) the longer we leave it to 'relax' the more likely the inevitable 'exit wave' will be hard to cope with. School holidays will offer a natural break in chain of transmission. Also, as time goes by, the protection of those vaccinated will wane and then we might need to wait until everyone has had their booster, delaying things even further. There is, in short, no easy time to release lockdown. I also think the politicians have made their and our bed and now we all have to lie in it.

Therefore, the most important thing is to try and get the public on board with doing everything they can to reduce transmission as the brakes come off. Face masks indoors, working from home where possible and avoiding crowded places would be good (face/place/space – can I have a job in the No 10 comms team?). We will need our politicians to promote this too and those in Westminster might learn much from Cardiff in this approach.

Sally G – SAS physicians week

I know I mentioned it in my last bulletin but just to remind everyone that this is SAS physicians week and we will be highlighting the work of SAS doctors via our channels throughout the week. My mum was an associate specialist (as well as the title of a song) and therefore I have a slight bias in trying to ensure this vital group of doctors is recognised.

...and finally

I will write more later in the week (when we know more about 19 July). This email is sent from an automated platform that will be temporarily out of action while we change our domain address from 'rcplondon.ac.uk' to 'rcp.ac.uk'. Thus, we won't be able to send out the bulletin for 3 weeks from the end of this week. We have other ways of highlighting important news to members, though, and I will highlight them in my next missive.

15 July 2021

Welcome to part 2 of my bulletins for this week. As mentioned previously, you can now enjoy a 3-week break from bulletins while our mailing platform is updated.

As expected, the PM is pushing forward with removal of the legal enforcement of lockdown rules on Monday 19 July. The mixed messaging on masks from English politicians is not particularly helpful – how many people on a (non-London) train carriage make a crowd? Although only 72 hours has passed since my last missive, they have been eventful ones.

Waterfalls – flooding at the RCP

As my first bulletin of the week was hitting your inboxes the summer storms were hitting parts of the UK, including Yorkshire and London. A month's rain fell in an afternoon and the London sewerage system, like some parts of the NHS, failed to cope with a significant surge. Unfortunately, the water found its way into the lower floors of the RCP's Regent's Park building, in particular the Wolfson and Seligman lecture theatres, Platt Room and Thomas Cotton Room.

A huge effort to push back the floodwaters by security staff, the fire brigade and other staff who were on site meant that damage was limited and could have been much worse. The tidemarks and unpleasant smell will take some sorting but thankfully the IT and AV systems survived and no damage was done to any of the RCP's treasures in the museum spaces. The leeches in the Hoffbrand jar collection must have been a bit excited as the waters rose.

The past couple of years have not been straightforward for the RCP. It never rains but it pours…

With a little luck – the health and care bill

You have to feel a bit for the new secretary of state for health and social care. He has inherited someone else's shiny bill and now has to get it through parliament. The bill was debated in the House of Commons yesterday and prior to that we made our views on it clear both in a briefing and via a letter to *The Times* which I co-signed with several others.

The BMA was among the signatories but I also note that yesterday they came out in direct opposition to the bill. This is slightly confusing but the position statement about opposition makes their thinking clear. Should we therefore oppose the bill? While not perfect (and I have written at length about the bill in previous bulletins) we support the formation of integrated care systems (ICSs) and the bill is needed to ensure they are legal entities. As many ICSs have already been established in shadow form it is hard to see how opposing the bill will reverse this.

What the bill does lack, and hence the letter to *The Times*, is clarity about workforce planning. Without a formal plan in this regard any reorganisation is doomed to failure in the long run. It also doesn't say anything about social care – a rather large piece of the health and social care jigsaw. Both can be addressed as the bill works its way through the legislative processes.

Fine line – getting through winter

If you want a very well-thought-out and evidence-based set of recommendations for getting through winter 2021 the report published by the Academy of Medical Sciences today is well worth looking at. It is not for the faint-hearted as it is jolly long. It also has very little filler and covers all aspects of the pandemic moving forwards as well as the other challenges of winter. As it was commissioned by Sir Patrick Vallance some of the recommendations may even make it through to policy – although many such reports are commissioned and historically their take-up has been patchy.

No more lonely nights – self-isolation and shielding

There isn't too much to add to my bulletin on Monday about the pandemic. Cases continue to increase as do hospital admissions, although the rates of increase are not changing rapidly. What we are hearing is lots of noise about staff having to self-isolate and this is aggravating shortages at a time when staff are usually a bit thinner on the ground due to annual leave.

I am hoping that we will soon have some guidance for healthcare workers who have been double vaccinated and are asked to self-isolate as contacts (no one would countenance anything bar self-isolation for positive cases) to improve the situation. It seems unlikely, though, that the NHS will be viewed as a particularly special case but let's wait and see. Enhanced testing and use of PPE should reduce the risk of spread from the 10–15% of contacts who will go on to be positive. Lack of staff remains the bigger risk to patient safety.

The other big topic of conversation at the moment is what to do with those patients who are clinically extremely vulnerable (CEV) and who have been vaccinated. The effectiveness of vaccination in certain patient groups such as the immunocompromised remains unproven and we will need to prioritise such patients for boosters. Many CEV patients are frightened by the relaxation of social distancing guidance and we need to ensure they are adequately protected moving forwards. There is work to be done to ensure we understand who is at highest risk and this will need the involvement of individual specialties.

Deliver your children – maternal mortality during the pandemic

Many readers will be aware of the annual MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) reports which look at maternal mortality in the UK. The latest report focuses on deaths in women

who had COVID-19 during pregnancy. Ten were identified between March and May of 2020 and their cases reviewed. All the women died after giving birth (two babies were stillborn) and seven were from causes directly related to COVID-19. In the same period four women died from suicide and two from domestic violence (in itself shocking).

The report is not as easy to read as some of their previous reports, but the case vignettes are powerful. The quality of care was only considered 'good' in two cases and in three it was felt that the outcome may have been different with improvements to care. Essentially, early identification of infection and then involvement of senior staff is critical. The report obviously covers a pre-vaccine era and did not look at other causes of death that may have been impacted by service changes related to the pandemic.

Another day – the weekend effect

Remember all the fuss that was made about 7-day services and the need to get specialists in hospitals at weekends to reduce the (proven) 16% excess mortality for patients admitted at the weekend? Many of you will have been involved with the definitive study that has now been published – the HiSLAC study (High-intensity Specialist-Led Acute Care).

This publication is a beast at 202 pages long (it is the full NIHR report) but those 202 pages include some fascinating detail. The crux is that while there is definite evidence of a weekend effect, as soon as you correct for the acuity of patients being admitted the difference in mortality disappears and the number of specialists doesn't seem to make any difference. In effect, the weekend effect is all to do with what happens before the patients come to hospital and the study exhorts those in charge of our health services to address this.

There is no evidence of poorer quality of care in hospitals at the weekend and no increase rate of error or harm. Primary care is a critical part of the system and the study showed that the referral rate from GPs into emergency care at the weekends was a third of that during the week. Lots to think about.

Listen to what the man said – research is coming home

Two weeks ago we held a very successful meeting with NIHR, DHSC and NHS representatives to discuss lessons learned from the pandemic about research and what this means for the future. It was a 'Chatham House' meeting but one of the speakers made the analogy that the pandemic and current situation in the NHS was like a rubber band. The pandemic could pull clinical research to become more embedded in the NHS or the pressures on the NHS could pull the advances made during the pandemic back to the 'old ways'.

There is no doubt that the pandemic has pushed clinical research up the political agenda and the benefits to the NHS and patients have been clear to see. The barriers to building on this that we identified at the meeting are NHS culture (and specifically creating clinician time), the role of clinicians as gatekeepers for patients entering trials, and the uncertainty of the future of platform trials and other study designs moving forwards.

I mentioned Good Clinical Practice (GCP) certification briefly having just had an email telling me I needed to do it all again. Deep sighs around the table and a general agreement that training needs to be made easier and simpler (but as consistent) made me realise that this is one simple hurdle that we can address. Others are ensuring it is seen as a normal part of job planning, is high in the metrics for ICSs and that those metrics are clear and apparent.

There were three NIHR associate principle investigators there from three DGHs who had recruited large numbers to the RECOVERY trial including a couple of registrars and one physician associate. Their enthusiasm was tangible – we must create a system that will allow those like them to flourish.

Here today – PACES clinical stations

We are getting the exam machinery up and running again and catching up with the backlog for PACES is a priority. Today saw the first RCP virtual PACES revision course and we plan to put these on regularly to support those taking the exam. The next one is planned for the 30 September. The course is delivered by previous PACES examiners and focuses on the clinical stations 1, 3 and 5. It covers the common errors and pitfalls using pre-recorded cases to allow course delegates to practise their case presentation skills. Despite what people may think we are very keen to improve pass rates!

Take it away – Prof Peter Kopelman

I was very sad to hear of the death of Peter Kopelman on Tuesday. He was a big part of RCP life for many years, chairing the Clinical Examining Board, Nutrition Committee and taking an active part in Council on top of his impressive career at St George's and in the international obesity research field. Latterly he was heavily involved in the evolution of the physician associate profession and laid many of the foundation stones to their development.

One of the last times I saw him was in Fowey in Cornwall where I almost ran him over on my bike. Ian Bullock (RCP chief executive) and I were navigating the tourists in a desperate search for a Cornish pasty for lunch during part of the 2018-mile ride we did for the RCP's quincentenary. Peter and his wife, Sue, were enjoying a quiet stroll only to see a flash of purple lycra going against the flow. He flagged us down, and in typical fashion was great company as we rested and recuperated. Rest in peace, Peter.

...and finally

The pandemic has resulted in many physicians returning to the acute and general medicine wards after a considerable time in their specialty (aka being redeployed). While this has been uncomfortable or even scary at times I sense that a few have quite enjoyed relearning the medicine of their youth. The changes in diagnostic criteria and management for some conditions, though, has been tricky for many.

One group of dermatologists decided to write down all the gems they have learned about caring for such patients to make it easier for others facing this challenge – I found it a useful revision piece too.

It is clear from such documents that many physicians have gone well outside their comfort zone to help in the pandemic. The NHS should be indebted to them.

9 August 2021

The RCP membership email system is back up and rebooted having had a 3-week holiday (we should all be so lucky) since my last bulletin.

As seems to happen every year on the first weekend after August changeover I have been on call for the past few days so apologies for any mistakes. On the plus side it was one of those rare weekends when both my brother and I were on call together in Derby and team Goddard confused both patients and switchboard.

It has been an eventful 3 weeks, including a changing of the guard at the top of the NHS, a changing of the guard on most wards last Wednesday and, of course, the Olympics. I will try to resist too many sporting or competitive analogies but let us start with the question of whether we are winning or not.

Chant No. 1 (I don't need this pressure on) – is the current wave waning?

The reduction in cases seen in the UK over the past couple of weeks has given hope to many and surprised a few of the modellers, although to be fair there was talk many weeks ago of a plateauing of hospitalised cases in early August. This doesn't seem to be a false dawn and given we are now 3 weeks post 'freedom day' I am optimistic that the worst of the current wave is over.

It is striking how different this wave has been to those before it. While we have no idea about the true number of cases in the first wave due to the lack of meaningful testing, it seems likely that it has been of a similar magnitude in the community. From the perspective of UK admissions, that wave peaked at 21,687 cases in hospital in April 2020. Deaths peaked at 1,075 per day a couple of weeks later. This time around, the peaks have been at 6,045 hospitalisations and 138 deaths respectively. Not only are admissions much lower but mortality as a proportion of admissions is too. This is in part related to the age of those admitted, immunity from previous infection and improved treatments, but the impact of vaccination is irrefutable.

While I am all for freedom of speech the behaviour of those opposed to vaccination has left me speechless. The lambasting by some in the public eye of those who have delivered the vaccine programme (and thus saved many lives) to foment discontent is difficult to watch. That it has resulted in threats to NHS staff makes it abhorrent.

One challenge when comparing different waves is the variability in testing numbers and behaviours. A useful way around this when assessing the current extent of infection is to look at the positivity rates of tests. This corrects for a reduction in testing that might occur as public perception of its importance reduces. There are good data on this on the 'Our World in Data' website.

We should be very thankful that the impact of the wave has been kept down as the system remains under considerable pressure from other admissions. Attendances to EDs nationally have fallen a little bit from their peak 2 weeks ago, but the situation remains very challenging. My own hospital continues to have significant numbers of medical outliers and a stretched workforce. The NHS is in a tough position. Who would want to lead it?

Gold – a new CEO for the NHS

Congratulations to Amanda Pritchard for being appointed as the new CEO of the NHS, taking over from Simon Stevens (or Baron Stevens of Birmingham to use his ennobled title). It was a very public competition for the post, with runners and riders falling at various political hurdles. Those I have spoken to who have worked with Ms Pritchard say she is an inclusive, collaborative and highly effective leader. She will need to be as the task ahead of her is immense.

As I have mentioned before, waiting lists will be the main political focus over the next couple of years. This is not good news for those of us trying to manage the urgent and emergency care pathway.

The tide of admissions shows no sign of stopping and as we move from what has traditionally been a quiet time of year into the carnage of winter, the acute medical patient group will be spread far and wide across the hospital.

Understandably (media pictures of ambulances queuing outside EDs is a winter staple), emergency medicine gets a high amount of press coverage. One of my jobs with both a new CEO and a new secretary of state is therefore to draw attention to the hidden part of the urgent care iceberg that is the medical wards and workforce. However, we must work closely with ED and surgical colleagues to avoid any notion of divide and conquer.

There have been a few blogs written about the new CEO and the challenges she faces by both think tanks (eg The King's Fund) and professional groups (eg Nursing Times). I think we need to give her a little time to settle into the role, establish her own priorities and support her as she tries to build on what has gone before.

I have tried to get some understanding of her priorities previously and if the operational plan she developed for Guy's and St Thomas' while she was COO there is anything to go by, putting patients first and striving to be the best are encouraging indicators. She has a strong reputation as a 'values-based leader' and the NHS should be the better for such an approach.

Lifeline – we need more workforce

I awoke on Friday to hear the news that the cap on medical and dental school places was to be lifted to 9,000 following a press release by the Departments of Education and Health and Social Care. This seemed even more needed when I arrived at my hospital on Saturday and discovered that trainee and ACP sickness and absence meant we had around 50% of normal staff levels. It was a 'fun' weekend …

Back to the removal of the cap. On the face of it, increasing numbers to 9,000 sounds great, but what does this actually mean? The target for home students this year was 7,576 for medicine and 890 for dentistry, so we're only talking about a maximum of 550ish extra places. If the proportion is roughly the same, about 485 of those should be at medical school. That is a 6.4% increase. A long way short of what is needed, especially post COVID. If you want to read a good review of medical school place distribution and changes over the past few years, our report *Double or quits* includes all the relevant facts.

Regarding the future planning of workforce, anyone can now input into plans for England following the launch of a consultation by Health Education England about how they should renew and update what is known as 'Framework 15', – their long-term strategic framework for workforce planning. As you might guess we will be submitting a fairly full and detailed response, but all can input via this consultation.

Instinction – changing public attitudes to health services

As we move out of lockdown and have to manage a 'brave' new world we should expect the attitudes of the public to change (and indeed many have already seen this). If you missed it, there was a report published a couple of weeks ago from the Richmond Group of Charities in collaboration with BritainThinks that puts some qualitative and quantitative data on the table.

The research shows that wave by wave the public's satisfaction with the services people receive in both primary and secondary care has fallen. Currently, 75% rate the access to secondary care services as good and 84% the quality of care received as good. In February these figures were 83% and 90% respectively. 27% of respondents rated waiting lists as their biggest concern and many talked about access issues and communication needing a focus of attention.

For long-term conditions, patients reported that increased expectations around self-management were a concern. There were mixed views about lockdown with some worried about the impacts on mental health and others the risks of infection when re-engaging with services physically.

None of this is surprising and as waiting lists grow and demands on all parts of the system increase, it is hard to see the situation improving.

Through the barricades – post-COVID demands

Whatever workforce we get moving forwards there seems little doubt that the demand will rise inexorably and indeed be greater as a result of the pandemic.

The new clinical lead for the National Asthma and COPD Audit Programme, Professor John Hurst, has written a blog about the changes in asthma and COPD over the course of the pandemic. He stresses the importance of ensuring we have accurate data about diagnosis and management, which I think we would all agree with.

The importance of data has also been shown in many of the GIRFT reports for the medical specialties. I am assured that these will see the light of day soon and hope that we can then use what has been learned across the NHS to ensure we collect the most useful data, feed it back to clinicians, and improve patient care.

A good (if rather alarming and worrying) view on the increase in demand over the next few years for cardiovascular services and the implications can be found in a report released by the British Heart Foundation today. They have modelled demand and how the waiting lists will change over the next 3 years. Even in their most optimistic scenario it looks bleak.

Muscle bound – myocarditis and pericarditis

Thinking about the heart, the debates around vaccination of children and young people have escalated of late with the decision by the Joint Committee on Vaccination and Immunisation (JCVI) last week to support vaccination of 16 and 17-year-olds. The main risks/benefits discussions have centred around side effects of the vaccine (Pfizer/BioNTech and Moderna in the UK as the AstraZeneca/Oxford vaccine is not indicated in this group due to concerns around VITT syndrome) and the severity of COVID-19 in this age cohort.

I haven't discussed vaccine-associated myocarditis and pericarditis in this bulletin before so must make up for that omission. There have been over 1,200 cases of myocarditis and pericarditis reported in the USA via the VAERS (their yellow card system for vaccines) following 300 million doses of mRNA COVID-19 vaccines. Such reporting systems may either overestimate numbers due to failure to verify cases or underestimate them as the cases are not reported. A study published in *JAMA* last week with a defined population and case verification is therefore very helpful.

The study found 20 cases of myocarditis and 37 cases of pericarditis in a population of almost exactly 2 million vaccinated individuals. The two conditions are distinct, with myocarditis occurring most commonly after the second dose in younger males. Pericarditis occurred after either the first or second dose and in older males. There were no deaths, although the long-term outcomes following myocarditis are as yet unknown.

The European Medicines Agency (EMA) has also reviewed cases occurring in Europe and although the incidence is much lower (145 cases of myocarditis and 138 of pericarditis in 177 million receiving Comirnaty – the EU name for the Pfizer/BioNTech vaccine) the pattern of those affected is the same. They observed 5 deaths though. As yet we don't understand why the mRNA vaccines cause these conditions. Myocarditis occurs with COVID-19 and the pathogenesis may be similar.

As an aside, the JCVI decision to hold off decisions around second dosing for 16 and 17-year-olds is probably related to the second dose pattern seen in cases. Although a 'single dose strategy' has been denied it may turn out that the risk/benefits in this age group mean it makes more sense than a two-dose strategy, especially given the high level of natural infection in this group (over 50%).

Communication – calling out name-calling

One of our Diversity and Inclusion Delivery Group representatives (thanks Syed) has drawn to my attention to the rather alarming report from the CQC about staff at one trust in the south west being encouraged to use 'Western' names to make them easier to pronounce. This behaviour is unacceptable and must be called out.

The trust has stated there is no such policy but the fact it was reported by staff is a huge concern. I know that some people find some names hard to pronounce (when I was RCP registrar, reading out the names at membership and fellowship ceremonies taught me much about the glorious variety of names out there), but asking people to change their identity is a fairly major step along the road to a very dangerous world. I would also note that for me personally the hardest names to pronounce correctly are Gaelic ones (both Scottish Gaelic and Irish). My geography may not be great but both are spoken in very 'Western' societies.

I note that two of our own fellows, Anton Emmanuel and Partha Kar, have already reached out to the trust in question, which is a relief to see. Both Anton and Partha are part of the NHS England Workforce Race Equality Standard team and it is great to know they are influencing diversity and inclusion at the highest level.

Only when you leave … and finally

I have a reputation in my household (and indeed at work) for telling bad jokes. I generally resist sharing them in this bulletin. However, it is August changeover and it is definitely medical (with thanks to Cliff Reid, an Australian pre-hospital critical care physician, for sharing it on his social media pages). I have adapted it for the UK market.

I showed an FY1 how to diagnose a pneumothoraces. She asked, 'don't you mean pneumothorax?'. I replied 'no, it's pleural'.

Please ignore the tumbleweed going past you at this point.

26 August 2021

The summer holidays are over for some and drawing to a close for others. I am writing this from a (slightly) sunny Wales having managed the first proper holiday since before the pandemic. It has been a welcome break. I am conscious, though, that the NHS in the UK and health services elsewhere in the world have continued to be really busy over the summer. The pandemic has continued to cause consternation but has not been the only thing to do so since my last bulletin.

Souvenir – COVID-19 update

Infections in the UK have stopped falling and are inexorably creeping back up again. This has caused much discussion as to the causes, and infection rates in young people have continued to be a significant issue. I am relieved my daughter decided not to attend the Boardmasters Festival in Cornwall where anecdotally there has been a very high rate of positivity in those with symptoms. Newquay already has the highest rate of infection in the UK at the moment and the impact of an additional 50,000 folk in the area will be a worry to local public health teams. To be fair to my daughter, it was the risk of infection that put her off travelling as much as the challenges of public transport over the summer holiday. She has a wiser head on her shoulders than I did at that age.

A recent paper looking at large numbers of cases linked to sporting events, including the Euros and Wimbledon, also makes for sobering reading, especially regarding the football. The authors feel the Euros was a unique event but I was struck by their comments on the differences in crowd behaviour between different types of event. Now that the football season has kicked off in earnest and loud vocal support is back on the terraces I am slightly anxious what effect such mixing (of people and droplets) in stadia will have. Time will tell.

I don't think we can rely on mass mask-wearing as a mitigation to become a routine at such events

and note the recent images from the House of Commons where mask-wearing seemed very much an occasional activity, especially on the government benches. One Jeremy Hunt MP stood out for wearing his. Leadership is about actions as well as words and if one is on a bench, whether green or sun-drenched, behaviour has big implications.

If you leave – Afghanistan

The reason we saw pictures of parliament last week was of course the crisis in Afghanistan. This has been awful to watch and the while the politics of it all is beyond this bulletin's remit we should all do what we can to support refugees from that terrible situation. We have co-signed a letter with the BMA and others on this issue which lays out our full position.

The RCP only has one member currently living in Afghanistan but I know many have friends and connections to the country. One connection is, of course, through the military and the current crisis will have a direct impact on those who have served in the country or indeed in similar deployments elsewhere in the world. I was pleased therefore to see the initiative 'Op COURAGE' being promoted by the new secretary of state (whom I have now had the pleasure of meeting). Op COURAGE is the NHS mental health and wellbeing service for those who have served in the armed forces and is coordinated on a regional basis.

The crisis unfolding in Afghanistan should serve to remind us of the impact large refugee numbers can have on neighbouring countries. One such example is that of Lebanon where over a million Syrian refugees have been forced to move. This has had a devastating impact on the infrastructure and in particular the health services in Lebanon.

(Forever) live and die – trials and reports on the pandemic

After discussing such topics it feels difficult to return to focus on the UK but there have been a few important trials/reports out in the past couple of weeks related to the pandemic which are worth highlighting.

The first of these has been produced by the British Geriatrics Society. Ambitions for change: improving healthcare in care homes is a review of what we have learned from the pandemic and how healthcare in care homes can be improved as a result. The focus is very much about improving the quality of care and ensuring that residents in care homes receive care that is on a parity with people in other healthcare institutions. It is an easy read and all makes utter sense. It will need investment to achieve the recommendations but having a blueprint we can all sign up to is very useful.

The role of heparin in patients with COVID-19 has been debated throughout the pandemic and the publication of the REMAP-CAP, ACTIV-4a and ATTACC trials in the *NEJM* 2 weeks ago is welcome, as is the accompanying editorial which tries to unpick the main messages. In short, therapeutic dose heparin is no better than prophylactic heparin in critically ill people, although it does seem to have a mortality benefit in non-critically ill patients. The latter does come at a cost of increased bleeding rates and there are some questions about differing patient populations. NICE is currently trying to pick through this to produce guidance.

The last study worth highlighting is our own study into the quality of hospital patient care during the pandemic. Using a structured judgement review of 510 patient case records across 19 different hospitals, the report found that 77.4% had good or excellent care, with only 3.5% having poor care. The themes identified will come as no surprise to anyone used to reading systematic reviews of care (such as the NCEPOD reports). Communication, end-of-life planning and documentation are the biggest problems identified in achieving good care.

If you want it – blood bottle shortages

Supply shortages seem to be a theme of the year (and I'm not talking about McDonald's here). Becton Dickinson (BD) supplies the NHS with many 'consumables'. After problems with giving sets and Venflons, blood bottles have become the latest supply issue and this is becoming quite a problem, especially for yellow-topped serum bottles. We apparently do around 1.7 million bottles' worth of tests in the NHS each week and the drop in supply means over the next few weeks (and especially this weekend) we risk running out in some parts of the NHS. We therefore need to be much more sparing about what blood tests we do in this period. Part of me thinks this is a good thing – we do far too many tests in a litigation-infected NHS.

This discipline of thinking hard about what tests we do and restricting them is not an easy one. There was a debate about this in the *BMJ* a few years ago and the notion that routine blood tests should never be 'routine' is an interesting one. Evidence around the safety and efficacy of intervals for different blood tests is very limited as we found out when writing the guidance for the management of iron deficiency anaemia, which is soon to be published. Maybe electronic health records data will give us insight moving forwards – perhaps it has been too easy to get tests done and that has led us to underestimate what a valuable resource they are.

I have learned much about how blood bottles need to be validated when a supplier changes. This is done at a national level and then needs to be repeated at a local level as well. Therefore, even though good progress has been made in getting alternatives or supply from other parts of the globe during the current shortages, even once they are in a hospital they still need to be validated before use.

It isn't only blood bottles that are in short supply. We have had a message in my area that international supplies of items that support discharge from hospitals, such as raised toilet seats, toilet frames and perching stools, are very limited due to the impact of COVID-19. Who would have thought that the pandemic would have resulted in a shortage of toilet seats? Joking aside, if this causes delays in patients being discharged from hospital it is not a good thing.

Pandora's box – ME/CFS guidance

There have been a few comments on social media and in emails to me following the decision by NICE not to release the latest iteration of their guidance on ME/CFS. It may help to outline our (and my) position on these guidelines.

Firstly, the guidelines have been produced by the National Guideline Centre (NGC) that we host. That we have reservations about a guideline produced by the centre should not be surprising. We would hope both the RCP and the centre can remain independent of each other and it would be improper to have undue influence over any NGC committee.

The ME/CFS guidance has been long in gestation and a previous version was felt to be unacceptable by patient groups. The latest iteration was produced by a committee which included extensive patient representation. This is a good thing and any issues we have with the guideline must not focus on this.

The main bone of contention is around the roles of cognitive behavioural therapy and 'graded exercise therapy' or GET. Trials in this topic have been problematic to put it mildly with results as contested as these guidelines. Our response to previous drafts of the guidance has relied on the input of experts in the field and my views have been shaped by them, as they are on many topics on which I have limited experience (although I do have patients with ME/CFS in my clinic as well as personal experience through friends). I found a very recent meta-analysis on the safety of GET interesting. Like all treatments, ensuring it is properly prescribed and supervised seems critical.

We made substantial comments on the proposed guidance through our experts and our main worry is that the latest version that we have seen has not taken into account any of these comments. We have been criticised by some as lobbying hard to prevent the guidance coming out. This has not been the case but we do feel our comments are important.

I have been personally criticised by some for commenting as 'just a gastroenterologist' and for citing clinical experience as relevant. I would respectfully point out that many ME/CFS patients attend GI clinics and it is important that all physicians understand the condition and what treatments are available. In an area where there is a paucity of high-quality trial data I think clinical and patient experience has relevance. If we had not used clinical experience in the pandemic before trial data was available many more would have died.

Shame – balanced fluids

Uncertainty of the benefits of treatments is a common problem and I was interested to read the results of the BaSICS trial looking at use of normal saline and 'balanced' fluids for fluid challenges in ITU patients in Brazil. I have always been a fan of balanced fluids such as Hartmann's and was slightly disappointed to see that they don't make any difference to mortality. The costs are not that different and going back to my earlier comments I would be interested to know if regular use of balanced fluids reduces swings in electrolytes and thus the need for blood tests.

The BaSICS trial also looked at rate of infusion for fluid challenges and confirmed what many of us have seen – that faster rates in this setting don't make any difference either. If someone is short of fluid, giving it over 3 hours or 1 seems intuitively to make little difference.

Electricity – conducted energy devices

While I use a lot of intravenous fluids in my clinical practice there are other things I know very little about. The Faculty of Forensic and Legal Medicine (FFLM) is one of our smaller faculties but has a crucial role nonetheless. One issue on which it has contributed recently is the provision of guidance around Tasers or 'conducted energy devices' (CEDs) as they should be more correctly known.

The FFLM guidance is intended for emergency department clinicians and makes for fascinating reading for anyone who may be faced with patients who have been 'shot' with a Taser (to be honest it makes for fascinating reading even if you don't work in an ED). If you haven't thought about the implications of the use of such devices, it is worth a quick glance. Its publication is timely as it coincides with the recent IOPC report expressing concerns about police use of Tasers.

Never turn away – post-CCT survey

If you got your CCT in the past year or so please look out for the RCP 'post-CCT survey' which should hit your inbox in the next day or two. We started this survey over a decade ago when I was working in the Medical Workforce Unit and it has provided invaluable data on consultant recruitment, new consultant working practices and what people do with their hard-earned CCTs. The more people who respond the better, and if you need an idea of how influential the data can be just look at the latest NHS Medical Workforce Race Equality Standard dashboard.

Talking loud and clear – RCP AGM

The annual general meeting (AGM) of fellows is rapidly approaching and will take place from 2–4pm on Monday 6 September (which reminds me, I must write my speech). We are looking forward to welcoming those who can attend. All fellows have been emailed regarding arrangements for the hybrid meeting and with access to the agenda and papers. Please log in to the AGM webpage if you have not received this email or wish to find out more.

…and finally

I have spent much of the past week on my bike in the Welsh hills. In my last bulletin I mentioned the Olympics and this resulted in an email from one fellow (thanks, K) about our most-decorated Olympians who had been visiting churches in the Bolton area. The relevant cleric was not aware of their profile and when they both arrived on bikes, said (with no sense of irony) – 'If you keep that up maybe you should enter the Olympics'.

Mr and Mrs Kenny, modest as ever, kept their counsel. If only we could all be as innocent and as humble as both parties in this story wouldn't it be great?

13 September 2021

What a difference a couple of weeks make here in the UK. An unexpected £36 billion to health and social care, the end of school holidays in England, and the worst COVID-19 case numbers ever seen in Scotland. Oh yes, and there is a new type of variant.

Money, money, money – backlogs and billions

Last Tuesday was a busy day politically. The British PM promised £5.4bn for the NHS to help deal with the backlog created by the pandemic and an increase in taxation to support an ongoing boost in funding for health and social care to the tune of circa £12bn per year. The arguments about the fairness of the form of taxation (initially a rise in National Insurance contributions) and whether this increase in funding was enough then dominated conversations.

I think we just need to acknowledge that this is a significant step in the right direction. We need to increase spending on health and social care and fund this through further taxation. That this or any government has started to try and grapple with this challenge has to be welcome. The distribution of the money is still a little vague and the Nuffield Trust have produced a pie chart to show where it is and isn't going. Social care will get a miserly £5.4bn, and the backlog will receive £8bn as part of a £15.8bn recovery package.

As the PM was preparing to address the House with his plans, I was down the corridor in the Palace of Westminster giving evidence to the Health and Social Care Select Committee on the backlog. If you want to, you can watch the whole session on parliament.tv (a thrilling channel), but a couple of highlight quotes can be found on our Twitter stream.

In my prep for the session I found the Institute for Fiscal Studies and Health Foundation analyses on waiting lists very helpful. The former is easier to read but the latter has lots of juicy detail. My take on these and other things I have read is as follows.

We still haven't defined what we mean by the backlog – at its lowest in 2009 the 18-week NHS referral to treatment (RTT) target had over 2 million patients on it – are we aiming for that or something else? The 5.6 million now on that list includes significant numbers of surgical patients (trauma and orthopaedics (T&O) and ophthalmology together make up 900,000) but medical specialties are a significant minority with almost 500,000 between gastroenterology and cardiology – this isn't just about more operations. The cost of controlling the backlog is going to be extreme and depends a lot on how 'productive' the NHS is – 100% of previous activity isn't enough and loss of beds through ongoing COVID-19 and infection control is going to make getting to 105% or even 110% very difficult. The Health Foundation's estimate of £17bn seems reasonable.

Lastly (and deserving of a new paragraph), is that all the beds in the world will make no difference if there are not enough staff. The Health Foundation estimates we will need 4,000 additional FTE doctors. Where are they going to come from? I made this point very firmly to the Select Committee. Yes, the £8bn for the backlog is great news, but if the workforce shelf is empty when you go shopping you will come home empty-handed no matter how much you have in your wallet or purse.

I also note that Sir Jim Mackey has been appointed as the elective recovery adviser to the NHS. This is good news as he has a good understanding of the issues. Let's see how it goes.

On and on and on – COVID-19

The ability to clear any backlog will be dependent on the pressures created in urgent and emergency care which in themselves will be influenced by the number of hospitalisations from COVID-19 and other respiratory diseases over winter.

The epidemiology of the pandemic in the UK is complex and varies between nations. The data from Scotland should be a wake-up call for other nations/countries. The Public Health Scotland dashboard shows just how dramatically cases have increased

over the past few weeks, although thankfully they seem to be falling now. This rise started before the schools went back but the mixing of school children will have accelerated things. Pre-school testing throughout the UK will, of course, have increased the number of positive tests. The positivity rate of tests is therefore useful – Scotland has a positivity rate of 14% (down from 15%).

The ONS data on population positivity has recently been updated and shows the differences between the different UK nations. England and Northern Ireland have plateaued for several weeks and Wales follows a similar pattern to Scotland.

It is therefore not surprising that no one is really sure what is going to happen next. Are we going to have further big peaks, a steady state where the R0 is around 1, or will cases slowly fall as more of the population gets immunity through infection or vaccination? The modellers cannot agree and that makes planning hard. There does seem to be an increase in cases in people above the age of 60 and this could be due to spread from other generations or, more likely, waning of vaccine effect.

The name of the game – vaccination

Thus, we all eagerly await the news on vaccination of children and booster vaccines. Both should be revealed soon (and may be out by the time this bulletin is sent on Monday). What we do know is that people who are immunocompromised are going to get a third dose as part of a primary course.

It is really important to stress that this group is not the same as the 'clinically extremely vulnerable' (CEV) group that was identified (with some difficulty) in the first wave. People who are immunocompromised will be part of the CEV cohort and number around 500,000 in the UK. We (the RCP) have been working with all the medical specialties to ensure there is a plan for and identification of those patients who need a third dose. This will be released shortly. We (the specialists) will need to liaise with both patients and GPs to ensure the third doses happen and that this will work for all parts of the system. However, this is a group who will definitely benefit from a further dose and as primary care are up for the challenge we should be too.

The visitors – variantwatch

The new kid on the block variant-wise is Mu (which is pronounced 'mee' if you, like me, have been saying it wrong all these years) or B.1.621 if you prefer a numerical notation. It was first detected in Colombia, quickly became the dominant strain there, and is now reasonably prevalent in South America.

Worries have been expressed as some in vitro studies suggest that the neutralising antibodies in plasma from those who have had natural infection or from those who have had the Pfizer/BioNTech vaccine are significantly less effective against the virus, with the caveat that such studies are limited and the paper is still in pre-print. However, Mu doesn't seem to be as transmissible as Delta and therefore, at the moment, Delta rules the roost in many countries. In the parlance of music shows gone by, it is 'one to watch'.

While the SARS-CoV-2 virus variants continue to excite interest on a weekly basis, there is one disgruntled virus which is getting restless in the wings as the young upstart dominates the stage. Thankfully the viral, public health and epidemiological worlds are keeping a beady eye offstage as well as onstage. Flu variants emerging this season may steal the show.

The winner takes it all – Theranos

With all the problems created by the shortage of Becton Dickinson blood bottles it seems rather timely that the US court case against Elizabeth Holmes is taking place. In case you missed it, it's a story of hubris, lies and the power of PR over science. She set up a company to build a way of analysing most routine blood tests through a skin prick sample via a machine called 'Edison'. Despite this feat having evaded many for years, she convinced the US investment community that her machine worked and was valued at one point at $9 billion. Oddly enough you can't do a full blood count, electrolytes, liver function tests, autoimmune screen, hepatitis

serology etc through a single finger prick sample and after a while the house of cards came tumbling down. The story was uncovered by the Washington Post journalist John Carreyrou and his book *Bad blood* is a great read. I devoured it in a day a few years ago and would recommend it as a stocking filler.

It sounds like the blood bottle shortage should ease after the end of this week. I hope so as it has created a lot of anxiety among patients. However, I also hope that some of the reduction in unnecessary testing that has happened as a result of the shortage continues long term.

I've been waiting for you – IDA guidelines

While I'm talking about matters haematological, this week has seen the publication of British Society of Gastroenterology guidelines for the management of iron deficiency anaemia (IDA). I think these are brilliant guidelines (OK I'm rather biased as I chaired the guideline committee), as not only do they suggest a reduction in the number of blood tests, but they put the final nail in the coffin of more than once daily iron treatment.

I have spent most of my career trying to stop people giving too much iron to patients but now the science and data are clear that you should only give iron orally once a day and it may be better in some to give it every other day. Not only can you absorb a limited amount of iron each day (about 50–100 mg elemental iron) due to saturation of the gut transporters, but repeated oral dosing reduces absorption due too. This is due to the stunning effect iron has on its own absorption. The BNF still recommends twice daily dosing – please ignore it.

The issue we grappled with was the use of faecal immunochemical testing (FIT) for occult human haemoglobin in the stool as a screen for those with IDA needing investigation. Many have seen this as an easy way to select those with likely GI cancer, but the studies in patients with IDA are not clear cut. It may change as more evidence comes out but as things stand, FIT is not recommended for those with IDA.

When all is said and done – AGM and RCP finances

It was the AGM last Monday and remarkably it finished 10 minutes ahead of schedule (something I've not seen for many years). If you want to hear what I and others said there will be a link on the members area of the website soon – it is just being edited as even finishing 10 minutes early still leaves 110 mins of video, which is a bit much. The RCP annual report was also presented at the AGM. The full report can be downloaded via our annual review and the shorter review and video content aim to make it easy to digest.

One of the key announcements was that after an extraordinarily hard year financially with everybody having to share the pain, we have moved into a position where we should achieve break even. This means our auditors have confirmed we are a going concern up to December 2022, which is important.

In all we lost £12 million income last year and most of the staff have taken voluntary reductions in pay. Sadly, we have also had to make some redundancies but hope that we can now move forwards and focus on the three areas that you, our membership, identified before the pandemic – educating, improving and influencing while at the same time improving the membership offer. As a starting point we have just published a series of three features to share our efforts from the past year.

The AGM was poignant as I read out the names of many friends who have died over the past year. These names included Donal O'Donoghue and that was particularly hard as Donal was at my right-hand side at the last AGM. We are having a memorial and celebration for Donal on 6 October.

Two for the price of one – members, buildings and plants

Part of the RCP membership offer is space for members and fellows in both of our buildings. That space has been purpose designed in RCP at The Spine in Liverpool and at the AGM I updated

those present or watching on the progress of The Spine, which is now open for business. The registrar and I are also keen that we improve the space for members and fellows in the London building. Both buildings are now opening up and we are keen that they are seen as a valuable resource by members. What this will look like for both sites will be announced in the next couple of weeks.

Today also sees the announcement of the new Pandemic Institute which will be based in The Spine, a testament to the success of both the building and the wider Paddington Village development in bringing together health and science bodies. I look forward to welcoming our new neighbours in due course.

The greenery inside RCP at The Spine is pretty special and has been recognised for two awards in the 'Plants at Work' awards (no, I hadn't heard of them either). For those horticulturally minded (such as me when I get the time) the judges were particularly impressed with our *Alocasia* and *Veitchia merrillii*. The latter is the Christmas palm and I now can't get a vision of the incoming president of the BSG (Andy Veitch) singing 'merrily on high' out of my head.

Hey, hey Helen – other RCP news

There are three other bits of RCP news I would like to draw your attention to.

Firstly, the Med+ conference is now open for registration. In previous years this used to be the 'Acute and general medicine conference'. Med+ will be in the last week of October and is planned to be part virtual and part face-to-face all being well. We have some corking speakers lined up: Baroness Finlay will discuss difficult decisions, mental capacity and unintended consequences; Major General Timothy Hodgetts will explore a systematic approach to multiple casualty experience; Professor Gerry Rayman MBE will explain how we can ensure safe care for people with diabetes in hospital assessment areas and wards; and Professor John Edmunds OBE will discuss modelling and public health – what every physician should know.

Secondly, the role of director of the Medical Workforce Unit will soon be open for applicants. Many will know that this was my first foray into an officer role for the RCP and given the situation with workforce I described above, is now more important than ever.

Lastly, congratulations to Amy Proffitt who has taken over as patient involvement officer following the brilliant Helen Gentle's end of term of office. Helen will be a tough act to follow but I know how passionate Amy is about patients so the future looks bright.

And finally …

The passing of the AGM means I now have only 51 weeks left to bore you with my jottings (or in other words you only have to put up with 24 more bulletins from me). Just 24 more artists/bands to think of…

27 September 2021

The long queues of cars outside garage forecourts this weekend reminded me of the panic buying at the onset of the pandemic and running out of toilet paper in our household. Those early days feel like an age ago but we seem to be lurching from one crisis to the next.

At least some aspects of 'normal' life are returning. Mrs G and I went to see Genesis in concert last Monday (not as good as Knebworth in '92 but still great) and it was a relief to be seeing live music again. One lyric from the seated Phil kept coming back to me – 'There is nothing you can do when you are next in line'. Thankfully I've seen and learned a few things this week that suggest this is not always the case.

Turn it on again – vaccine efficacy

I had a text from my GP asking me to come for my flu vaccine this week and another one from the NHS asking me to come for a COVID-19 booster. Both are timely as there is now good evidence of the waning of vaccine efficacy with admissions for those who were vaccinated earlier in the year as well as incomplete protection for people who are immunosuppressed or have certain diseases. We have produced some guidance on COVID-19 vaccination for people who are severely immunosuppressed which I hope readers will find helpful.

I am grateful to Prof Tim Higenbottam from the Faculty of Pharmaceutical Medicine (FPM) for drawing my attention to two important recent articles on this topic in Nature.

In the first paper the authors model the protective effect of different COVID-19 vaccines – both the neutralising antibody response and clinical efficacy from trials. This allows us to be reasonably certain that such antibody titres are highly predictive as a measure of how good a particular vaccine is and how well it protects an individual. This is very relevant when considering the new monoclonal antibody treatments for COVID-19 which I will discuss later. The paper also makes clear that the neutralising antibody levels needed to protect against hospitalisation are lower than for protection against infection, which again mirrors what we are seeing clinically. Figures 1a and 2a are critical and show beautifully that not all vaccines are equal and that all vaccines lose effectiveness with time. They can help us explain to particular patients why they might benefit from a booster.

This waning of efficacy also leads to the important concept that vaccination is not going to eradicate the infection in a way that immunisation has for smallpox. It makes the implementation of global vaccination programmes even harder to achieve as we will need to consider boosters as well as the initial round of immunisation. This is a rather sobering thought, and we must get used to the concept of endemic COVID-19 (even if some may not like the term 'learning to live with the virus').

The second paper shows that the outcome of infection depends on how quickly an individual can mount a neutralising antibody response. This sounds like common sense but we haven't had proof of this before and it explains why some patient groups have poor outcomes. If a patient hasn't produced adequate neutralising antibody levels at 14 days after infection they are in for a stormy course.

I know that humoral immunity isn't everything and that cellular immunity is an unmeasured but important part of how we will respond to infection. However, I think the evidence now reassures us that the measurable humoral response is clinically useful.

Behind the lines – monoclonals

Many readers will have seen the recent alert from the NHS recommending the use of the combined monoclonal antibodies casirivimab and imdevimab (marketed as Ronapreve and also known as REGEN-COV) for patients hospitalised with COVID-19 and who are seronegative for anti-spike antibodies. This is a big deal in many ways.

The recommendation is based on the RECOVERY trial data published 3 months ago which showed a single dose of 8 g of REGEN-COV reduced mortality

of seronegative hospitalised patients by 18% from 30% to 24% as well as shortening hospital length of stay. It is important to note that the dose being recommended is 2.4 g rather than 8 g (another trial outside of hospital used this dose) and that NICE have not yet pronounced on this treatment (the review is being done as I type). To be eligible, patients have to be hospitalised, have 'proven' COVID-19 (by PCR test ideally although an MDT can make the diagnosis), be seronegative and be from a higher risk group. The latter groups are anyone over 50 or anyone aged 12–49 who is determined to be immunocompromised following an MDT assessment. These criteria will require fast laboratory response times, regular MDTs and good communication between teams.

I am assured by those in the pathology world that the labs are ready for this and the recent blood bottle shortage will not impact delivery. As an aside I note that we don't have much information as to how much this combination treatment costs. One estimate is £500–600 (not unusual for a monoclonal antibody) and while it might be argued we may be using an expensive treatment for patients who have chosen not to be vaccinated, it is probably very cost-effective at this price in the NHS setting. For countries that cannot afford even adequate oxygen supplies, though, it is a pipe dream – although I probably shouldn't use that phrase as it is apparently related to the dreams experienced by historical opium smokers.

Cul-de-sac – obesity

One positive response to the pandemic has been the refocus on health inequalities and areas of public health in which the RCP has a strong interest. The Office for Health Improvement and Disparities (OHID) is about to open up shop on 1 October and will be led by Jonathan Marron (DHSC) and Dr Jeanelle de Gruchy (the new deputy CMO). I know the former of old and know he gets the issues. I do not know the latter but am told good things.

Related to this in the new cabinet reshuffle, Jo Churchill MP has made way for Maggie Throup MP. Ms Throup, a local MP to me in the Midlands, will be overseeing vaccines and public health and has a strong history of campaigning on obesity. She attended and spoke at a meeting last week held in the RCP at Regent's Park on the scientific and innovative solutions to the obesity crisis. It was a fascinating meeting and other speakers included Prof Rachel Batterham (RCP special adviser on obesity), Prof Jonathan Valabhji (NHS national clinical director for diabetes and obesity), Prof Chris Whitty and Sir Keith Mills.

Sir Keith is the person responsible for Nectar points and Air Miles and has been commissioned by Boris (apologies for the informality) to pilot ways of using reward schemes to improve diet and thus reduce obesity. What was clear from the meeting is that a multipronged approach will be needed to tackle the challenges we all face. Action will be needed by individuals, society, the food industry and the health service. I was encouraged though, especially by the increasing understanding about the genetics of obesity, the success of new pharmacological treatments such as semaglutide (see the *NEJM* article published earlier this year), the impact of digital interventions used in the NHS and the reduction in poor food choices that supermarkets can easily achieve. It is not a hopeless situation.

With that information fresh in our minds a group of us were then able to meet the following day in Downing Street to discuss the issue further. There is a definite appetite (sorry) from government to take bold steps to reduce the prevalence of obesity which is encouraging. The publication tomorrow of Turning the tide – a 10-year healthy weight strategy by the Obesity Health Alliance (of which the RCP is a member) will add further to the debate.

On a somewhat tangential note, Larry the cat was waiting for us on our arrival at No 10 and showed his usual disdain for visitors. Thankfully when it comes to obesity many others in that postcode are far more willing to engage.

Man of our times – public health royalty and the real thing

One strong proponent for improving public health is the other deputy CMO, Professor Jonathan Van-Tam. There are not many doctors who are famous by a three-letter acronym (sorry JDQ) and I am truly delighted and excited that he is giving the Harveian Oration in 4 weeks' time on 20 October. His Oration will be streamed live from RCP at The Spine (the first time ever outside London). Register to watch for free online and read more about the event.

JVT was born and raised in Boston, Lincolnshire and is fellow of the above-mentioned FPM and the Faculty of Public Health. I had always assumed he was FRCP but it turns out not to be the case. This is being corrected and I am really pleased that I will be able to make him Hon FRCP this Wednesday at our first face-to-face fellowship ceremony since pre-pandemic. I just hope he doesn't rip his pants.

This talk of faculties reminds me that I was lucky enough to attend the Faculty of Sport and Exercise Medicine (FSEM) diploma ceremony last week which was attended by HRH Princess Anne. Most readers will know I am a fan of Her Majesty The Queen but this was the first chance I have had to meet her daughter. The Princess Royal was fantastic company and was brilliant with all those getting diplomas or fellowship. She is a passionate advocate of physical activity and sport and it was interesting to hear of her father's passion for both as well; indeed, he was instrumental in the faculty being established. It was also humbling to listen to all the achievements of those at the ceremony. Formed as a joint faculty between ourselves and the Royal College of Surgeons of Edinburgh (an unusual combination I know), the FSEM is 15 years old and has grown significantly in that time and achieved much.

Guide vocal – the Pandemic Institute

While I am thinking about the Harveian Oration being in Liverpool this year it reminds me that The Spine is now going to be home to the new Pandemic Institute, an academic partnership between many regional organisations whose mission will be to help the UK prepare and respond to future pandemics. The building is steadily becoming the health hub for the north west we envisaged when we started working with Liverpool City Council.

Please don't ask – workforce and surveys

I am pleased to see more and more bodies coming to the conclusion that there is a workforce crisis and that we need more doctors, nurses and other healthcare staff. That is where my pleasure stops as the scale of the problem is so big and likely to get so much worse that I genuinely fear for the future of the NHS. In recent talks the new CEO of the NHS, Amanda Pritchard, has acknowledged this too, although the levers she has to change anything are limited. The Nuffield Trust has produced a short 'primer' on the NHS workforce which is worth a read.

The awful situation in primary care is going to aggravate the problems of the workforce and the media portrayal of lazy doctors not seeing patients is so terribly wrong. Mrs G is a GP receptionist and I remain in awe of her ability to manage the tide of enquiries and scared and/or irate patients that come her way. I suspect that many of us would not do her job, especially at £10 an hour.

I also sense that staff absences remain a big challenge for those of us working in urgent and emergency care at the moment, in particular because of positive COVID contacts in the family now the schools have gone back. We haven't done a survey since June to see the scale of this and other issues so will be sending one out this week. It would be great if you could complete it when it drops through the electronic door.

Heathaze – Chelsea Flower Show

In view of the recent (worryingly) unseasonal weather I have been out and about cycling. My evening ride on Wednesday was a bit busier than normal as I cycled past the site of the Chelsea Flower Show. I've never been (and will do so when I get a bit more time) but those who have been this year have said it has been a success. The Orchid

Society of Great Britain's exhibit had a medicinal theme that I was able to support with a quote for their display. It won a silver-gilt medal so many congratulations to them.

...and finally

Talking of cycling, since my last bulletin I have managed a few days cycling in the Alps (I can confirm gravity is still working in Europe). It wasn't as much hassle getting in and out of France as I had feared, and the French are far better set up regarding vaccination status than we are in the UK. You can't get a drink in a bar without proof of vaccination and, remarkably, the NHS app works to this end.

One of my cycling buddies had his birthday when we got back and, feeling philosophical, I sent him a note saying 'the years are like cycling, they pass much quicker with friends' (yes, it was a bit pretentious now I look at it). One of my other mates brought it back down as he replied, 'the years are like cycling, full of pain and regret'. I hope yours are more the former analogy than the latter.

11 October 2021

Welcome to this week's bulletin, which requires neither gas nor petrol to deliver it and can be found without the need to trawl supermarket shelves. A week ago I was at the Conservative Party conference in Manchester (or 'Conservative and Unionist Party' to give them their full title, although this commitment to unions doesn't extend to the European one). The only obvious shortage at the convention was of discussion about shortages. We live in unbalanced times.

I've also been to Glasgow this week and the disparity in mask-wearing behaviour between the two cities was remarkable. Glasgow is home to a vibrant music scene (although this is less vibrant following the cancellation of the Genesis dates due to COVID-19 positivity). The wearing of masks was not apparent at the recent TRNSMT festival and the news that there have been at least 551 cases of COVID-19 among the crowd of 50,000 seems ironic given the nomenclature of said gathering. Low levels of vaccination in those under 18 may be part of the reason too. Talking of which …

Always the last to know – vaccines for people who are immunosuppressed and triallists

According to the current NHS England estimate there are around 510,000 people who classify as immunosuppressed by the JCVI criteria and this week these individuals will be sent a letter offering them a third dose of the primary course. This is separate from the boosters many of us are getting at the moment – I'm due mine on Friday. They will be offered either the Pfizer/BioNTech vaccine (otherwise known as Comirnaty – I still can't get used to this) or the Moderna one. The latter should be available this week and the dose is 0.5 mL for a third primary course dose and 0.25 mL for a booster shot.

The letter will say that the NHS believes the recipient may be eligible and this may cause some additional work for us all in secondary care if there are patient queries. There is guidance on our website to help clinicians if there is confusion about this. There may also be patients who we feel are eligible but are not sent a letter. Close liaison with GP colleagues will be needed over the next few weeks.

Another group that will be offered additional doses will be those who have taken part in vaccine trials. Certain hospital hubs will be running this service so while it will be slightly more inconvenient than for others it does correct a problem that needed sorting. These volunteers were critical to the world developing effective vaccines and they should not be disadvantaged just because the trials didn't result in a marketable product. Moving forwards, we must make sure that participating in clinical trials is seen as an advantage, as well as the altruistic thing that it is.

Be my downfall – vaccine waning

In my last bulletin I shared some data on the modelling of vaccine waning effect and typically, the next day a highly pertinent paper was published in the *NEJM*. It follows 4,868 healthcare workers from one institution who all had the Pfizer/BioNTech vaccine (it wasn't called Comirnaty then). Of note was that it was in a centre in Israel where the 3-week dosing was strictly adhered to – something we now know was less effective than the 11–12-week strategy adopted in the UK when it comes to neutralising antibody levels (see the PITCH study).

I know that many people reading this have had the Pfizer/BioNTech/the other name vaccine and a significant number had 3-week dosing so will be interested in the findings. Simply put, antibody levels at 6 months after the second dose were lower in men, those over the age of 65 and in people who were immunosuppressed. The latter two are unsurprising but the former is hard to explain (I'm not sure the study corrected for weight, although oddly antibody levels were higher in those with a BMI of >30).

A recent preprint on patients in the UK suggests that this falling of antibody levels results in increased risk of hospitalisation in the over 65 age group and those with comorbidities. So the evidence for boosters in this group is good.

Kiss this thing goodbye – why do doctors leave the NHS?

An RCP survey from July showed 27% of consultant physicians plan to retire in the next 3 years so it's timely that the GMC has published the findings of a survey of 13,158 doctors who left the NHS over the past 15 years, including their reasons for doing so and how likely they are to come back. Over such a long period of time and given the wide variety of doctors surveyed with respect to age and backgrounds, it is hard to be sure the results are completely relatable to current times. The GMC has called the report 'Completing the picture' but it would probably be better titled 'Here is a view of the picture from a distance'. However, it is the only data we have so must be fed into thinking about current workforce retention issues.

There are no great surprises in the report findings, but some stand out. The reasons for leaving are related to working conditions, how valued people feel and the need for a better quality of life. Financial reasons (including pensions) are cited by 20% of men and 9% of women, and the likelihood of return is substantially lower for GPs than for physicians. If you have retired there is only a 1.3% chance that you are 'likely' to return. That tells me that the 27% figure we found represents a potential iceberg in the path of SS NHS (the unsinkable ship).

I've been pushing hard for the NHS to get all trusts to review the retirement plans of their consultants and SAS doctors. Some have done this and it has allowed conversations about how working lives could be improved to allow them to stay. Those trusts who have yet to do this may be enjoying the bliss of ignorance. I have also raised the issue of the retention crisis with MPs this week and they seem surprised. Using the analogy of petrol stations without fuel having long queues outside has been helpful.

Cry to be found – how we are all feeling

We are currently reviewing the data from our last survey which many of you did last weekend. We will release the results in a few days' time and that will be timely, as debates about the Health and Care Bill go through parliament. Reading through the free-text comments of that survey was really hard. Words like 'broken', 'bullied', 'relentless' and 'unsupported' recurred time and time again. There were scattered rays of positivity but these were few and far between. I sense we are at a tipping point.

One of the reasons for such comments is the lack of hope in the system. The promised billions for the NHS and social care are great but most realise that without more people in those services the money will sit like fuel in a refinery – unusable. There does seem to be increasing appetite for a clear workforce plan and investment in more medical students. It will not help the current situation but would at least provide some light at the end of the tunnel. Mr Sunak has control of that particular light switch. You can find out more about the evidence we submitted to the 2021 Spending Review.

Here and now – history, diversity and inclusion

This month is Black History Month and (once again) I have enjoyed learning more about the history of the UK from a more holistic perspective than the one I was fed at school. It seems timely then that we have just published our report on the progress the RCP has made since the Summerskill review into diversity and inclusion just over a year ago.

The first recommendation in the review was 'Announce an ambition that by 2030 those in both voluntary and staff roles across the RCP should reflect the diversity of the qualified medical workforce, at all levels including trustees and Council.' To achieve this recommendation, we must also ensure we determine the diversity of our members, fellows and other stakeholders who work with the RCP, so we know the representation we are aiming for. We 'cannot be what we cannot see' as Ben Summerskill described it having spoken to members and fellows.

We are therefore beginning an overarching diversity data collection initiative. Please use the link below to complete a data collection form. This form is the same for everyone and we ask that you fill it in, even if you 'prefer not to say' – this is an option on every question, and a valid choice. You can be reassured that we will only report on aggregated data, never individual. Thank you for taking the time to fill out the form.

We have also been supportive of the STOMP study looking at racism towards medical students and spearheaded by Bristol University. If you are a medical student, a parent of one (or more) or are teaching them in the next few weeks, please do point them to the study questionnaire.

Spit in the rain – 'Ride for their lives'

In Glasgow last week I had lots of conversations about the public health challenges that the city faces when it hosts COP26 at the end of the month. The mass gathering of groups from around the world will need careful handling to prevent another TRNSMT. The conference, though, is a major opportunity to push forward the agenda on climate change and air pollution.

In a weak moment I agreed to join a group of doctors and staff from children's hospitals around the UK in a cycle ride from London to Glasgow for COP26 to raise the profile of the impact of air pollution on children's health. The ride, which has been organised by Climate Acceptance Studios, has been appropriately named 'Ride for their lives'. The group will be stopping off in cities on the trip with 'pollution pods' that will allow members of the public to gain a unique understanding of what it is like to breathe the air in different parts of the world.

The ride is open to everyone to contribute in some way. We are looking to gather as many 'virtual' cyclists as possible on Strava to accumulate 1 million kilometres before COP26 as a signal of how important this issue is. If you do any cycling please join up via Strava at the above link. It will act as a

massive incentive for the group who are riding the route to Glasgow. I'm only doing two legs of the ride (in the hilly Midlands) and am hoping it doesn't rain too much – the climate may have other ideas.

…and finally

Last Wednesday we held a commemoration and celebration of Donal O'Donoghue's life at RCP at The Spine in Liverpool. It was a difficult but also paradoxically uplifting afternoon. Donal's portrait now hangs on the memorial wall that bears his name, and anyone visiting The Spine will hopefully be pleased with the way he is remembered on canvas.

Among the presentations that afternoon was one from the renal patient community or, as Donal preferred, 'people with kidney disease'. The impact he had on so many lives was palpable and inspiring from their stories. It reminded me that we all have an impact on the lives of others, and most often in a positive way. Being a physician is tough much of the time but the difference we can make to people's lives is humbling.

25 October 2021

It has been an odd couple of weeks, with a bittersweet combination of news and events – both national and personal. COVID-19 continues to dominate the news, but the realisation that the NHS is under extreme pressure is beginning to seep into the public consciousness. Everyone needs a bit of a boost in more ways than one.

Buy it in bottles – boosters

The waning of COVID-19 vaccine efficacy has now become a main driver of infections, although the low vaccine uptake in 12-15-year-olds is also a significant contributor. As JVT so brilliantly explained in his Harveian Oration last week (see later), the transmission of infections in children is often the biggest determinant of respiratory viral epidemics.

The evidence from Israel now makes an extremely compelling argument for the need for boosters. The original paper, published in *The New England Journal of Medicine* in mid-September, showed a reduction in the rates of infection and severe infection of 11 and 19 times respectively, following a Pfizer booster on top of Pfizer vaccination compared with 5 months previously. Longitudinal data since has confirmed this strong protection, best shown in a graph on the Israeli Ministry of Health website – look at the second chart on the dashboard and note that those who have been vaccinated (had three doses) have a very low rate of severe illness compared with those who have been 'vaccinated without validity' (ie had one of two doses) or are unvaccinated.

If you were ever in doubt as to the importance of a booster dose, this graph should convince you. I was first drawn to it through a tweet by the *Financial Times* journalist John Burn-Murdoch. The rest of that thread of tweets makes for fascinating reading and debates the roles of mask-wearing and indoor mixing in our current UK situation. As I've

said before, trying to model the next stages of the pandemic is remarkably hard at the moment. What advice are the UK government getting?

God in the numbers – SAGE modelling

At the end of last week, SAGE published (alongside a large number of other documents to fill up your evenings) its latest modelling advice from the SPI-M-O committee regarding what might happen this autumn/winter. I was particularly amused by the line: 'The pattern of transmission in England since 19 July has been very unexpected' – which I read as: 'No-one really knew what was going to happen'.

The paper suggests that infection rates for the rest of the year will be determined mainly by behaviours – such as mixing, mask-wearing and self-testing – whereas infection rates next year will be determined by vaccine waning and uptake of the booster programme. There is some disagreement between the modellers as to whether English society has returned to 'near normal' or still has a long way to go. I can assure you that in certain pockets (such as the Crewe to Derby train on a Thursday rush hour) mask-wearing and social distancing are non-existent and 'near' is very much the norm.

Reassuringly all the modellers agree that a repeat of the levels of hospitalisation we saw last winter is unlikely unless there is another variant. The Scottish EAVE II study, published last week, does show that both Pfizer and AZ vaccines are highly effective (90–91%) in reducing mortality from the Delta variant, which gives some hope should a new variant arise that pushes Delta off its throne. Also, all modellers agree that cases will start to fall over the next few weeks, and January should be much better (in contrast to this year).

Hospitalisations due to COVID-19 are up 19% in the UK over the past week, which is a concern, but the increase in cases remains predominantly in the young. Half-term holidays should slow things down a bit, but I suspect that even if COVID-19 infections were to halve in the next week, it would do little to ease the pressures on the NHS.

Professor John Edmunds gave a talk this morning at Med+ that went through much of the detail of current modelling and where we might be going. It was an excellent talk and hopefully all at the conference thought the same. He pointed out that immunity is not the same as having been vaccinated, and that when a virus has a large R0, vaccination alone is unlikely to control things. We have the 'advantage' (and at considerable cost) of having had large amounts of natural infection in the UK. New Zealand and Australia will struggle to achieve 'herd immunity' as they have only vaccination to provide this.

Stormy clouds – NHS pressures

All of which brings me to what many of us are seeing and feeling on a day-to-day basis. The NHS is full and silted up. COVID-19 cases currently only fill just over 6,400 of the 93,000 'acute and general' hospital beds available in England – or 7%. Talking to colleagues around the country, it seems that around 20–25% of beds in most hospitals are filled with patients who are 'medically ready for discharge'. Lack of community beds and support services are the main reasons for delays to l discharge and the pressure on social care is immense. NHS data on 'delays to discharge' has not been published recently, which is always a cause for concern.

The UK has been running its hospital services with very low bed numbers compared with other OECD countries for many years, and the loss of beds due to infection prevention and control measures, as well as cohorting of COVID-19 positive patients, has turned a tight situation into a suffocating one.

The situation in adult social care is worse than in the NHS, with the latest CQC *State of Care* report talking about a 'tsunami of unmet needs'. The analysis of adult social care shows that (as in healthcare services) it is the workforce and bed shortages that are of most concern. Many care homes, especially privately run ones, are struggling and everyone is fearful of what will happen when the mandatory vaccination of care home staff comes into full effect in 2-and-a-bit weeks. Recruiting staff will get even harder.

The latest NHS performance stats for England reflect this logjam in the system and were the worst ever, with only 75.2% of ED attendances being seen within 4 hours. In August, 5,025 patients waited in 'corridor trolley beds' (all of us know that they are not beds in any true sense of the word) for over 12 hours once a decision to admit had been made. The data for the other home nations is even worse and talking to physicians in Northern Ireland last week, the pressures there are enormous. The graphs of all performance metrics continue their inexorable rise in the wrong direction.

Come on – the Budget

These pressures will be very much in the minds of both the secretary of state for health and social care and the chancellor of the exchequer. The latter has announced this morning (the advantage of not having time to write the bulletin this weekend is that I can include breaking news as dawn rises) an additional £5.9 billion for England and matching amounts elsewhere in the UK. £1.5bn is for more beds, equipment and new surgical hubs with additional theatres. £2.1bn is for improving IT and digital technology (IT is the hardware; digital tech the content, apparently).

This £5.9bn is in addition to the £12bn announced previously and such funding has to be welcomed. The money for IT and digital is particularly welcome, as this remains the Achilles heel of the NHS. Time and time again, the IT falls over for many of us and the blue spinning wheel of death becomes the only sign of activity on our desktops. I suspect, though, that £2.1bn will not go far and we will continue to have multiple, non-communicating legacy systems.

I also fear that the 'lessons learned' from creating Nightingale hospitals during the early stages of the pandemic have not been learned. Those hospitals cost around £0.5bn to set up and looked after around 500 patients in total according to this King's Fund graph (see Fig 2b). Lack of staff and planning (but mostly the former) were the limiting factors. I wonder where all the staff for the new hubs will come from – although it is pretty obvious they will come from the acute sector, which will worsen pressures.

History – Harveian Oration

'Lessons learned' was the theme of the Harveian Oration this year, which was given by Professor Jonathan Van-Tam and titled 'Moving Forwards, understanding backwards: respiratory virus vaccines, therapeutics and public health policy'. This was the first Oration given outside of London and was delivered on the top floor of The Spine in Liverpool. It was a stunning setting (made more stunning by a spectacular moonrise behind the Orator's head as he spoke) and all those who had not been in the building before were impressed. I know that some readers of this bulletin still have doubts about the building – but I would say don't knock it 'til you've tried it.

Back to the Oration. You can watch it all on the RCP Player and JVT makes a compelling case for collecting data, analysing it quickly and then acting on it. While many are critical of the response to COVID-19 compared with previous pandemics, the medical world was far more evidence-based in its decision-making. As you would imagine, it is a compelling lecture.

The video (am I allowed to use such an archaic term?) on the Player opens with the annual presentation of RCP prizes and medals. This, along with the Oration, is something to be celebrated and it was brilliant to be able to give the medals and awards in person. It will be my last time, so I made sure I enjoyed it.

Lucky man – BAPIO conference

I was also fortunate to be able to attend the annual conference and 25th anniversary celebration of the British Association of Physicians of Indian Origin (BAPIO) in Birmingham over the weekend. BAPIO have been a leading light in the push for equality, diversity and inclusion and have produced an incisive report, *Bridging the Gap*, looking at how we might address differential attainment/awards in medicine.

Whenever I talk at such meetings, I am acutely aware of my position of privilege and that others have not had the access to education and support that I have had. I truly hope that we can eradicate

the unfairness in our systems, especially with regard to training opportunities. We can all play our part in that – encouraging everyone, no matter their background, in our individual specialties is vital. This was brought home in a talk by a third-year medical student, who as a woman from an Indian family had been advised not to do orthopaedic surgery due to the 'demands of the specialty'. Thankfully it was clear from her talk that she will be successful, whatever antediluvian advice she is given.

...and finally

The other celebration I've had this week was my youngest daughter's 21st birthday. It was lovely to be able to get all the family together for the first time in years.

Mrs G and I also made a brief appearance at her party for uni friends in Nottingham. We felt very old but some of her friends (they were a tad merry from more than the occasion) observed that we must have had her at a young age, as we looked so young. It is amazing how uplifting such comments can be. My aim this week is to be more complimentary to others.

8 November 2021

Today is a special day, not least as it is National Cappuccino Day in the USA (it is also World Town Planning Day). A certain bulletin writer is a year older and thus has been reflecting on the past year and the future, as we all do on such days. It is fair to say that more has happened in the world of medicine and medical science over the past 12 months than for many decades and those developments continue to pour forth in single or double shots.

This week also traditionally sees an uptick in UK flu cases and serves as a reminder that we should all get flu vaccinations before they become mandatory. I wonder how we will feel about our 'flu fighters' sticker when that happens?

Breakout – the antiviral marvels

Last week two antivirals hit the headlines. The first, molnupiravir (Lagevrio, produced by Ridgeback Biotherapeutics and MSD) was conditionally authorised for use in the UK by the MHRA in patients with mild to moderate COVID-19 and one risk factor for developing severe disease (such as age >60, obesity, heart disease or diabetes mellitus). Molnupiravir works via 'viral error catastrophe' (a great term) and is a prodrug that eventually gets converted into a nucleoside triphosphate (NHC-TP) which accumulates in the viral genome and stops further replication. Its name apparently derives from Thor's hammer, Mjölnir, which will excite fans of Norse mythology or Marvel comics.

The move follows an interim analysis of the MOVe-OUT trial in which 775 of 1,550 planned recruited patients showed 'compelling' evidence of high efficacy with a reduction of hospitalisation of around 50% (from 14.1% to 7.3%) if given within 5 days of symptoms. There were no deaths in the treated group which is also very encouraging (there were eight in the placebo group). Having said all of this, it is one trial (and one that was not completed) so we must be cautiously optimistic rather than utterly convinced. Let's see what NICE say.

The second antiviral that caused fireworks on Friday was PF-07321332 (Paxlovid, produced by Pfizer). In combination with ritonavir, which readers will recognise as a protease inhibitor first developed for HIV and part of HAART (highly active antiretroviral therapy), PF-07321332 seems as effective as molnupiravir monotherapy. The release of the (again) interim results of the EPIC-HR trial showed that patients at high risk of hospitalisation (the HR in the study name) had an 89% reduction in admission if PF-07321332/ritonavir was given within 3 days of symptom onset from 7.0% in controls to 0.8% in those getting the drug. The trial size analysed for this was almost identical to the MOVe-OUT trial and the benefit also replicated in a larger trial size (1,219 patients) when given within 5 days of symptoms.

The caveats with this study are the same as for molnupiravir and we don't have the reassurance of MHRA review of the data yet. MHRA will undoubtedly pronounce within the next month or so and NICE thereafter. However, such additional options in the management of COVID-19 have to be welcomed. Molnupiravir may not trip easily off the tongue but I hope they come up with a better drug name than PF-etc.

In an era of monoclonals, vaccines and variants we will need to start thinking about how best to use these antivirals. We may also need to think about combination treatments to try and reduce the risk of variant escape. The drugs are only useful if taken early so society will need to get used to early testing (and possibly retesting) for mild symptoms in those at high risk.

All my life – auto-injectors for anaphylaxis

The MHRA also wrote to me last week to share the report produced by the Commission on Human Medicines adrenaline auto-injectors expert working group. I can't find a link yet on the web but as they asked me to share the report's findings widely, I hope the following are useful for all readers – I suspect that most of you know much of this but it does no harm to have a reminder of the best use of autoinjectors in anaphylaxis.

Firstly, an autoinjector should be used immediately at the onset of symptoms and then a further dose given at 5 minutes if the patient is not improving. Once the first dose is given, the 999 call should made citing anaphylaxis and the individual should lie down with their legs in the air. If there are breathing problems, sitting upright with legs in the air is allowed.

Secondly, all patients who carry auto-injectors should always carry two. This has been recommended for a few years but remains low in the consciousness of the profession. This is based on the need for two doses in severe cases and occasional auto-injector failure. The dose is different between the three auto-injectors used most commonly in the UK – 0.3 mg for Epipen and Jext and 0.5 mg for the Emerade injector – but they are comparable in efficacy. I have avoided the term 'pen' on purpose as this is not favoured to prevent confusion.

My hero – GPs

Another letter I had last week was from the BMA (conflict of interest – I am a member and other unions are available) about the need for support for the GP community and asking me to explain the difficulties facing primary care to RCP members. It came from the chairs of the BMA's GP Committee, Richard Vautrey, and its patient liaison group, Christine Douglass. I'm pretty sure most hospital-based physicians are very aware of the pressures on primary care and (despite what some other GP leaders might say in social media) are fully supportive of their colleagues in that setting.

The letter asks me to raise the profile of the Support your surgery campaign which I am happy to do, and we will all continue to support colleagues in primary care when talking to patients. The letter also points out the decline in FTE GP numbers over the past 5

years which is a cause for concern for all of the NHS – if primary care falls over the NHS as a whole falls over.

The BMA has recently echoed our longstanding call for a doubling of medical school places and when we first produced that call in 2018 it included the expansion needed in primary care. We cannot think of different parts of the system in isolation and a unified voice is best when speaking on workforce issues.

I note that Richard Vautrey has announced he is resigning as chair of the BMA GPC. This is a worrying development as the BMA ballots on industrial action for GPs. I hope industrial action can be avoided – it rarely achieves a net positive outcome.

Best of you – public health and education

Public health and education are two areas of health spending that often miss out. The boost to both of these in Mr Sunak's recent spending review is welcome, although appears to be a false dawn as levels of funding in 2023–24 will be 5% lower than in 2014–15. This is shown strikingly in the Nuffield Trust's chart of the week and we will all need to push for improved funding for both.

The role of public health in the handling of the pandemic has been critical and we must ensure that we do not forget it as austerity bites and COVID-19 drops off the front pages. My holiday reading last week was Michael Lewis' book *The premonition*, which is about the USA's preparedness and response to the pandemic. I would recommend it. It describes brilliantly the loneliness of a public health decision to impose restrictions to prevent a worsening of a crisis, as well as the role of a small group called the 'Wolverines'.

Times like these – COP26

As promised in an earlier bulletin I joined the Ride for their Lives team on the way to Glasgow to deliver a healthy climate prescription letter. I was lucky insofar as the two legs I did from Birmingham to Harrogate were blessed with dry conditions and a following breeze. I am grateful to all those who made me feel welcome, with a special mention for Ewan Wallace, a paediatric anaesthetist, who was great company and had to put up with me as a roommate.

As most will be aware I hope, COP26 continues this week and after the bluster of world leaders in the first couple of days it is the negotiating that is most critical to the 'conference of parties' being a success. The RCP is attending this week and will be represented by our academic vice president Ramesh Arasaradnam and RCP sustainability fellow Toby Hillman, who are as passionate about this issue as me. Tuesday is the 'health' day of COP26 and I'm looking forward to seeing what comes out of it. We will be co-chairing an open forum with the RCPsych and RCPCH on Wednesday 10 November at 5pm – do join us – and I will update you on any actions that arise from that meeting.

The Montreal Protocol that was produced to tackle the depletion of the ozone layer shows that the world can act cohesively and collaboratively to solve climate issues. A recent paper in Nature shows that the Montreal Protocol had many positive unintended consequences and may have prevented a further 0.5–1 degree rise in temperatures. I'm grateful to Ashley Woodcock for drawing my attention to this and his ongoing work as co-chair of the Technology and Economic Assessment Panel, which continues to advise the UN on this issue. It is great that an RCP fellow has such a pivotal role. Ashley rightly also reminds me that reducing the use of inhalers and anaesthetic gases are things that the NHS can do to lower its carbon footprint.

I have got into trouble with one fellow who believes, based on evidence from a family member who is an expert, that climate change is not a real thing and the

RCP should not get involved in the politics of this. I respectfully disagree and await to see said evidence.

Learn to fly – getting into academia

Members of our Trainees Committee have raised the issue that there is a lack of NIHR-funded academic clinical fellowship (ACF) posts for those applying into ST4 from IMY3 level and this is causing considerable stress for some of our trainees. As we (the RCP) understand it from NIHR there will still be ACF posts for people in group 1 specialties and as always these are limited by region and specialty.

Any concerned trainees can find information which outlines the criteria and the continued guidance for 2022 ACF posts and where ST4 recruitment is exceptionally permitted. You can also get in touch with the team at NIHR Academy by emailing iat@nihr.ac.uk

This is a call – the census

If I may, can I give another plug for filling in the consultant census and ask if you have it on your

to-do list to complete it this week. The information it provides allows us to put pressure on politicians, national leaders and local systems about the workforce. If you haven't had an email about it, please do a search of your spam folder for emails from medicalworkforce.unit@rcp.ac.uk. If you can't find it there, please email the same address.

Skin and bones – and finally

One of my best friends was knocked off his bike last week and sent me a mournful X-ray image of his fractured wrist from his hospital bed in Australia. His cricket season is thus over just as it started and he is not a happy bunny.

It reminded me that you never know what lies around the next corner and should enjoy today as much as you can. As winter starts to hit I can't help but worry that the NHS is about to be knocked off its bike.

22 November 2021

As we move into the meteorological winter in the Northern Hemisphere and the days feel short and dark, the world of medicine also feels long and dark. This is not just because the lightbulb in my trust office has been broken for many weeks and I'm not sure we can afford a new one, but because the clouds seem to be gathering both politically and health-wise. I will start with the clouds to the East and take a trip down the autobahn.

Trans-Europe Express – COVID-19 fourth wave

Many of us will have been watching the rapidly increasing number of cases in Europe – Austria and Germany in particular – which has been described by some as the fourth wave. To get a good overview of the situation I would suggest the 'Our World in Data' graphs that compare case numbers, test numbers, positivity rates and reproduction rates (the drop down box for 'metric' allows this). You can filter countries out and in, and this allows direct comparison between countries. The rates of increase in Germany and Austria are frightening and it is understandable that lockdown measures are being introduced. However, this may be too late, as the data on ICU patients (a fair way down the metric dropdown list) shows that there are over three times as many patients per population in ICU beds in Austria compared with here. Given this rate will have a 2-week lag on total case numbers (which continue to increase rapidly) and there are already major capacity issues, it seems likely the ICU capacity will be exceeded soon. Germany is not far behind – it is grim times for the land of Grimm.

Two questions arise from this situation. Is this fourth wave coming to the UK, and should actions have been taken earlier?

The former is vexing many and there is no easy answer. Vaccination rates per population are not too dissimilar (Austria is only 4% behind us and Germany 1%) but those programmes are about 3 months behind the UK's from the point of initiation and peak – remember concerns about the AZ vaccine in the EU and arguments about supply earlier in the year? Thus, it could be argued that the increase in cases we saw 4 months ago is now being seen in the EU. Changes in behaviour in the UK started meaningfully in early summer and it was always planned that the timing of relaxation of lockdown would coincide with an increase of cases during the summer. On the converse side, we know from previous winters that viral waves often move east to west in Europe – certainly the first wave of COVID-19 did that. At the moment, more people are positive about the UK's future than negative, but it will be a nervous few weeks.

It is slightly remarkable that once again, despite all we know about this disease, countries are facing seemingly uncontrolled waves despite having effective vaccines, proven measures that reduce transmission and no major new variants (I'm coming onto that). There will be many inquiries about this pandemic in the years to come and all will have a political bent. The WHO and the European Observatory on Health Systems and Policy have produced a fascinating and non-political review of health system resilience in the pandemic, sent to me by Martin McKee (thanks Martin). It is a long read, but debates many of the reasons and gets one thinking. It looks like not all the lessons have been learned.

Numbers – new variants

There has been some excitement over the past week about AY.4.2, which is a sub-lineage of the Delta variant. The most recent UKHSA (pronounced uck-sah by those in the know) technical briefing, number 28, gives lots of useful information for the obsessive and paranoid alike. AY.4.2 is known as VUI-21OCT-01 and remains a 'variant of interest' rather than a 'variant of concern (VOC)'.

Delta now accounts for 99.8% of UK cases and AY.4.2 makes up 15% of these (and it is steadily increasing its market share – see Figure 7 of the briefing). AY.4 lineages have been predominating since May and have a mutation in the Nsp3 protein involved in replication. The additional mutations for AY.4.2 are on the spike protein and there has been some evidence, shown through secondary attack rate data and household transmission risk data, that this variant is more transmissible. However, this is by no means certain and not of the order of increased risk seen in previous VOCs.

The good news is that our current vaccines are no less effective against AY.4.2 than other Delta lineages based on both in vitro and in vivo data. In vitro studies look at post-vaccination sera antibody titres needed to neutralise live virus and, if anything, lower levels are needed than for other Delta variants. In vivo data are from hospitalised cases, and sadly there are lots of unvaccinated cases to act as a control group.

Airwaves – vaccination in pregnancy

I was shocked to see some data that suggested that vaccination uptake remains low in pregnant women and that those ending up on ICU are almost all unvaccinated – 98% to be exact. Vaccination rates up to July (the latest official data) showed that only 16% of pregnant women were vaccinated, with the lowest rates in Black women and those from the most deprived backgrounds. This has since increased, and the latest (unofficial) estimate is 22%. On ICUs 32% of women under 50 on ECMO for all conditions are unvaccinated pregnant women.

The reasons behind this are related to fear about adverse effects of the vaccine and mixed messaging during the rollout. Both have travelled through the airwaves and word of mouth in the absence of clear data. However, we now have good evidence that vaccines are safe for both mother and baby. There is no increase in adverse events for the mother, and as well as there being no difference in still birth rates for vaccinated versus unvaccinated, babies born to unvaccinated mothers have a lower birth weight.

We all have a part to play in trying to dispel the myths around vaccination in this setting and if ever asked by a patient (or friend) for your views I hope the above is helpful. Having listened to the experience of patients unfortunate enough to end up on ICU when pregnant, it is something to be avoided.

Pocket calculator – workforce

Last week was a busy week regarding workforce information. Our census (conducted with the two colleges in Scotland) was published this week and it is not a reassuring read. 48% of consultant physician posts were unfilled last year, varying from 38% in London to 63% in my own patch. I was on ITV news explaining the reasons behind this, and the media are slowly understanding that we are not training enough doctors.

We have an unexpected political ally in this regard, one Jeremy Hunt MP. He was impressive in his polite but dogged questioning of a beleaguered PM in the Commons last week on this topic. He has also tabled an amendment to Clause 34 of the Health and Social Care Bill - amendment 10 - with the co-signatures of almost 50 other MPs on workforce planning. Many health organisations back this amendment and we managed to get a letter about this issue in *The Times* on Friday.

The aim of the amendment is to ensure that every 2 years the secretary of state publishes independently verified assessments of the workforce numbers needed in future to meet patient demand. This is really important - the standard line the minister gave at an earlier stage of the bill that 'we have more doctors and nurses than ever before' and '17,800 more professionally qualified clinical staff … including 2,700 more doctors than in June last year' is irrelevant if those numbers are insufficient. It is like having more fuel in the tank than last week but not enough to get you to your destination. I know Mr Hunt is not popular with many of us following his time as SoS (and that many of the issues we face were aggravated in his custodianship), but he is increasingly seen as a voice of reason in the current government and I'm happy to let head rule heart on this one.

The rest of the census shows that the trends in increasing less-than-full-time working continue, with 24% of the consultant workforce being employed on such contracts, compared with 10% in 2004. The proportion of female consultants also continues to rise (as would be expected from the change in medical school demographics) and now stands at 38% compared with 23% in 2004. Satisfaction with specialty working remains high, but satisfaction with GIM roles is at an all-time low.

The Model – healthcare knows no borders

When I speak to physicians on our regular trust visits, the pressures on us all are writ large. Over the past few months I have visited a lot of hospitals across England and Wales and the challenges that face us are pretty consistent. Trainees as a whole feel very supported by consultant colleagues and relentless workload is the theme for both groups. Re-configuration of services is common and causes much angst. We have got into hot water with some NHS bodies for relaying how physicians on the ground feel about such changes. I am uncomfortable with such criticism, as all we are doing is saying how it is and feels. A culture of denial is not a healthy one.

One thing that has struck me seeing the health systems in different nations in our supposed United Kingdom is the difference in regulation and how information is collected (and shared). I don't think we can have one regulator for all the UK, but I would support much closer working and standardisation of information collection. It would also be good if patient information was easily shared across borders and that applies not only nationally but regionally and locally – getting data between different trusts, in one nation would be a good start.

Computer love – IT glitches and social media

Regular readers will know my love/hate relationship with IT. I love the potential of IT to make our lives and patient care better, but hate the real-world experience. I was therefore mortified to know part

of our website, MyRCP, was 'down' last weekend. Obviously we apologise profusely for this and it was related to a problem in the servers hosted by our external partners. We moved to external provision a few years ago when we felt the internal servers didn't have the resilience or capacity we needed (and were housed in a part of the college where leaks from ancient London water systems were common).

We were contacted by folk trying to access the elections pages that we had emailed details of late last week. It is great to see lots of interest in the elections and I suspect IT will be on the list of things the successful candidates will want to focus on.

We have had enquiries about our social media guidelines, to which we have drawn attention in the election material. To be clear, we are not trying to prevent people doing things they normally do and our approach to social media hasn't changed at all. Indeed it mirrors the GMC's approach. However, anybody pursuing a higher office in the RCP needs to know that the spotlight will be on them and, as we see on a daily basis in the press, what is said on social media is scrutinised in detail and many are hoist by their own petard. By the way, this saying relates to a small medieval bomb prone to early explosion, which seems especially apt in respect to social media.

I get slightly bemused by those who say their views are expressed 'in a personal capacity'. Unfortunately, it doesn't really work like that and once you put the chains of office on (whatever the office may be) everything you say will be seen with those chains visible. I have become enormously wary of social media over the past few years and while it is often a force for good, I have seen it do significant harm to individuals, especially with respect to their mental health. Beware the petard.

… and finally

This bulletin is dedicated to Linda Cuthbertson, who is leaving as our head of communications after a 25+ year career with the RCP. Linda has always been 'there for me' and a constant source of wisdom and corporate memory. We have shared many a wry smile over the slings and arrows that come our way over policy matters. It is Linda who gets to see the bulletin first and tempers my injudicious language and points out what I have forgotten. The band of the week today is one of her favourites.

There is much that she should be proud of, but the work on smoking cessation and reducing harm from tobacco must be top of these. Much of the RCP's success in this area is due to the collaboration with other stakeholders and groups such as ASH. Linda has been the linchpin (I'll leave it to readers to look up this historical metaphor) in this work.

Thank you Linda.

Stay safe everyone.

6 December 2021

The world has rather swung on its axis in the past two weeks and my bulletin musings on the AY.4.2 seem inconsequential compared with the variant that has since emerged. The number of cases of the Omicron variant have risen sharply in recent days and there have been outbreaks linked to public gatherings. Steps have had to be taken (off tour). Other issues need to be mentioned but I will start with Omicron, and apologise that this bulletin is slightly longer than normal.

Here and now – Omicron

Lots has been said about the new variant, some based on fact and some on conjecture. Here is a summary of what I think we know, which is informed heavily by the latest UKHSA technical briefing produced on Friday, and the pandemic of commentaries in the medical press.

Omicron is also known as B.1.1.529 and it is the 13th variant to be granted a Greek letter by the WHO as a variant of concern. Omicron, as Greek scholars will know, is the 15th letter in the alphabet but Nu was felt to be confusing (Nu variant sounds like 'new' variant) and Xi is a common surname. It means 'small O' – Omega being 'big O'. I must admit that my throwaway comment in a June bulletin that I was looking forward to seeing 'omicron, upsilon and xi have their moment in the spotlight' now seems pretty foolish. As our PM would say, forgive me, forgive me… forgive me.

The first sequence was obtained in Hong Kong from an individual returning from South Africa and reported on 22 November. Concurrently, virologists in Botswana uploaded three cases and the number has escalated from there. As I write, there have been 336 cases in the UK and they are increasing rapidly – although some of this will be because the world is looking harder for this variant.

Whole genome sequencing is not possible on all positive swabs, especially in poorer countries. Thankfully, Omicron has a feature that makes identification of 'highly probable' cases much easier – the S-gene target failure (SGTF) – from some of the commercial gene PCR tests which include three genes, ORF1, the N-gene and the S-gene. All three are recognised in Delta variants but only ORF1 and the N-gene are positive in Omicron (and Alpha, as it happens). As Delta has become so dominant over the past 6 months across the globe, the emergence of increasing numbers of SGTF samples acts as a good proxy for Omicron cases. The Gauteng region in South Africa, home to Johannesburg, has been the epicentre of cases and SGTF has been used to show this. Looking at the UK data for SGTF (Figure 11 in the briefing) strongly suggests Omicron is spreading quickly and is here to stay.

To understand where Omicron sits in the family tree of SARS-CoV-2, imagine the original Wuhan variant in the middle of a line and Delta and Alpha on one side of that point, Beta and Omicron are on the other side. Omicron shares many of the mutations of Beta such that some virologists have described it as 'Beta on steroids'. I think of it as 'Beta's big bad brother'. It has 55 mutations of note with 32 on the spike protein, although these numbers may change with time as Omicron subclasses develop. It must be remembered that there have been hundreds of thousands of mutations of the SARS-CoV-2 genome over the past 2 years but the scale and the type of mutations in Omicron make it worrying.

As a quick aside, the South African community feel they have been blamed for this new variant and punished (eg by stopping flights) for detecting it. We saw this with Alpha (the 'Kent variant') and Delta (the 'Indian' variant) and indeed such stigmatisation was why the WHO developed the Greek nomenclature. We owe a lot to the South African virology labs for acting quickly and sharing their knowledge. This will have saved lives.

What we know with reasonable certainty is that it will bind to ACE-2 receptors more avidly than Delta (the comparator for all the following statements

given its current dominance) – molecular modelling of binding due to such mutations predicted this many months ago. Thus it is very likely it will be at least as (if not more) transmissible. Data from South Africa show that previous infection provides only minimal protection from infection and ongoing transmission. It is unclear if vaccination, especially with three doses, affords more protection. The variant and pseudo-virus models with similar mutations are now being grown in several labs around the world and in a week or so neutralising antibody studies (as I described in my last bulletin) will give us further clues. However, it won't be until we have had 500–1,000 cases in the UK that we will have a better understanding of the impact of real-life vaccine effectiveness.

Importantly, lateral flow devices (LFDs) are able to detect Omicron and thus should be an important part of our defence against spread, especially in busy environments with potentially vulnerable people, such as hospitals. Nosocomial spread is a real worry for UK experts and we all need to do our bit to minimise it. Therefore, get your booster if you haven't had it already and we should all do LFD tests twice a week. Mask-wearing is hopefully a given for readers of this bulletin. Mask-wearing on trains, tubes and buses in the past week does seem to have improved but is far from ubiquitous.

There is no reason to think the new antivirals such as molnupiravir will be less effective but the anti-spike monoclonals will need to be assessed carefully and there are some concerns expressed in the UKSHA technical briefing. The nature of mRNA vaccine technology means that updated booster vaccines can be prepared quickly and this will need the regulatory authorities and government to be fleet of foot and also brave. I know both are very possible.

The technical briefing explains that no cases of Omicron have been detected yet in wastewater samples. I knew this was planned as a way to look at the epidemiology of the virus but it seems it is becoming an important part of surveillance. The briefing also uses bright pink to notate Omicron in its charts and I will be watching those charts carefully over the next few weeks.

Chain reaction – the role of boosters

It cannot be understated how important the transmissibility of a variant is to determining the impact that variant will have. A 30% increase in transmissibility can lead to a fourfold increase in mortality. Compound interest of infectious diseases is not a good thing. Also, even a small drop in protection against severe disease will have a big effect on the number of hospitalised cases. If a vaccine provides 90% protection against Delta but 80% against Omicron there would be a doubling of hospitalisations.

It is also unclear how severe the disease is in different groups (unvaccinated, previous infection, double vaccinated, boosted etc) but we should take some heart from the high levels of antibody titres seen in recent studies of boosters. In the COV-BOOST trial published in *The Lancet* last week antibody levels were around 20x higher post booster and T-cell levels 3x higher. The relative protective effects of humoral and cellular immunity do need to be defined though.

This is the rationale behind the large expansion of the booster programme seen in the UK in the past week. The challenge for our GP colleagues is a big one and there will inevitably be a reduction in other activities. That the press and government have been less than supportive to primary care over the past few weeks does not help. As one GP colleague described it, going from 'hero to zero to hero' in a cycle is very hard.

On the subject of COVID-19 vaccines, we have been receiving queries from people who are immunosuppressed and have received three primary doses, about the timing of their booster. The JCVI hasn't issued that guidance yet. In the meantime, a reminder that we've produced guidance on a third primary dose for people who are immunosuppressed.

Heartbeat – cardiovascular events with mRNA vaccines

Ten days ago, my attention was drawn to social media following the concerns raised by some groups about a possible link between the Pfizer/BioNTech vaccine and cardiac ischaemia. One individual was interviewed on GB News and his claims that the findings of a study were of great concern have been circulated across the internet.

I have spent a fair bit of time this week looking into the evidence for this claim and am reassured that there is no significant signal of such harm. The original 'paper' was an abstract published in Circulation by a single author who is a writer for Goop among other things. Circulation has now published a note of concern about that abstract and several 'fact-checker websites' (eg Reuters Fact Check) have also raised strong concerns about the 'science' behind the study.

The MHRA has had 23 reports of acute MI and 26 of sudden death through the Yellow Card system for the 24 million people who have had two doses of the Pfizer/BioNTech vaccine. Given there are around 100,000 hospital admissions per year in the UK with MI and nearly all of the at-risk population will have been vaccinated, it would be very odd if there were no events in the week following a vaccine. The Pfizer/BioNTech vaccine has been associated with myocarditis and pericarditis and these events are rare at around one in 50,000 doses. That such a signal has not been seen for ischaemic heart disease is therefore very reassuring and makes rather a mockery of the claim that the vaccine doubles the risk of cardiovascular disease.

Looking at the literature around ischaemic heart disease and COVID-19 the benefits of vaccination become even clearer. STEMI outcomes are worse in COVID-19 positive patients, STEMIs in COVID-19 positive patients often have normal angiography and COVID-19 itself is a risk factor for STEMI. Thus, I think there is a clear case that the public should not avoid vaccination for fear of an MI.

I hope it is obvious to everyone, but for the avoidance of doubt, the RCP does not endorse the views of any individual on social media just because the College is mentioned and/or the individual is affiliated to the RCP. The only statements that can be attributable to the RCP are those which come from the College's own social media and care is taken to be respectful in our messages to the range of views held by our broad membership.

I am all for freedom of speech and people are entitled to have an opinion. As we are all taught in mental capacity training, people are reasonably allowed to have a view that others might think foolish. I guess the big question we need to ask is, at what point does the impact of such statements stop being just a personal view and become one that has an impact on public health?

5,6,7,8 – notable birthdays

I had the great pleasure of attending the 90th anniversary celebrations of the British Pharmacological Society (BPS) last week and the 50th anniversary of Action on Smoking and Health (ASH). Both included talks by some of the giants of medicine. I must confess I was a little starstruck at times. Listening to the likes of Prof Carlo Patrono and Sir Richard Peto was very inspiring.

At the BPS meeting we announced the upcoming joint report between the RCP and BPS on pharmacogenomics in practice. This was a collaborative piece of work that Prof Donal O'Donoghue and Sir Munir Pirmohamed initiated pre-pandemic and I hope will be the springboard to getting genomics working effectively in everyday clinical practice. Many medical specialties have contributed to the report, which we will hopefully launch in the spring. The interaction between genomics and drug prescribing is an intimate one and reading a draft of the report I was staggered by the situation in Hawaii where an $8 billion legal case rages between the state and the manufacturers of clopidogrel. This is over marketing claims that failed to take into account that 30% of the Hawaiian population carry genetic variants of the CYP2C19 enzyme which cannot convert clopidogrel to its

active form. For a good read about the issues around this while waiting for the report, I'd recommend an *NEJM* piece on race and genetic ancestry in medicine published last February.

ASH has been a powerful lobbying body in the fight against tobacco-related harm and it was good to celebrate what has been achieved, but also rather sobering to look at what lies ahead. Hearing Lord Young talk of the political tricks played against his and other parliamentarian's efforts to control tobacco over the years was both fascinating and disheartening. You can listen to his talk (and indeed the others at that meeting). Lord Young's talk is 11 minutes in.

Sir Richard Peto revealed the staggering fact that 8 million people have died in the UK from tobacco since ASH was founded in 1971 and that another million will die per decade moving forwards. He reiterated the benefits of stopping smoking. That smoking rates have increased by 25% in young people during the pandemic should sit very uneasily with us as physicians.

When I said goodbye – advance care planning

Regular readers will know I am a fan of Dr Kathryn Mannix and her ongoing crusade to improve public understanding of death and advance care planning. Her book With the end in mind remains required reading for all medical students. Together with Hospice UK, our ethics committee (thanks Alexis and team) and others, a new tool to support individuals in advance care planning will launch for public consultation on 10 December 2021.

The Planning Ahead online tool aims to help people think through the healthcare choices that may lie ahead for them, with supportive information to help them to consider their options. Users are encouraged to seek the advice of a healthcare professional who knows their health needs well, in order to personalise any decision-making. Do take a look and comment as the tool will be refined following user feedback, which can be made via a link on the site.

Last thing on my mind – RCP Christmas lecture

Given the challenges that all of the above have thrown our way it is easy to forget the importance of inspiring future generations about medicine, but this is still important if we are to have a health service in future years.

Our annual Christmas lecture aimed at 12–18 year olds will be online-only this year and delivered by Dr Sheuli Porkess, vice president of the Faculty of Pharmaceutical Medicine, at 3pm on 22 December 2021. Called 'Drugs and bugs', the lecture will focus on how medicines can be used to fight diseases caused by bugs, why antibiotic resistance is an issue and what young people can do to help. I hope I can encourage everyone to watch it live from home and engage in the Q&A session. The webinar is free for all but pre-booking is required. It will also be available on demand soon after the webinar if you can share with kids and grandkids you may know.

…and finally

Gastroenterology may be a great specialty but obviously causes some people a bit of a challenge spelling-wise. Until the temporary mortuary was built over it during the first wave of the pandemic, the on-call spot we used to have in our hospital was labelled 'On-call Gastrology'. We can see into the future as well you know.

Things took an even more bizarre turn this week in Derby. GP colleagues are under pressure as never before and can be forgiven for not having time for personalised referrals – 'Dear Gastroenterology team' is fine. We were a little taken aback, though, to get a referral that suggested we were part of the workforce problem: 'Dear Gastroenteritis'.

Given the speed of changes with Omicron at the moment I may need to do a short bulletin next week, on call allowing.

14 December 2021

As expected, I have had to move to weekly bulletins due to the rapidly changing situation with the pandemic. I've been on call this weekend so I apologise if there are any errors or it feels rushed.

It has been a very eventful week in the UK. Aside from party politics (boom boom), the UK has moved to 'Plan B' – although some might say it is more of a 'Plan A minus' (and there are already talks of Plan C) – and demand for lateral flow devices (LFDs) is at an all-time high.

There have been loud announcements about the extension of the booster programme and there have also been rather quieter announcements around new treatment hubs for COVID-19. I will cover the latter but will start with the latest update on Omicron where, for once, not all is doom and gloom.

Hard times – Omicron case numbers

According to the data, the UK now leads the world in confirmed Omicron cases but most EU countries are now seeing cases in non-travellers with only 13% of Omicron being found in travellers. As of 13 December there have been 1,686 recorded cases in the EU which compares with 4,713 cases in the UK, with a daily total of 1,576. Ten people are in hospital with Omicron and there has been one death.

There was a hiccup yesterday in the supply of LFDs following an increase in demand – I was informed of this by an irate daughter before it made the news. The spike in demand was related to changes in testing rules after contact with a positive case and as a response to the increased media coverage about Omicron. I have had it confirmed that the interruption was due to the delivery capacity via Royal Mail being reached rather than a lack of the tests themselves. This capacity is being increased as you read this (in itself a challenge at the busiest time of year for postal services) so the message is 'if at first you don't succeed, try and try again'.

The UKHSA published a briefing on Omicron and SGTF (ie probable Omicron) last Wednesday. At that stage PCR test results with SGTF (S-gene target failure) were approaching 1%, although that figure is now approaching 3%. The increase in cases gives a doubling time of 2–3 days, although some of these cases will be due to a clustering of increased testing in household contacts of those found to have SGTF.

In a separate briefing, the UKHSA give evidence that Omicron is 3.2-fold more likely to be transmitted to household contacts than Delta and close contacts have a 2.1-fold increased risk of becoming infected. As I said last week, this is bad news and confirms what was feared from modelling of the binding of spike protein to ACE-2 receptors. Omicron has now been found in waste water samples from four out of 477 sewage sites in the UK.

Ill Manors – South Africa

All eyes are therefore on South Africa (SA) for clues as to how Omicron may behave over the next few weeks. While the population of the UK and SA is not dissimilar (around 70 million v 60 million), there are substantial differences both with regard to the demographics of the population and the management of the pandemic. We must be careful not to over-infer but in short it looks like they are 2 weeks ahead of the UK.

The Our World in Data country report for SA is a good place to start and allows direct comparison with the UK if you click on the 'Add country' button. Cases in SA have risen sharply from 4 weeks ago and it seems almost certain that the highest peak of cases seen in their previous three waves will be passed today. The number of tests done per head of population is very different from the UK and the positivity rate of tests is 28.5% in SA compared with 4.4% in the UK (as of 12 December). This suggests that the actual number of cases in SA is much greater than official figures. Unfortunately, getting comparable hospitalisation data for SA is less easy. There are some data on the Spectator COVID dashboard but these seem slightly

out of kilter with the SA National Institute for Communicable Diseases dashboard. Both, though, are somewhat reassuring as to the impact of cases on hospitalisations. The last SA wave (almost entirely Delta) peaked in the first week at just under 20,000 cases a day. Hospitalisations peaked a week later with 14,709 admissions per week. Currently this figure stands at 3,876 admissions per week so the next 2 weeks' data will be critical.

On the positive side from a UK perspective, only 25% of people in SA have had two doses of vaccine and only a very select few have had a booster. 34% of people in the UK have had a booster dose and understanding how effective boosters are is critical (see next section). There has been extensive infection throughout the SA population since the start of the pandemic with estimates of up to 80% having had infection. This may in part explain the low hospitalisation rates alongside the younger age of the population.

Prayin' – efficacy of vaccines

I still marvel at the experts who appear on the media and make bold claims about the epidemiology of the Omicron wave and/or effectiveness of vaccines. On Saturday night I almost choked on my cocoa when one such expert exclaimed that we know three doses of the vaccine are effective against Omicron. I don't think we can be quite so bullish but we now have several in vitro studies and one in vivo study which do give us more insight and some reassurance.

Four relevant in vitro studies looking at the neutralisation of virus by sera were published in preliminary form last week. It is important to say that some of the information in these publications lacked detail and the authors themselves state correction may be needed.

The first, from a group in South Africa collaborating with Australian researchers, showed a 41-fold reduction in the measure of neutralisation effectiveness (geometric mean titre of FRNT50 if you really want to know) for Omicron v an ancestral SARS-CoV-2 virus, D614G. They used sera from 12 individuals who had been vaccinated with the Pfizer/BioNTech vaccine, half of whom had antibodies from previous infections and half who did not. Neutralisation was 'improved' in those with antibodies suggesting previous infection + vaccination may be more protective than vaccination alone.

The second, from a South African and Swedish collaborative, showed a similar (40-fold) reduction in effectiveness of neutralisation of Omicron v the founder Wuhan strain (WuHu-1) using a lentiviral pseudotype neutralisation assay with sera from 34 individuals. Seventeen of these were Swedish blood donors and 17 were healthcare workers, the latter having higher levels of WuHu-1 antibodies. This suggests that previous infection will not provide adequate protection.

The third, from a German group, used Omicron grown from a traveller returning from Zimbabwe and tested sera from an undisclosed number of individuals (although the scatter plots suggest not that many) who had been vaccinated with two or three doses of the Pfizer/BioNTech vaccine. They compared neutralisation levels with the Delta variant and also tested the effectiveness of imdevimab and casirivimab (Ronapreve) against Omicron. Their results were equally worrying with a 33-fold reduction for double vaccinated sera and 27-fold for triple vaccinated. Ronapreve failed to neutralise Omicron which is a significant concern for planned treatment algorithms.

The fourth was a press release from Pfizer (so not a classic peer-reviewed study in any way) which used pseudovirus assays and suggested that sera from triple vaccinated individuals was comparable in efficacy between Omicron and the 'wild-type'. Much was also made of the booster increasing neutralising antibodies 25-fold.

In short, these in vitro studies suggest T-cell immunity is going to be critical and the results of the benefits of three doses of Pfizer/BioNTech vaccines are mixed at best.

The in vivo study can be found on page 20 in the UKHSA report mentioned above. The important

graphs are in Figure 7. The paper has now also been published in a pre-print version if you want slightly more detail. Comparing 56,439 cases of Delta with 581 cases of Omicron in a case-control study, the protection against symptomatic infection afforded by a Pfizer/BioNTech booster was 71% for those who had AstraZeneca/Oxford as the primary course and 76% for those who had a Pfizer/BioNTech primary course (conflict of interest – that includes me). The protective effect was seen from 2 weeks after the booster. Given we know that vaccine effectiveness from boosters against severe disease and hospitalisation is better than for symptomatic disease this is a very encouraging study. I have to say given the remarkably short time these data have been created over, the UKHSA has done a brilliant job. Thank you, colleagues.

However (and I won't get any prime-time TV exposure for saying it), we still need to wait for further real-world evidence before we have a clear understanding of the protection vaccination or previous infection will give us against Omicron, significant disease and hospitalisations. Mystic Meg predictions will continue I suspect, but unless you believe in astrology I would suggest we should all focus on getting the booster programme rolled out to as much of the population at risk of severe disease as possible.

The criteria for who is eligible for a booster and how they get it seems to change on a daily basis and the news that the system plans to administer a million doses a day is welcome, if a little challenging.

See, it didn't kill me did it? – COVID Medicines Delivery Units (CMDUs)

I try and keep on top of the latest developments in the NHS and pandemic but I need to up my game as I was rather blindsided when I heard about a new network of treatment programmes for Ronapreve and molnupiravir that have been 'stood-up' by the NHS to start later this week.

The plan is that each STP/ICS will have one or two CMDUs that will prescribe and deliver Ronapreve or molnupiravir to symptomatic PCR positive patients in the first 5 days of illness who don't need admission. Those eligible need to have one or more of a list of underlying conditions that is similar to that created for the shielding programme. This is a population of around 1.2 million and most physicians reading this will have eligible patients. I am still struggling to find many physicians who have heard of this new programme both locally and nationally though, which is a bit disconcerting. It may be that some are being set up in the community (as in my patch – the two CMDUs in Derbyshire have been set up in that way by a not-for-profit organisation) but I'm told that many other CMDUs will be run by acute trusts. Current estimates suggest 6–12 patients per STP/ICS will get treatment per day (although a lot will depend on how the number of cases changes over the next few weeks) and I think the logistics of assessing and then treating patients will not be as simple as has been envisaged.

The details can be found in the commissioning policy document issued by the NHS last week. This all makes reasonable sense although the RECOVERY trial showed most benefit from Ronapreve was gained in those who were antibody negative. I guess it is a pragmatic decision that all will be considered regardless of their antibody status. The biggest issue aside from the logistics will be the emergence of Omicron given the data above. There seems little point giving Ronapreve to patients with Omicron and they would be better off having molnupiravir. This suggests that genotyping will be needed before treatment.

Treatments given by these units will run alongside the PANORAMIC study being run by Oxford University (other universities are available). In that study anyone over the age of 50, or people over the age of 18 with the same long-term conditions will be offered molnupiravir or standard care. GPs will be able to refer patients to this study and this will allow us to have a good idea of the usefulness of this antiviral in the UK population outside of hospital. However, I think it is important to say that while those with high-risk conditions are eligible for PANORAMIC, they should be initially assessed by a CMDU so that they get an active treatment as the default.

If I sound a bit negative, I think this is only because I am worried about engagement with the specialties and patients. There seems little doubt that these treatments are very likely to save lives so both the trial and CMDUs themselves are to be warmly welcomed.

Paint it blacker – redeployment

As the next wave hots up and the winter pressures persist, many trusts will be having serious conversations about staff redeployment to manage this (if they haven't already been redeployed to give vaccines – anyone would think we didn't have enough staff on the NHS). I was therefore pleased to see some guidance from HEE that came out yesterday to try and reduce inappropriate redeployment of trainees who have already fallen behind with their training. Like all of us, I hope the winter does not necessitate such redeployment.

…and finally

Some members and fellows will have stayed at William Harvey House, the impressive columned building at the end of St Andrews Place (and sometimes used as a photo of the RCP by the media as it fits more with their idea of what the college should look like). It is made up of two houses on the Place, numbers 9 and 10. The Baillie Room is in House number 10 and is available for fellows and guests to use.

Given the mistakes that the media can make, I would just like to state for the record that we have never had, nor intend to have, any Christmas parties in Number 10.

22 December 2021

The steady march of Omicron across the UK continues, although there are some glimmers of hope in the data. There have been increasing numbers of healthcare workers (including regular readers of this bulletin) who have contracted COVID-19 and this is taking its toll on services, especially in London. Over the weekend we conducted a brief survey to see where we are at as physicians, which I will reference throughout this bulletin.

Our politicians continue to plough a different furrow and further images in the media of 'business meetings' have caused much anger in the profession and clashes in the media. This will not help the public messaging that is needed when debating evidence-poor decisions. There are many complex issues to be faced at the moment and I will cover some today.

London calling – a slowing in progress?

There are encouraging data emerging from South Africa. The current wave appears to have peaked as do hospital admissions. Those hospital admissions were at half the level seen for a smaller case peak in July. Obviously, this all comes with the house-sized caveat that relying on a week's trend is a fool's game (as shown by our case numbers chart over the past 3 months before Omicron which looks more like VF than any recognised epidemiological curve).

When it comes to the UK, the rate of increase in Omicron numbers has slowed down over the past few days based on both proven Omicron and SGTF case numbers published in the UKSHA daily Omicron overview. Figure 1 in this document beautifully shows regional differences and the London curve looks to be plateauing, which is good news. Figure 2 makes it clear that Omicron is now the dominant variant in the UK. House-sized caveats still apply.

Should I stay or should I go – physician COVID absence

Our survey went out to everyone who gets this bulletin and got 2,160 responses (a massive thank you to everyone who replied). 1,879 of respondents are currently in clinical practice, 90% of whom are in hospital practice and 77% are consultants.

In the UK, 10.5% are currently off work and 4.2% of these absences are due to COVID-19 (1 in 24 is the figure we will use in the media). As expected, London has the biggest rates of absence at 13.9%, with 7.4% (or 1 in 13) due to COVID-19. These data are greater than official NHS figures but we shouldn't be surprised by this as doctor absence is often poorly recorded on NHS systems. I still prize the letter I got from my then manager for 100% attendance in the year I had 4 weeks off for my nephrectomy.

It seems likely that other staff absence will be as high if not higher (they were in previous waves), although the recent changes to length of self-isolation from 10 to 7 days will make a big difference moving forwards. The current levels of absence are the highest we have seen at any point in the pandemic, bar the last week of March 2020 when 9.0% were off with COVID-19 in London and 5.5% in the rest of England. After that, COVID-19 sickness rates dropped rapidly to between 3–4%.

Three things are important to say here. The first is that provision of PPE in those early days was awful (I will come onto PPE later in the bulletin) and should be blamed for significant numbers of healthcare worker infection. Secondly, the impact on the remaining staff was mitigated by the mass cancellation of other activities in the first wave. At the moment we are continuing to try and do as much 'normal winter stuff' as possible – this is at best a stressful juggling act. Lastly, we are dealing with a different beast in Omicron. Its significantly increased transmissibility means far more infections will be acquired in the community and we are still at an early stage of this wave. We must therefore expect and plan for large gaps in rotas and the ability to conduct normal business.

I think one survey respondent summed it up. 'I'm not sure I'm ready to do this again, but we will'. We will support each other to get through this wave and as physicians have shown repeatedly through the pandemic if the NHS shows us a plate, we'll stand up to it. For this wave I know this will mean redeployment for some, short-notice gap-filling for others and stress for all. I am hoping this will be for a much shorter time than previously but also know that physicians will put patients' needs at the centre of what we do.

I fought the law – mandatory vaccination

I see the *Daily Mail* has had a dig at the RCP for expressing worries about mandatory vaccination (alongside the BMA, RCN, and Academy of Medical Royal Colleges...). I won't reiterate our reasons for this, aside from saying that 99.1% of physicians have been vaccinated according to our survey and my concerns are very much about the resilience of other parts of the workforce as the mandatory vaccination orders bite. The NHS has published guidance for trusts around this policy and the wording around the regulations is worth digesting. Verbatim it says:

'The Department of Health and Social Care, on 9 November 2021, laid regulations which amend the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 ("the 2014 Regulations"), to provide that the registered person can only employ or otherwise engage a person in respect of a CQC regulated activity, if the person provides evidence that they have been vaccinated with a complete course of an authorised vaccine against COVID-19 or, if otherwise vaccinated against coronavirus is also within a specified time period, vaccinated with a single dose of an authorised vaccine, subject to specific exemptions.'

This makes it clear that anyone not vaccinated or exempt cannot be employed in patient-facing activity in the NHS. The reasons for exemption are limited and only extreme allergy or previous adverse effect of vaccination would apply to doctors. This means that we will lose staff, although the number

of physicians is likely to be very small, if any. In England, HEE has already confirmed those who are not exempt will be unable to be part of a training programme. If any readers are in that position there is considerable support available, and given that vaccination is not mandatory in other home nations, training opportunities will still be available.

Rudie can't fail – vaccination status

One bulletin reader asked me this week to provide some data on the vaccination status of patients being admitted to hospital, so after some digging, I've found the relevant couple of key reports. For hospital admissions current data from UKHSA looking at weeks 46–49 for this year suggest that 43% of patients with COVID-19 who require at least one night's stay are unvaccinated (I had to play with the data on a spreadsheet to get that figure). This changes dramatically through the age groups, being 63% for those aged 18–19 years old, 42% for 50–59 and 18% for >80. For ITU admissions the latest ICNARC report gives fascinating insight (although be warned it is a long one).

Currently, around 50% of patients admitted to critical care are double-vaccinated (Figure 27 in the report) compared with <5% in May (I've estimated these figures from the histogram) and there has been a steady shift towards more vaccinated patients being admitted to ITUs over the past 6 months. This will be related to loss of vaccine efficacy with time and the data for November are too soon for conclusions around the booster programme and Omicron to be drawn.

The rest I know from free text responses to our survey this week that many physicians are struggling with the ethical challenges of looking after patients who have made a choice not to be vaccinated. The latest ONS survey results give insight as to why people choose not to get vaccinated. Fears about long-term risks, a mistrust in the development process and a reliance on individual good health and resilience are the key themes. It is perhaps worth saying that our survey replicated these reasons in the 0.9% of physicians who have chosen not to get vaccinated.

As an aside, the ICNARC report I cited above includes some sobering data on the survival rates of patients admitted to critical care. Figure 35 shows Kaplan-Meier curves for 90-day survival in patients admitted to critical care. This currently stands at 66.9%, having been 57.8% in the first wave.

The call up – boosters

The booster programme continues apace and another big thank you to all those helping out – a remarkable number of survey respondents are doing so. 96% of physicians have now had a booster and the commonest reasons for not having one were having intercurrent COVID-19 and it being too soon for a booster.

One concern that has been raised is that the current IT systems are unable to differentiate between a booster third dose and a primary course third dose (for those patients with certain long-term conditions). The reasons for this are technical and related to the systems we use in the NHS. However, it will mean that in order to ensure the latter group get a fourth dose as a booster a specific call will need to be made. The RCP registrar is working with the NHS vaccination team to ensure that the medical specialties will be kept in the loop moving forwards.

This is England – COVID medicine delivery units (CMDUs)

Last week I mentioned the new CMDUs in England and I understand that they are now seeing and treating patients in some parts of the country. A week is a long time in the world of COVID and the treatments being offered to eligible patients have changed. The fears I mentioned about the effectiveness of Ronapreve against Omicron mean that it has been replaced with sotrovimab or Xevudy (I'm not sure how that should be pronounced but I'm sure the GSK marketing team thought it was a great name).

Sotrovimab is a monoclonal antibody which was originally derived from the B-cells of a patient who recovered from the original SARS outbreak in 2002. It targets an area of the spike protein which

is not mutated in any of the variants of concern currently identified, including Omicron. The COMET-ICE study interim results, published in the *NEJM* in mid-November, showed sotrovimab reduced the composite end-point of hospitalisation or death by 85%. The final data have been published in pre-print and the end-point remains very encouraging at 79% reduction. GSK have done a press release to show lab data using pseudovirus assays show it binds effectively to Omicron spike.

This is all good news but I remain a little worried that one group of patients at high risk of death are not covered in the guidance for CMDUs – frail older people. This may be due to a lack of data on the protective effects of the drugs (the number of such patients in trials of sotrovimab or molnupiravir are tiny), a pragmatic one due to the need to get the units up and working first, or even a supply issue. Together with Dr Jennifer Burns, president of the British Geriatrics Society (BGS), I have written to the four CMOs and asked them to consider this. To their credit they are looking at the possibilities.

Know your rights – PPE and RPE

PPE provision remains an issue for a significant number of physicians. In the survey, 85.3% said they have been able to access the PPE 'they need' and 88.6% the PPE that UKHSA recommend. That suggests a small percentage feel the UKHSA and NHSE/I guidance leave them exposed. 5.1% of respondents said they were 'unsure' about the guidance, which is unsurprising given the frequent (understandable) reiterations. The free text comments give granularity as many say they can access FFP3 masks, some say that they still cannot access FFP3 masks on COVID-19 wards and some that the RCP should call strongly for FFP3 masks throughout the hospital.

Let's take each of those themes in turn. The NHSE/I infection prevention and control (IPC) guidance has been updated this week in light of Omicron. The key phrase is:

'In response to Omicron and other variants of concern (VoC) it is recommended that staff and organisations continue to undertake risk assessments using the hierarchy of controls which include an evaluation of the ventilation in the area, operational capacity, physical distancing and prevalence. Where an unacceptable risk of transmission remains following this risk assessment, it may be necessary to consider the use of respiratory protective equipment (RPE) in clinical areas where suspected or confirmed COVID-19 patients are being managed.'

In other words, if you work on a COVID-19 ward or area (such as an ED or AMU) where there are large numbers of patients whose COVID status is unknown and with poor ventilation, lots of patients or few staff, then RPE should be used. A risk assessment is needed and that is a stumbling block in some hospitals but hopefully this statement will give the prod that those trusts need. For the avoidance of doubt this has been the RCP position for the past year, but I think because we haven't backed the call for FFP3 masks for all in hospitals our position has been misinterpreted. The increased transmissibility of Omicron will change any risk assessment done previously in favour of an RPE approach.

Based on the (lack of) evidence it is still a big step to call for FFP3 masks for all in the hospital. Most cases of COVID-19 currently being contracted by healthcare workers not on COVID-19 wards are likely to be in the community – remembering we now test all admissions. Improved PPE provision and attention to IPC have also clearly helped reduce the risk of hospital transmission since the first wave. In a study at University College London Hospitals NHS Foundation Trust, 15% of COVID-19 cases were acquired in hospital with 55% definitely patient-to-patient but then cases dropped substantially when consistent PPE (surgical masks) and IPC were introduced.

The few published genome studies also fit with this. A study using genome sequencing in Dublin suggested that nosocomial spread was acquired during close contact and favoured droplet transmission. In Hong Kong one genomic study of

two cases of healthcare worker infection suggested transmission was not due to infection from patients.

There are practical challenges too. If we have FFP3 masks outside of the areas that need RPE based on risk assessments it will need to be for all staff from ward administrators, through catering staff, cleaners and porters to clinical staff. Accepting that more than 20% will fail a fit-test (especially those whose face size and shape does not suit FFP3 masks such as many women) this has major implications for our workforce. One solution is to consider respirator hoods such as the PeRSo hood used in Southampton. This has high user acceptability and was associated with a decline in staff infection rates in the second wave. Figure 4 in that paper shows the fall in staff infection rates and included my own hospital as a comparator and is worth a look. Oxford also seems to do as well as Southampton so understanding the reasons for this would be helpful in the FFP3 debate.

I think we need a clear and definitive trial for FFP3 masks with apron and gloves on non-COVID wards. Given the high prevalence of Omicron this needs to be sooner rather than later.

The equaliser – new tool for health inequalities

The Office for Health Improvement and Disparities (OHID) set up in October is building up its influence and output. Its tool looking at the effect of health inequalities and COVID is called CHIME (COVID-19 Health Inequalities Monitoring for England). The graphics are slightly confusing but useful to demonstrate the impact of deprivation on such things as hospital admission and vaccination rates. The 'data' tab is the most useful, although there is a rather wordy 'main messages' page.

The Magnificent Seven – PRCP election

Nomination of candidates for the next president of the RCP have now closed, and while I'm not allowed to know who they are yet, I'm told there are seven. If anything I have said above has got you wondering what those candidates' positions are on the many issues we face, now is the time to ask questions.

Members and fellows are invited to submit questions by 19 January 2022 to the candidates for PRCP about how they would carry out the role. Find out more and submit a question. We will get written answers and also put them to the candidates at a hustings, the date for which will be shared in the new year.

And finally...

I think Christmas for many of us will be a bittersweet affair. If you have the chance to have a break, I wish you a relaxing and enjoyable few days. If not, and you are working over the Christmas weekend, I say thank you and I hope it goes quickly and safely (I will also be sharing your experience).

Thankfully, being a physician is for life, not just for Christmas.

2022

4 January 2022

Happy 2022! Christmas aside, the 2 weeks since my last bulletin have been 'testing' for the NHS and for me personally. Apart from the issues with access to PCR tests and lateral flow devices (LFDs), much has been said in the media about the current Omicron wave that needs a little sense checking and I will start with that.

A winter's tale – hospital COVID-19 cases

Rumours abound that many patients currently hospitalised have had COVID-19 diagnosed 'coincidentally' and thus it is a mild disease and the impact on NHS hospitals is overstated. Usefully, the NHS publishes relatively contemporary data on this, although it takes some digging to find. The relevant report is the 'primary diagnosis supplement' which can be found on the NHS England COVID-19 hospital activity webpages. The most recent data from 28 December (published 31 December) show that there were 8,321 patients in English hospitals with COVID-19 and 5,578 (67%) of these had COVID-19 as the primary diagnosis.

That 33% of patients had 'coincidental' COVID-19 sounds a lot but these patients made up 3.5% of all occupied 'acute and general' beds in England on that day (almost all the sevens – 77,778). The latest ONS data show that the community prevalence of COVID-19 is 3.71% or 1 in 25 people. It will surprise no one if I say 'there is a lot of it about'. The impact of any positive case in hospital cannot be underestimated though, given the isolation policies that must be applied once a case is diagnosed. A tight bed capacity gets even tighter when beds are unusable in a bay and, given the transmissibility of Omicron, infection control becomes even more important.

The (arguably) most important set of data is around critical care and those data are found graphically on the UK government COVID-19 dashboard healthcare pages. There is always a lag in admitted cases and those being mechanically ventilated (MV) but over the pandemic it has averaged 4–6 days lag and the fact that MV patients in the UK have not increased at the rate of hospital cases over the past 3 weeks is reassuring. The MV graph needs watching carefully over the next 2 weeks.

Anecdotally, hospital length of stay seems shorter with Omicron cases although hard data behind this have yet to be seen (and need to be of those with COVID-19 as the primary diagnosis). The rates of admission per case compared with Delta are undoubtedly lower and current estimates put this at a rate of 0.33 (0.30–0.37) based on the latest UKHSA technical briefing (No 33) published on New Year's Eve. The last bulletin came out the evening that studies from Imperial, South Africa and Scotland first showed this reduced admission rate but the data from a much larger number of cases now confirm this. Vaccination remains important.

Hold me close – vaccine effectiveness

The UKHSA briefing mentioned above reports a large case–control study with 169,888 Delta cases and 204,036 Omicron cases looking at vaccine effectiveness against symptomatic disease and hospitalisation. As expected, the findings mirror those of the study cited in my bulletin of 14 December. Two doses of either the AstraZeneca/Oxford or Pfizer/BioNTech vaccines do not meaningfully protect against symptomatic disease with Omicron after 20 weeks from the second dose. Even boosting with Pfizer or Moderna does not bring protection up to the levels seen against Delta (look at Figure 2 in the briefing), being at best 65–75%. This protection then falls with time, being 40–50% at 10 weeks after boosting. This is the bad news.

The good news is that the protection against hospitalisation seems much greater with 88% effectiveness at preventing hospitalisation with Omicron at 2 or more weeks after a booster. There are as yet no longer-term data and it seems likely this effectiveness will wane but it is still a good start.

This then raises the question as to whether people

need a fourth dose of vaccine, and if so, what that vaccine should be. There are lots of variables at play in these two questions. Knowing how much the effectiveness of a booster against hospitalisation wanes is the first, and T-cell immunity will be relevant in that. The PITCH study is looking at T-cell immunity in healthcare workers and hopefully there will be some results out soon to inform us. From an immunological perspective it seems sensible to change the vaccine (I hope that Pfizer shares don't drop when I say that) to encourage both humoral and cellular immunity to other parts of the spike protein or, more importantly, the viral envelope. While the COV-BOOST study suggests that such mixing of vaccines will be effective, Omicron has come (and not gone) since its publication and we still don't know which combination is likely to be the most effective.

Many are agreed though, that a further booster is likely to be needed for those most vulnerable. The JCVI still has much work to do.

Lamplight – testing and COVID-19 sickness rates

As many predicted the major challenge currently facing the NHS (and other healthcare systems) is staff sickness. On Friday the NHS released an alert about this stating the NHS was on a 'war footing' as COVID-19 staff absence rates had increased by 42% in the past week and 96% in the past 2 weeks. In my hospital it feels like we are spread incredibly thinly and we are playing the COVID-19 version of Squid Game.

We know from our own survey data that around half of absences will be due to self-isolation with household contacts and half because of having a positive test, and there has been some confusion around how soon healthcare workers can return. Hopefully I can clarify that, although I know some trusts are deviating from the official advice.

If you are PCR positive you can potentially return to work on day 7 (from PCR if asymptomatic and the day of symptoms if present) if you have a negative LFD result on two consecutive LFDs more than 24 hours apart done on day 6 and day 7. You will still need to do daily LFDs until day 10, even if negative. If you are still 'LFD positive' on day 7 you continue to test daily until day 14 and return to work when negative (most will be negative by day 10). If still positive on day 14 you can return to work on day 15 as it is presumed you will have a very low risk of transmitting at that stage.

Some journalists have asked me why we don't adopt the US practice of allowing a return to work after 5 days. The UKHSA published a very easy to read and helpful explanation on New Year's Day of their rationale (if you need to keep yourself occupied waiting in the car for your PCR slot as I did). In short, we do things differently on this side of the pond. Most positive tests in the USA are made several days following the onset of symptoms and they use far fewer LFDs in the diagnosis of mild/asymptomatic infection. The US government does not supply free LFDs in a mass testing programme as we do so that seems unlikely to change. The UKHSA estimates that 10–30% of PCR positive patients will still be infectious at 6 days, hence the use of LFDs on days 6 and 7. Changing this to 5 days would be very risky.

This is all of course dependent on being able to source PCR tests or LFDs, and as I write I know many have found this more stressful than isolation or the symptoms they are experiencing. A big thank you to the NHS in Wales for donating four million LFDs to England – I suspect Mr Drakeford had a smile on his face as he made that offer.

On a personal note, Mrs G awoke with symptoms on New Year's Day and I was able to arrange a PCR for her and I in the neighbouring county – getting up early was key as all the slots were filled in the East Midlands by 11am. The PCR confirmed the ingress of COVID-19 into the Goddard household but I was negative and have been dutifully doing my daily LFDs since. Stocks are getting low and I may need to take up a box of Welsh finest, although I have been told that trusts in England have been told to release boxes of 25 LFDs to staff in extremis.

Oh what a circus – a Nightingale was built in Berkeley Square

The creation of 'mini' Nightingales on hospital car parks has been another topic of huge debate over the past week or so. I find myself slightly torn on the topic as I fully understand the importance of 'in extremis' planning and thus additional clinical capacity planned early has to be a good thing. The problem comes, though, with staffing of such capacity. As I have repeatedly said, we couldn't staff the 'maxi' Nightingales in the first wave so why should it be any different this time? The sickness absences discussed above add to this challenge and the escalation of staffing problems to a critical incident in Lincolnshire over the weekend brings the point home.

Lincolnshire, like many rural parts of the UK, has always had lower levels of staffing than the big cities and should be seen as a bellwether for the impact COVID absences may have in the next few weeks. I know that the physicians in Lincolnshire will be going well above and beyond to keep emergency services going and am proud to have learned many of my gastroenterology and medicine skills in that county.

Just to digress briefly, the term 'bellwether' comes from the ancient farming practice of placing a bell around the neck of the leading sheep in a flock, allowing the shepherd to know where they were without needing to see them (they must have been very loud bells or ancient farmers quite short-sighted).

Staffing and the paucity of car park space aside, if these new facilities are to house COVID-19 patients it is imperative they are well-ventilated and that the speed of construction does not compromise the attention to detail on this point. Not only is it clear that good ventilation is key to reducing spread of the virus, as Florence Nightingale herself said, 'the form of the ward should be such as to enable the air to be renewed with the greatest facility'.

If I could – New Year's resolutions

If gyms were not seen as potential infection-fomenting points, this week would see a large increase in membership rates by those keen to address the calorific insults of the season. I have been somewhat protected this year (see later) but am all for increasing physical activity to improve health.

I was contacted a couple of months ago by a fellow in the north east who has been working with local groups and specialties to create a set of resources called 'How fit' which aims to help those who have had little exercise to gain the most benefit. The resources are really helpful and elegant, so if faced with a patient in clinic or on the ward who says 'I wouldn't know where to start, doc' they make the answer easy.

These work well alongside the Moving Medicine programme of the Faculty of Sport and Exercise Medicine (FSEM). I know I have plugged this before in the bulletin but increasing physical activity is one of the most effective health improvement activities we as physicians can 'prescribe'.

Gonna make you a star – New Year Honours

Whenever honours lists are announced I have a scan through to see which physicians have made the cut. Singling anyone out always runs the risk of offending others who have been honoured and that is why the RCP tends not to mention individuals in social media. To this end then, many congratulations to members and fellows who have received honours this time around – your success reflects well on all physicians.

There is one person, though, for whom I was quietly delighted. I won't name him (both for the above reasons and as he would hate it) but he has been one of the hardest-working and modest individuals of the pandemic. His devotion to public service in the face of constant verbal and occasional physical abuse is an inspiration.

One person who wasn't honoured nationally but does need to be honoured in this bulletin is Heather Drane. Heather, who has run the FRCP process since 2007, has left the RCP after 20 years of fantastic service. Since taking on the organisation of FRCP Heather has overseen the election of a staggering 10,120 fellows – a remarkable feat. She will be missed.

...and finally

I have always preferred Christmas Eve to Christmas Day but this year 24 December was unseasonably eventful. I was knocked off my bike cycling home and ended up needing the attentions of Derby ED and MaxFax teams – suffice to say my assertion that I have a 'face for radio' is truer than ever.

It did help me to understand the importance of lips in much that we do – speaking, drinking, eating and communicating non-verbally. Never again will I pay just lip service to the guardians of my mouth. I also have a new appreciation for that most wonderful of devices – the straw.

17 January 2022

I marvel at the rapidity of change in our situation with respect to COVID-19 and the past fortnight has not disappointed. I hesitate to say that sunlit uplands are now visible, but the darkened skies are definitely lightening and certainly the media are stressing the positives. I will endeavour not to be too much of a party pooper but the results of our latest survey a week ago suggest that all is not well in the NHS.

Today – case numbers

There was palpable relief in the media when the case numbers reported for the UK dropped below 100,000 last Friday. There are a few things to say on this, the most obvious one is that it is truly remarkable that we think having 'only' 99,652 cases is a cause for celebration. The second is that this figure must be interpreted with considerable caution. The dropping of the need for PCR confirmation of lateral flow device (LFD) results in asymptomatic individuals has reduced the number of PCR tests being performed, which may mean that individuals with positive LFDs who do not report their result are not included in the figures. This drop in PCR tests can clearly be seen on the UK government testing dashboard.

Using the 7-day average for the week of 6–13 January, cases fell by 37%, which sounds brilliant. However, the number of PCR tests performed fell by 32% in that week, which translates to a fall in the positivity rate of only 1.8% from 24.9% to 23.1%. Not such an impressive recovery.

We will therefore need to rely on the weekly ONS data to truly understand what is happening with infections in the UK from here on in and these data are always a week behind the NHS Test and Trace data used in the dashboards above. The latest headline data for the week ending 6 January were published last Wednesday (2 days early) and more detailed data were published on Friday.

These data are encouraging and confirm that cases as a whole for the UK seem to have plateaued and have now fallen in London and the East of England. This is not the case in the North East and Yorkshire and the Humber. The map of the UK in Figure 3 on that ONS page shows positivity rates as a percentage and has an oddly political feel to it. There is a 'red wall' of high numbers in the north of England. I am optimistically waiting for this week's release of data. Not only will this tell us if we have truly passed the peak, as seems likely, but it will also begin to give us an idea of the rate of decline of cases we can expect.

The rate of decline may be slower than previous waves as we have only minimal social distancing measures in place compared with previous waves (and Plan B may not last many more weeks) and the public will behave differently as they see the daily cases fall rapidly. One thing in our favour is that so many people have now had Omicron or been boosted that the virus has an ever-decreasing susceptible population for this wave.

It's my life – hospitalisation and mortality

While case numbers remain higher than in any previous waves, hospitalisation numbers in the UK remain substantially lower and this is something for which to be grateful. It also does look like the national picture is peaking and there is no doubt that the number of patients needing mechanical ventilation has fallen and is the lowest it has been since October.

Death rates, though, are increasing which seems at odds with the lack of increase in ventilated patients. Some caution is needed in interpreting this. The data reported nationally are for 'deaths within 28 days of a positive test'. Given the rate of incidental infection for hospitalised patients is currently around 44%, we should expect there to be a significant number of patients dying in hospital from other causes who have had a positive test incidentally (NB this is very different to it being described as nosocomial as was done erroneously in the Sunday Times last week). We will need to await future releases of ONS death registration data to understand this better, as there are frequently data lags in death registration when there are bank holidays.

Thankfully for this bulletin, NHS Digital published its mortality data for September 2020–August 2021 on Thursday. In that year there were 8.1 million discharges and 237,000 deaths in hospital or within 30 days of discharge. This means that each day you might see about seven deaths per 1,000 hospital beds. Currently, around 15,000 beds are occupied with COVID-19 patients and 6,600 of these are coincidental infections. We could therefore expect around 50 deaths per day to be from non-COVID causes with a positive test and this figure is likely to be even higher as my rough calculations take no account of age and underlying diagnosis. If anyone has a better handle on this issue I would be happy to link to it in a future bulletin.

Such a shame – self-isolation and staff sickness

The ever-changing (and confusing) rules for self-isolation in different parts of the UK continue to be updated. To see what they are for different nations and the days they apply from, this is helpfully at the top of the government's main Coronavirus (COVID-19) webpage. The page also gives the rules for social distancing and other non-pharmacological interventions.

From today in England (and including NHS workers) if you have a negative LFD test on days 5 and 6 you can return to work having been self-isolating from a positive test, or from the start of your symptoms if they pre-date your result. Thankfully, the NHS England guidance is both helpful and clear. This reduction in self-isolation comes after considerable political pressure and as I said in the last bulletin, comes with some risk as up to 30% of cases will still be infectious on day 6.

One obvious concern is that if the LFD test is not done correctly people may be falsely reassured. From personal experience in our household the positive test strip took 10 days to go completely

and faded day by day in the last 5 days. It was barely visible on day 9 but was definitely there if you looked hard enough. The second concern is there may be pressure for people to return to work when they are still unwell despite having a negative test, and this pressure will be greater for self-employed workers and those who feel guilty about letting colleagues down (which I suspect applies to many of us).

I mention this as much from some personal insight about perhaps returning to work too soon recently and the extreme pressure that many of us feel at the moment. The results of the member survey we did last weekend were encouraging as they suggest that absence rates had fallen from 10.5% 3 weeks previously to 7.5%, and COVID-related absence from 4.2% to 3.5%. However, a staggering 69% reported having felt overwhelmed in the previous 3 weeks and 55% had had to fill a rota gap at short notice in that period. To me, these are really worrying figures and I suspect would have had more news coverage had it not been for 'partygate' and Prince Andrew being stripped of his HRH, patronages and military titles.

Living in another world – mandatory vaccination (VCOD)

One event that did get lots of media coverage was the statement by a consultant in critical care and exercise training about his reasons for not being vaccinated. In short, his reasons were that he had protection from previous infection and that vaccination does not reduce transmission. His comments were made to the health secretary who was visiting the ICU at King's College Hospital and were immediately seized on by those opposing the vaccination programme.

The following days then saw a massive response from many doctors on social media denouncing his claims and advocating very strongly for vaccination, as well as 'fact checker' responses to his comments about the 'science' (the BBC one is helpful). The Royal College of Anaesthetists and the Faculty of Intensive Care Medicine, of which the doctor in question is a fellow, produced a clear statement supporting the science of vaccination.

I was quite dismayed at the individual's comments as although I support freedom of speech, I think the science is pretty clear and doesn't fit with his statement (and he spoke over a group of nurses which upset me). I have since looked at a few videos of the individual being interviewed (including on one channel called 'UnHerd' which I guess has a particular angle) and his position seems to be based on the assertion that he personally has a low risk of developing complications from COVID-19 and that he has concerns about the cardiovascular risks of vaccination to himself. That is understandable but he hasn't focused on the benefits to others of a healthcare worker being vaccinated in those interviews and thus to my mind it comes across as an 'I'm alright Jack' position.

Much of the data used in the fact-checker sites has looked at evidence from studies of Delta and previous variants but we do now have data on Omicron and can be clearer around 'the science'.

Regarding protection against Omicron afforded by previous infection with other variants, this has been estimated at 19% by the Imperial College Group – data which were in the headlines a couple of weeks before Christmas. More recent data from the SIREN study published by UKHSA this week puts this at 44% with wide confidence intervals of 4–67% (see Table 3). Thus, I think at best we can say that prior infection affords some limited protection.

Regarding the benefits of vaccination to others (and for healthcare workers I think we do have to focus on others as much as ourselves) it has been clear for several weeks that vaccination with three doses provides significant protection against both symptomatic and asymptomatic Omicron. The SIREN study mentioned above also shows that for healthcare workers this protection is 62% if no previous infection and 71% if there has been prior infection. Asymptomatic carriage is also an important mode of transmission. Asymptomatic rates were 27% in South Africa and ONS data through previous waves have suggested half of PCR positive cases are asymptomatic. Importantly, the most recent data published last week by the COVID-19 Infection Survey have put this at 46%.

This means that for healthcare workers vaccination will significantly reduce the transmission to patients and co-workers from asymptomatic individuals.

As readers will know I think there are ethical reasons why mandatory vaccination for healthcare workers can be criticised and the RCP expressed concerns about the introduction of mandatory vaccination for those in patient-facing 'CQC-regulated settings'. The phrase now being used for mandatory vaccination in such settings is 'vaccination as a condition of deployment' or VCOD for short. NHS England has recently published operational guidance which makes it clear that 3 February is the last date for those unvaccinated to get their first dose, before plans for redeployment can be instigated by trusts. Latest figures suggest that 5.5% of NHS staff are unvaccinated, although there is significant variation between settings and groups of staff.

I find the use of the word deployment slightly odd but never really thought about it when many have been 're-deployed' during the pandemic thus far. The dictionary definition of deployment very much puts it in a military sense, although also includes 'the action of bringing resources into effective action'. As employers consider the deployment of staff, I hope they remember that they are people, not widgets.

As I have said before, the reasons for the 0.9% of physicians not being vaccinated mirror those of the general population and I wonder how much personal reflection and insight by colleagues will influence this. I was really moved by a recent piece in the *NEJM* about a patient with AIDS refusing anti-HIV medication (thank you for recommending it, Mark) and it gives fascinating insight into the power of personal testimony over science – or 'the doctor's oldest tool' as the article puts it.

Talk talk – clear masks

I was pleased to hear from one of our members (thanks, Helen) about the progress that has been made with transparent masks to improve communication with people with hearing loss. The DHSC has approved two clear masks for NHS use which facilitate lipreading: Contechs' transparent surgical face mask and Alpha Solway's Haika MX C transparent face mask. It has taken a while to reach this point but good we have finally got there.

The party's over – PRCP election

As the nation considers whether its leader should depart (or as one wag put it on Twitter following JVT's announcement he was stepping back, that they should 'follow the science') I am keen that as many as possible participate in the RCP presidential election process now we have seven candidates.

It is now the last opportunity for members and fellows to submit questions to those candidates about how they would carry out the role. You can find out more and submit a question by 19 January. There will be more information about the 2022 elections for president, clinical vice president and councillors in the next edition of *Commentary*. I'll also keep you posted in future bulletins, but for now, please note that online voting for fellows will open on 9 March 2022 and College Day (including the presidential election) will take place on 11 April 2022.

Give it up – National Lung Cancer Audit

The National Lung Cancer Audit (NLCA) was developed in response to the finding in the late 1990s that outcomes for lung cancer patients in the UK lagged behind those in other westernised countries. The audit began collecting data nationally in 2005 and has become an exemplar of national cancer audit. The RCP has run the audit for many years, but from next month it will move to the Royal College of Surgeons.

Thank you to the many clinical leads, including Mick Peake, Ian Woolhouse, Paul Beckett, Susie Harden, John Conibear and Neal Navani, as well as the RCP staff who have been involved over the years. The audit programme has been revolutionary in terms of being one of the first to involve patients as part of the process to improve healthcare. I'd also particularly like to acknowledge the work of lung

cancer teams over the past 2 years when so many have been redeployed to support patients with COVID-19. Thanks to their dedication and resilience the NLCA has still been provided with data to report on lung cancer care. The latest NLCA annual report (and the last from the RCP) has just been published.

… and finally

I've been writing my piece for the next edition of *Commentary* and without too much of a spoiler have set it around the use of words and analogies in the pandemic. This was before JVT announced his news and I am sad that we are losing one of the great analogists of our time. Talking of words, we seem to have had a week of typos.

I was listening to the lecture given by Prof Chris Bunker for the medical dermatology meeting last week on genital dermatoses (a fascinating if rather graphic talk just after breakfast) and he mentioned the challenge of 'vile thoughts' described in a referral letter. He is pretty sure it was meant to be 'viral warts'.

In our department last week (thanks to my colleague Catherine for showing me) we had a letter stating that a patient potentially needing a colonoscopy may consider other options including a 'primate colonoscopy'. Now I know there are some silverbacks in the world of private endoscopy …

31 January 2022

I was expecting to write something about the Gray report this week but like most of the trains I (try to) catch, it was delayed. Typically, the initial version of the report has been published in the few hours between the writing and sending of this bulletin, and the prime minister has responded this afternoon. However, there is still more than enough to tell you about with plateauing infections, new variants, new data on vaccination and an update on VCOD (as well as some other important news).

Bang bang – current infection rates

As some feared, infection levels in the UK seem to have plateaued and this is seen in both testing data and the most recent ONS data. This is in part due to schools returning – the only age group where infections are rising at the moment is the under 20s. Relaxation of Plan B and a general 'phew it is over' feeling in society are also contributing. I also suspect that government is keen that it has been seen to conquer the pandemic, although such celebrations may be premature.

Hospitalisations are falling slowly and certainly have peaked for this wave. I do know, though, that COVID-19 wards remain busy and patients continue to be both very ill and dying from the disease – the idea that 'it is all over' is a false one.

Hot shot – BA.2

We have a new variant under investigation to watch carefully – BA.2. If you want a good up-to-date summary of what we know about this variant (which is responsible for about 4% of COVID-19 cases in the UK at the moment), the latest UKHSA technical briefing (number 35) is the place to go, with a review of the 1,072 cases we have definitely identified in the UK so far.

BA.2 should be considered as closely related to Omicron, both were detected around the same time and have a lot of mutations in common, and it is useful to remember that such 'sister variants' are to be expected. We think BA.2 arose in South Africa alongside BA.1 (what we all think of as Omicron), although it has dominated some countries more than others – Denmark has an almost 50:50 split of BA.1 and BA.2 cases – probably simply due to which variant seeded where at the start of the wave. Unlike BA.1, it doesn't have S-gene target failure which means UKHSA are now tracking S-gene positives as a leading indicator of BA.2

There has been some concern that it has a faster growth rate than BA.1 and may be slightly more transmissible (13% v 10% household contact positivity) but the implications of this need to be awaited. On the plus side, vaccines seem equally effective against infection (it is far too early to have data on hospitalisation) and there is no evidence it results in worse disease. Keep calm and carry on is the mantra for the moment.

Technical briefing 35 also includes some other important data. It mentions the VIVALDI study, which has been looking at Omicron infections in care homes. A pre-print (I'll talk more about pre-prints later) comparing Delta-dominant SARS-CoV-2 infections with Omicron showed that Omicron was significantly less likely to result in hospitalisation (4.0% v 10.8%). While this is good news and shows the importance of the booster programme in this population, it also shows that care home residents are still a vulnerable population and that they have a higher hospitalisation rate than almost any other population.

Finally on this topic, the briefing gives data on HDU/ITU admissions with Omicron. Getting an analysis of genotypes of patients on ITU is not easy as by that stage the virus is in decline and the immunological catastrophe that it has invoked is to the fore. Having said that it looks clear that at least half of ITU admissions are now due to Omicron. The ICNARC data show that most (61% is the latest official figure) of these patients are unvaccinated. Thus Omicron in those who are unvaccinated is not something to be dismissed.

To be or not to be – vaccination

The political debates about mandatory vaccination (VCOD) escalated today to a change of direction (and possibly heart) from the government. This evening the secretary of state for health and social care Sajid Javid announced that there will be a new consultation on ending VCOD in health and care settings. Subject to this consultation and parliamentary approval, government will revoke the regulations on VCOD. We should all still play our part to maximise vaccination rates among our colleagues and helping to put risks and benefits of vaccination into context is part of that.

One fear that has been expressed to me is about the cardiovascular risks of the vaccine. I have previously talked about the evidence around ischaemic heart disease (in short – no evidence that vaccination increases risk of IHD-related events and lots that COVID-19 worsens them), but we now have good data on myocarditis. In *JAMA* this week the data on myocarditis from the US VAERS database were summarised. Data from 192 million people receiving 354 million doses were associated with 1,626 cases of verified myocarditis – 4.6 per million doses. 82% of cases were in men and the median age was 21. This mirrors other viral-associated myocarditidies (if that is a word). Symptoms usually occurred 3 days after the first dose, were more frequent after the second dose and resolved in 87% of those hospitalised before discharge. The highest rate of myocarditis was in men aged 16–17 at 106 per million doses. This fell to 52 for men aged 18–24. These data are consistent with a Danish study published in the *BMJ* a month ago.

To put that into context, viral myocarditis is common in young men and viral myocarditis has been associated with COVID-19 at higher rates. A recent pre-print from a US population of 60 million showed COVID-19 associated myocarditis at a rate of 561 per million for men aged 16–19. Thus, not only can we say that the risk of myocarditis if you are a woman and over 24 (much of the unvaccinated NHS workforce) is very low, but getting COVID-19 is 5–10x more likely to damage your heart if you are in the most at-risk group from vaccination.

The other topic that I have been thinking about with respect to vaccination is long COVID. We know from our surveys that a number of physicians continue to be off work due to long COVID and the impact of this condition on those affected can be life changing. We now have evidence that vaccination halves the rate of long COVID (as well as some evidence vaccination itself results in improvement of long COVID symptoms). A survey by the ONS (who have achieved national treasure status in my mind over the past 2 years) showed a 41% fall in symptoms reported at 12 weeks after infection in vaccinated individuals compared with those who were unvaccinated. Long COVID symptoms were reported by 14.6% of unvaccinated people and, importantly, limited daily activities in 8.7%. The latter is an important point as it shows that COVID-19 will result in long-term problems in one in 11 unvaccinated people who get infected.

Finally on vaccination, we are the first royal college to endorse the Vaccinate the World campaign, focused on addressing inequity in access to COVID-19 vaccines globally. The campaign is led by grassroots healthcare professionals and senior NHS leaders who believe that access to high-quality healthcare is a basic human right.

Knocked it off – coronavirus medicine delivery units (CMDUs)

My last directly COVID-related topic is on our new friends, CMDUs. Given these didn't exist 6 weeks ago it is remarkable how important they have become in the pandemic response. They have now treated over 10,000 vulnerable patients with COVID-19 and have had to assess 10 times this number. This workload has fallen on a few individuals, often infectious diseases (ID) physicians, acute physicians and geriatricians. I would like to say a big thank you to all involved with the programme.

The guidance for patients who should be assessed by CMDUs is constantly changing which makes a difficult job harder, and it seems that the medical specialties will continue to be an important resource point for patients and GPs when considering if someone is eligible. If you have patients who you think are eligible for treatment but have not been notified you can check their eligibility and use the template letter to refer them.

It seems likely that the drugs issued by CMDUs will change as a shift to Paxlovid from molnupiravir occurs. The former is more effective but has more drug interactions and thus prescription is a little more thought-requiring. We may also move to subcutaneous dosing of monoclonals which may speed up treatment. The other thought moving forwards is what role CMDUs will play in the management of new variants and 'endemic COVID' (whatever that looks like).

Goosebumps – antimicrobial resistance (AMR)

I have spoken to many ID and public health physicians over the past 2 years and one worry that has been simmering about the pandemic is the impact on AMR, both direct and indirect – the direct effect of increased antimicrobial prescription and the indirect one of focusing our infection prevention and control attentions on a single virus while other pathogens continue to play dirty.

A group called the 'Antimicrobial Resistance Collaborators' published a sobering article in *The Lancet* 10 days ago estimating the global burden of deaths from AMR in 2019. A staggering 1.27 million deaths (the same as HIV and malaria combined) was the headline figure, although the paper includes lots of fascinating granularity especially on the burden for different parts of the world. I would recommend the article as well as the associated editorial.

Wired for sound – pre-prints

I often refer to and link to pre-prints in this bulletin and the rise of these as an evidence base during the pandemic has been remarkable. In the course of reading a review of assessment of credibility of health information in social media I found some interesting stats related to this form of 'publication'.

In the first 10 months of the pandemic 125,000 articles (!) were published on the topic and, of these, 30,000 (around 25 %), were in pre-print form. Not only is the volume of research impressive but the use of pre-prints in the media has become normal practice. This is despite the disclaimer that 'they should not be reported in the news media' according to the websites that publish them. I'm afraid I can't see many authors or their institutions asking for their research not to be published. Indeed, most institutions produce accompanying press releases and I also think that wide dissemination can be helpful. Perhaps we have to agree a new way to ensure all are aware of the limitations of pre-prints.

The article on credibility mentioned above is on the US National Academy of Medicine website and is long but worth a read if you have time. To my mind they have missed an opportunity in not debating how we assess the credibility of health information produced by individuals on social media. This is surely one of the challenges of modern communication. I know who to trust on Twitter to some degree but having a trusted rating for people I've not heard of would be useful, not only for me but also for the public.

The living years – delays in emergency departments (EDs) and mortality

Anyone working in urgent and emergency care will be only too aware of how much the system is under pressure at the moment. The fact that the worst-ever NHS urgent care performance figures were released a couple of weeks ago with barely a ripple in the media is a worrying sign that society has become rather insensitive to the situation. Even non-medical colleagues are affected by this and I was lost for words when another NHS leader from a non-physicianly background told me that they thought it was wrong to call this the worst-ever winter and things were not really too bad. If they didn't work so far away I would take them down to my ED to talk to colleagues working there.

The harms of having patients in emergency departments and acute assessment areas longer than needed have been known for some time but we have had very little good evidence from the UK. A paper published on the association of delays to admission in EDs and mortality by a group including the late (and much-missed) Cliff Mann has changed this. Based on data from almost 27 million people attending ED in 2016–18 there was a linear increase in mortality after 5 hours waiting in ED, the worst increase being a wait beyond 6–8 hours. To put it in easy-to-understand terms, for every 82 people waiting over 6–8 hours in ED there was one excess death.

Thus, while I and many others await the 'elective recovery plan' for the NHS, we must not forget that urgent and emergency care waits are as in need of a national and coordinated plan.

Silent running (on dangerous ground) – Burma/Myanmar

I have mentioned the situation in Burma/Myanmar on a few occasions in this bulletin and continue to send our strong support to physicians in that country. We're holding a virtual event to mark the first anniversary of the Burma/Myanmar military coup and explore how RCP members and fellows can support the healthcare community in the aftermath of the coup and COVID-19. The event will take place on 1 February at 6pm (GMT). Please email global@rcp.ac.uk to register.

Also on 1 February, along with a number of other royal colleges, we will light up the RCP at Regent's Park building in red. This is a moment of solidarity and remembrance for the health workers there who have risked, and lost, their lives to provide care over the past year.

You will notice that we are using Burma/Myanmar to refer to the country. This is a change that many organisations have moved to given the political interpretation made by some of using either Burma or Myanmar on their own.

We have a dream – the new RCP strategy

Last week we published a new RCP strategy for 2022–24. The last strategy was for 2015–20 and we had worked on one for 2021–25 but decided to put it on hold during the worst parts of the pandemic (he said, hopefully). The new strategy has been altered a bit due to the pandemic and its effects on both the RCP, physicians and society as a whole. We have also shortened it slightly so that the next president (see section below) can help shape the next one once they have found their feet.

It has three main priorities: educating physicians and supporting them to fulfil their potential; improving health and care and leading the prevention of ill health across communities; and influencing the way that healthcare is designed and delivered. The strategy was produced following consultation with the RCP's membership and our many stakeholders and will be enabled by proactive engagement with both and a strong commitment to diversity and inclusion, good governance and sustainability throughout the organisation. The latter is particularly important.

You will see that we have not focused on the detail of our influencing priorities. At the moment these are workforce, health inequalities, NHS structures (eg the upcoming bill) and research. These are unlikely to change much but you never know what is around the corner.

I wanna be a winner – RCP elections

I'm delighted to be able to announce the names of fellows standing for election as president, clinical vice president and councillors in 2022.

(A magnificent) seven candidates have been nominated to stand for the role of president to take up post in September 2022. Alphabetically they are: Sarah Clarke, David Oliver, Gerrard Phillips, Iqbal Singh, Cheng-Hock Toh, Emma Vaux and Olwen Williams. Two candidates have been nominated to stand for the role of clinical vice president to succeed Sarah Clarke in August 2022: Susan Crossland and John Dean. Ten candidates have been nominated to stand for the role of elected councillor (four vacancies) to take up post in August 2022: Andrew Deaner, Toby Hillman, Wajid Hussain, Rachael Jones, Khin Swe Myint, Claire Pulford, Russell Roberts, Amit Saraf, Ajay Verma and Hilary Williams.

Thank you to everyone who has nominated others or agreed to stand for election. Fellows will receive an email notification with links to election material and how to vote. Voting will be open from 9 March until midday on 11 April. Find out more about the process.

I am often asked who I would like to be the next PRCP. I have views, of course, but it would be wholly wrong of me to try to influence the outcome of the election and I have confidence that the fellowship will vote wisely. My only comment is that whoever it is will need to have a strong devotion to the RCP. The job is not one for those who are in it for their own edification.

...and finally

I wonder how many people get a 'Microsoft Viva daily briefing' each morning generated by their Outlook calendar. I have tended to ignore them but one I had last week made me choke on my cornflakes.

It remarked that I had a few hours with nothing in the diary and I should consider taking 30 mins each day to catch up on my emails and chat. I reckon that gives me around 10–15 seconds per email (presumably the Outlook system is well aware of how many I have) each day. I hope the successful PRCP candidate can speed type.

Finally, for those who have an interest, this week's tracks are all written by the same musician and include the first 7-inch single I bought in '79.

14 February 2022

It has been a worrying 2 weeks with political posturing both within the UK and on the wider world stage. Like many, I am watching the events in Ukraine with trepidation and memories of the cold war and 'Threads' (that'll date me) have come flooding back. The winter Olympics seem oddly distant and irrelevant in view of other world events and climate change.

COVID-19 continues to affect all we do in health services and even though some politicians and parts of the public want us to 'forget and move on', the virus and the damage it has wrought remain the main topics of this week's bulletin.

Relax – self-isolation

As I write this there is a discussion around removing the legal enforcement of self-isolation 'providing the current encouraging trends in the data continue' as our esteemed PM has stated. This has been met by a range of opinions as to both the reasons behind this and the evidence for such a view. I won't go into my thoughts on the politics of it all (except to say it makes me quite angry), so let's look at the evidence.

What constitutes a trend? I think most statisticians would say it describes a pattern of movement either upwards or downwards in a series of data over time. Looking at the many sources of COVID-19 case number data, you know I am a firm fan of the ONS survey data – the UK being the only country that obtains random population sampling data over time. From the latest data published 3 days ago I am struggling to see a 'trend' over the recent weeks in England. The ONS itself describes it as 'the percentage of people testing positive … increased in the two weeks up to 5 February 2022, but the trend was uncertain in the most recent week'. Cases are falling in Wales but increasing in Scotland and NI. Things are obviously much improved across the UK compared with 6 weeks ago, but in such a rapidly changing situation we mustn't cherry-pick the data points to fit with the narrative we wish to create.

If the legal enforcement of self-isolation were to be removed in a week or so, would it make any difference? It would certainly send a clear signal that the government wishes to move away from a set of public health measures and already changes in behaviour are being seen in some settings. However, the public as a whole have been pretty canny over the course of the pandemic by making their own interpretation of the data. There hasn't been a sharp drop in those complying with non-pharmacological interventions (NPIs) according to separate ONS data and thus even if the legal enforcement were removed tomorrow I cannot see streets full of mask-less folk hugging everyone they meet.

The main direct result of removal of legal enforcement is that employees have no defence to employers who say they must work if they are positive. It may reduce the provision of tests by employers and indeed testing by people who are self-employed. We don't know how health and social care settings will respond to such an edict, but I think we as a profession should push back hard against any further changes to self-isolation for NHS workers. We should also be wary of the removal of easy testing for members of the public.

The non-statistical interpretation of the word 'trend' is a way of describing how people are behaving (I have never been trendy in my life), or what they are most interested in on social media. Whatever happens there will continue to be 'trends' in COVID-related behaviours.

While thinking about the ONS data, I wish to state for the record that it would be remarkably short-sighted to remove funding for the ONS COVID-19 surveys as is currently being mooted. They give us insights that few other countries have and turning this data gathering off would be a bit like switching off the cardiac monitor on a patient with a STEMI. If you have to wait for them to stop breathing and turn very pale when they develop VF, your chances of successful resuscitation are more limited.

Two tribes – variantwatch

I talked about BA.2 in my last bulletin and note that it has now become the utterly dominant variant in South Africa. An update was published by the UKHSA last Friday and is, as always, most enlightening.

BA.2 remains a small player in COVID-19 cases but is definitely on the rise. Infection with BA.1 (the original Omicron) seems to provide complete protection from infection with BA.2 – although this immunity is likely to wane over the months as it has with other variants. Vaccines also seem to be as effective against both variants, which is a relief.

BA.2 causes earlier symptoms in contacts than BA.1, with the 'serial interval' being 3.27 days for the former and 3.72 days for the latter. The serial interval is the average time from symptoms developing in an index case and then developing in contacts. This is obviously a competitive advantage for BA.2 and explains why it has pushed its sibling out of the way in other parts of the world.

Warriors of the wasteland – elective care recovery plan

Last week saw the publication of NHS England's 'Elective care recovery plan' as it has been known colloquially. This is a document that has been under construction for many months and was initially slated for release in November 2021 but has been delayed by both Omicron and political wrangling (does anyone else hanker for a health service that is not a political device?).

The first observation is on the actual title of the plan which is 'Delivery plan for tackling the COVID-19 backlog of elective care'. This has been carefully worded given the inexorable rise of waiting times since mid 2009 (when there were 2.3 million on the list) and the growing realisation that returning to pre-pandemic waiting lists (when there were 4.5 million on the list) is going to be hard enough. This also sets up a subtle narrative that much of the backlog can be blamed on external factors beyond the control of any government. I'll leave that one with you.

The plan is careful not to mention specific goals in terms of the number of millions of patients on waiting lists at any time but it does specify some 'challenging' targets, not least the increase of 30% elective activity by March 2025, 95% of diagnostic tests being done within 6 weeks by March 2025 and 75% of cancer referrals having a cancer diagnosis or exclusion within 4 weeks by March 2024. Both the latter will need a revolution in diagnostic services including pathology (a much underrated and under-resourced specialty) if we are to have any hope of success.

The plan is relatively easy to read as 50-page documents go and is supported by £16.6 bn funding. According to my maths that's a 10% increase in NHS funding for 1 year to get a 30% increase in activity over 3 years. That is good value for money if successful. There are mentions of urgent and emergency care and the workforce implications but very little detail. Until we see the operational plans for the recovery, I remain both concerned and sceptical.

I was a bit troubled by the proud statement in the document that 'our workforce continues to grow – with around 87,000 more full-time equivalent staff than in October 2019'. The GMC emergency register still has 22,000 staff on it who re-joined for the pandemic and there were 13,000 on the Nursing and Midwifery Council register in late 2021. We also know that many have not retired during the past 2 years in order to help out with the pandemic. The ongoing mantra that 'we have more staff in the NHS than ever before' is a dangerous misdirection and I shared some of my thoughts on just this in a column for *The Guardian* on Saturday.

The plan will only be successful if it is part of a bigger plan around primary care and urgent and emergency care. Friday saw (yet again) the worst-ever ED performance figures in England with more than 16,000 people waiting over 12 hours for admission in January. The challenges of discharging patients from wards continue to cause a logjam throughout the pathway. Our primary care colleagues continue to have as difficult service demands placed on them. Reconfiguring acute beds

to support the elective recovery either on- or off-site will heighten these challenges.

One minor observation is the design of the title page of the document. I think the cog-like borders around the images of people is supposed to represent the coronavirus capsid reiterating the COVID-19 backlog. If not, it is slightly concerning the cogs do not interdigitate and I hope it is not representative of how different parts of the NHS will work together in trying to achieve the plan's aim.

Despite all the concerns I've raised above I welcome the plan as at least we now know what we are working towards. I have great respect for Sir Jim Mackey who was given the unenviable task of coming up with and then negotiating the plan with government. He is an experienced NHS CEO and he knows the realities of the current NHS. We need to continue to challenge, but do so constructively and engage to try to find solutions to the situation we are in.

As part of that, today we have published a statement from our RCP/Getting it Right First Time (GIRFT) clinical pathway improvement group about the need for a coordinated and evidence-based approach to managing acute pressures. We clearly need more workforce but we also must use what resources we have as wisely as possible. There is much to learn from the GIRFT reports for the medical specialties – but we must also ensure that we don't hunker down in our own specialties when times are tough but work together across medicine for the good of all our patients.

The world is my oyster – F3 posts

If you have time to read another 50-pager here is an eye-opening one. Last week, in conjunction with Health Education England (although I think the lessons learned can apply to all nations within and without the UK), we published some research on why people take time out after foundation training – the so-called 'F3 phenomenon'. Taking time out of training programmes is now the norm for most trainees after exiting foundation schools, with 65% doing so in 2019.

The report is stark and realistic in its findings to the three questions it asked: why do people take an F3 year, was the experience what they hoped for, and what are the implications moving forwards for training and workforce planning. The results are not surprising to any trainees or anyone who works with them – a break is needed by most from the conveyor belt the NHS training system has created and 'F3' provides autonomy and opportunities that were not provided in foundation training (nor will be in the next stages of training).

I'll leave you to read the detail of the report but many found the year valuable and would recommend it to their colleagues coming behind them. We should therefore plan for this to be an expected, integral and planned part of training and recognise the skills learned during such time. We will have to change the name as most felt that F3 made it sound part of the Foundation Programme when it is most definitely not. Might I suggest 'SHO' as that is what many F3s see themselves as…

There has been a bit of social media debate following this report, including the nomenclature. In this debate there was one commentator blaming us for the findings of our report: 'Colleges – you won't fix trainees' wellbeing when it's you who are the major contributors in making them miserable'. I think this is a good, if unfair, challenge. If we set aside the fact that we (the RCP) have almost nothing to do with the Foundation Programme (and I have been openly critical of it in my time), most of the factors that make the foundation training experience bad are ones we've known about for years. The report on medical registrars we produced in 2013 showed that high workload, poor rota design and the triad deficiencies of team cohesion, flexibility and educational opportunities are the recurrent factors in the NHS. This new report reiterates those findings.

Most of these are outside of the control of 'colleges', and more about the workload and workforce within hospitals. That doesn't absolve us as part of the system, though. I think we all have a duty to support trainees as much as we can, advocate for them with hospital management when

they are expected to do the impossible and give them opportunities to fulfil their considerable potential. We can also shout loud and hard about workforce issues at the highest level (I think I may have developed a bit of a reputation in the corridors of power as a stuck record on this). In my own hospital we saw F3 posts as a way of doing this, using them to achieve the benefits the report describes. That our F3 rotations were set up and supported by our RCP college tutors, Lindsay and Janson, suggests that 'colleges' can be a force for good.

The power of love – Valentine's Day

Happy Valentine's Day. As an (unrequited in love) youth I never had much time for the day and wonder what the original St Valentine (or Valentines plural depending on which part of Italy you favour) would have made of it all now. My only reason for mentioning it is the tenuous link to an important topic, SUDEP (sudden unexpected death in epilepsy). I was contacted recently by a charity related to this condition to ask what we had done in response to a previous MBRRACE-UK report about deaths from SUDEP in pregnancy. The 'Green-top guideline' (famed in obstetric circles) on epilepsy in pregnancy produced by the Royal College of Obstetricians and Gynaecologists and endorsed by the RCP among others is worth a quick read if you have any patients with epilepsy who are considering pregnancy, or indeed are pregnant.

'And what is the link with Valentine's Day?' I hear you ask. Epilepsy was historically known as St Valentine's malady and children in Monselice, Padua, are given small keys known as Saint Valentine's keys on 14 February to ward off epilepsy.

Ferry cross the Mersey – Medicine 2022

The Medicine 2022 programme is now out and includes what we think will be a profession-defining lecture by Chris Whitty on the 'Relative roles of the state, medical profession and the public'. Our role as we move forwards from COVID-19 is going to be pivotal.

The programme will hopefully appeal to all, and we plan to hold the conference face-to-face in both London and Liverpool, as well as making it available virtually. I hope to see you there – I will be in both London and Liverpool (although will use a train rather than Hermione Grainger's time-turner).

As a bit of light relief during the conference, I will have the honour of captaining the RCP team in a University Challenge-style competition against a Royal College of Surgeons of England team. Team selection was extremely competitive from members of RCP Council and we hope to do you proud. I suspect the event itself will be even more competitive.

...and finally

Talking of University Challenge, I was sad to hear of the death of Bamber Gascoigne last week as it was yet another reminder that I am getting older and the totems of my youth continue to fall. I was then staggered to learn that Jeremy Paxman has now presented University Challenge for longer than Mr Gascoigne did.

The faster passage of time as we get older is well recognised, although the explanation unclear. I like the hypothesis that as our neural processing slows down, time speeds up. There have to be some advantages to a slowing brain.

28 February 2022

The world has turned a little bit upside down since my last bulletin and some far-reaching political decisions have been made on both sides of Europe. What the final outcome of those decisions will be remains to be seen. This week's bulletin is slightly shorter than usual (thank goodness, some may say) but the issues are all hopefully important and interesting.

If you tolerate this your children will be next – Ukraine

The RCP has members and staff who are Ukrainian and have family in that now war-torn country. All of us at the RCP send our thoughts and love out to those affected by the crisis. I suspect many of us also have friends with links to Ukraine and there is a dark and depressing air in the village where I live as Tarasivka, a Ukrainian youth centre, forms an important part of our local community.

The actions of Putin have had immediate and dramatic effects on the healthcare system in Ukraine and experience tells us that the health of that population will suffer in unseen ways for many years to come. The movement of refugees across the EU will have an impact on the neighbouring states. Thinking about the healthcare system in Ukraine led me to do some background reading and I would recommend Judy Twigg's commentary published in 2020, which gives a useful overview.

Ukraine has its own national health system (NHSU) which was created in 2017 and has been making significant strides towards a fair and equitable system for both population and employees since. Although somewhat younger than the UK NHS, the problems NHSU has had are not dissimilar. There has been a succession of health ministers which has created rapidly changing political policies and a fear of slipping back to the cronyism of pre-NHSU days. The involvement of UNICEF and others in procurement for medicines in 2015 showed how transparency can reduce corruption and medicine prices – something we can all learn from. The NHSU (before the war) was struggling with a move towards decentralisation and creation of local healthcare systems. The tensions between the politicians at the centre and local groups of those responsible for delivering healthcare seem oddly reminiscent of the current reform in England.

Let us hope that stability and normality will return quickly to the Ukrainian people and the improvements that were seen in NHSU can be the centre of attention, rather than the need to fight for their freedom and lives.

A design for life – living with COVID-19

Our own worries about the next steps in the pandemic pale a little compared to a country at war but are important, nevertheless. Cases continue to fall slowly and hospital admissions by around 10% per week. Last week the UK government produced its Living with COVID-19 plan and the content is no great surprise given the current vogue for leaking government news days or even weeks before its official release. It is a reasonably long read so I will try and summarise.

After a backslapping review of the response to the pandemic so far, it talks through the four SAGE scenarios moving forwards (reasonable best case, reasonable worst case, optimistic central and pessimistic central) before then talking about the future response to the inevitable further waves and variants. This is perhaps the key section, clearly stating four principles which are then covered in much more depth.

The first of these is the 'Living with COVID-19' mentioned in the title and removes domestic restrictions while 'encouraging safer behaviours through public health advice'. The domestic restriction language is a very important point but its subtlety is being lost on many attending healthcare settings. The NHS in England has made it clear that mask-wearing and visiting restrictions will continue to apply but already conflict in primary and secondary care settings is being initiated by those insistent they don't need to wear a mask. GP

receptionists and ED staff are all bearing the brunt. A clearer message on this from our politicians would be helpful.

The second principle is protecting those most vulnerable through vaccination under JCVI advice and targeted testing. The former is more of the same, the latter less. The test, tracing and isolation budget was £15.7bn in 2020–21 and exceeded the Home Office budget. The Treasury is understandably unhappy about this and to be fair when only 14% of lateral flow tests sent out were done and reported back, it does not come across as the most efficient use of such 'eye-watering amounts' as described by the Public Accounts Committee. I know that many tests will have been done and not reported but that counts for little in the Treasury's eyes (if it isn't written down it didn't happen, as the NHS legal teams would say). The advent of 'routine' use of near patient tests (ie LFDs) during the pandemic has been a remarkable transformation in clinical and public behaviour. While we should definitely rationalise how we use these tests, they have provided very useful information and we must be careful not to throw them out with the bathwater. It seems certain that testing will need to continue for those who are going to have (expensive) antivirals and monoclonals.

The future for NHS workforce-related testing is unclear and is being worked on as I write. For the moment we should all continue to test twice weekly with LFDs and self-isolate if positive. Thirdly, the paper focuses on maintaining 'resilience'. Now you know what I think of that particular word and this is better phrased 'risk management' as the evidence that we as individuals or a system have any resilience left is pretty slim. The future of the ONS survey seems secure, although the paper suggests it will be scaled down and the exact detail of what it will look like moving forwards is absent. More space is given to the future of flight travel than to surveillance, which is telling.

The last principle is on research and innovation. There isn't anything new in this that hasn't been announced previously, although it is a clear commitment to the ongoing existence of the UKHSA and the vaccine taskforce. However, as testing has been a major part of the UKHSA's work and needs considerable human and laboratory support, the rapid turning off of testing will have a massive impact on the morale of those working with and for the UKHSA. We must also remember that one of the reasons we were ill-prepared for the pandemic and struggled to get adequate testing up and running quickly was the erosion of our NHS pathology services. If we are to fall back (especially in primary and secondary care) on relying on local pathology labs to do testing when we suspect COVID-19 inpatients, those services will need support.

The everlasting – variants

There isn't much new to report about variants, although the latest technical briefing from the UKHSA on Friday reiterates that vaccines continue to be as effective against BA.2 as Omicron (BA.1), and that BA.2 is more infectious with 14.3% of household contacts being infected compared with 11.4% with Omicron. It would need to be a pretty big household for this to be noticeable though.

My eyes did prick up a bit (mutating my metaphors) at an observation of some cases with mutations seen in both B.1.1 (Omicron family) and AY.4.2.2 (Delta family) suggesting a recombinant. This is a tad worrying as the severity of Delta combined with the infectiousness of Omicron is not a good (re) combination. One to watch.

The masses against the classes – #StrengthInNumbers

Workforce has been a golden thread through my RCP career and the pandemic has reinforced what most of us see as the biggest threat to the immediate future of the NHS and care system – the need for more workforce. Unfortunately, the government's new Health and Care Bill gives no clarity on how many staff we need to deliver care and we need to do something about that. The RCP is one of almost 100 organisations backing an amendment to the bill that mandates the publication of how many staff we need now and in future to meet patient demand.

In a rare step (we think it is that important) we're asking RCP members to write to their MP using a template letter we've created to ask for their support on this amendment. This amendment won't solve the workforce crisis, but it will enable us to understand the gap between supply and demand and provide strong foundations on which to build a solution. It also ensures that everyone is working from one set of data rather than picking and choosing what suits. Hence the title for our campaign on this: #StrengthInNumbers.

I suspect there are lots of things that readers might want to write to their MP about, but it is important that the letter remains focused on this one ask – politicians can get easily distracted, especially if it suits their needs. Such interventions work and the fairly relentless pressure we've been exerting on other aspects of the bill have already borne fruit with successful amendments being made around research and health inequalities (you know it has been successful when the government introduces its own amendments on the lines of the ones you have been asking for). The workforce amendment needs a bit more pressure, though, and your help would be much appreciated.

If you have an interest in workforce, the Royal College of Anaesthetists has just produced a report on the anaesthetic workforce at the moment and modelled the needs moving forwards to 2040. This is both ambitious and scary and shows the importance of an adequate workforce for meeting the needs of pandemic recovery and the changing demographic in the UK.

Roses in the hospital – International Women's Day

International Women's Day is on 8 March. 77% of staff in the NHS are women and it's important that we mark this occasion and celebrate the outstanding contribution that women make to our health and care services. This year's theme is Break the Bias and calls on us all to come together to take action and call out behaviours which are discriminatory and go some way to levelling the playing field. This includes the stereotyping and gender bias that is still all too present on our wards and in clinic.

The RCP will be marking International Women's Day from 8 March with videos, blogs and links to RCP programmes and resources which we hope you will enjoy and find of interest. If you don't already, do follow us on social media – the focus of our activity will be on Instagram. You can also find out more about our work on equality, diversity and inclusion.

Faster – My Planned Care

As part of the elective recovery programme I talked about 2 weeks ago, a new website has been launched by NHS England called My Planned Care. This is a resource set up for patients to help them understand waiting times locally and give them routes to more information and support for their individual case. The website allows anyone to look at their region (via a map), followed by hospital and then specialty, and the data are apparently live.

The website is easy to use (have a go) but is a little too high level at the moment as it gives an average waiting time in weeks, which can be misleading as it does not break down by urgency of referral or by outpatient appointment to procedure date. Thus (and we are already hearing reports of this) it may lead to a lot of enquiries for patients who have gone past the average waiting time figure on the website. I would recommend RCP members have a look at the local figure for their specialty and see if this feels right. If not, the first step is to discuss it with department/directorate leads to see what data are being used. This can then be escalated via the trust to the programme centrally.

I think these types of data are really powerful for patients and clinicians for driving change, provided they are both contemporary and representative. I'm told that the website will evolve and by necessity is in a fairly simple form at the moment.

...and finally

Like many, our household was affected by the sequence of storms in the UK over the past couple of weeks with a tree next door deciding to literally gatecrash our garden. It wasn't a particularly pretty tree and now it has gone there is more light and better soil in that part of our garden (albeit with a rather large dent and lots of sawdust).

Every big beast has its day and sometimes needs to be removed or cut down to size to allow those in its shadow to thrive. This week that seems a rather pertinent thought.

14 March 2022

In the UK spring is straining at the leash, with brighter mornings and shoots of green beginning to appear in the beds and hedgerows. The world is not showing such a positive direction of travel and there is not much cheer to be had in the news each day. There is much to discuss.

War – Ukraine

Over the past 2 weeks the invasion of Ukraine has become a humanitarian disaster, with the displacement of over 2 million refugees, civilian deaths and enormous hardship for those trapped in the war zone. The health system in Ukraine has all but collapsed and neighbouring countries, especially Poland, are supporting the immediate health needs of the country. The NHS across all four nations is coordinating its response and this covers a wide range of matters in the short and medium term.

Firstly, aid. The emergency response is being led by the World Health Organization (WHO) and at the moment UK-Med is the main UK charity coordinating the healthcare response on the ground in Ukraine and Poland, working alongside other international charities. It is really important that support to the aid effort is coordinated to maximise its effect. I know that many local communities have worked together to send shipments of supplies to Ukraine and I was astounded at the response in my own village, filling a massive hall with clothes, sanitary products and other vital supplies. Many organisations across the NHS and the health and care sector as a whole are keen to do anything they can to help but, to avoid creating disruption or duplication, I have been asked by the NHS to ensure coordination by asking such organisations to submit offers of assistance to England.incident14@nhs.net

So far, the NHS has been able to send seven planeloads of our own stockpiled supplies to Poland and these have been trucked into Ukraine, with a further flight arriving this morning and more scheduled for the next few days. Aid has included

medicines, including much-needed insulin on the first flight, medical equipment such as trauma dressing packs and consumables. The contents are closely aligned with the needs on the ground, in collaboration with the WHO and the Ukrainian Ministry of Health. The outpouring of support for the country and people has been remarkable. Those on the ground say that supplies and words are welcome, but what is really needed is money. Therefore, if you would like to donate you can do so either via the DEC Ukraine Humanitarian Appeal, or via UK-Med if you want your money to be used specifically by them.

Secondly, there is a need to offer support for those who are sick. The main focus in the past week has been on children: of a population of 41 million, 7 million are children, of whom 1,600 are undergoing treatment for cancer. Poland is doing the heavy lifting to support this population but will need support and, last night, 21 Ukrainian children arrived in the UK to receive cancer treatment after being brought over by our government with the support of Polish authorities and clinicians. We know that the hospitals in Kyiv and other cities are in dire straits from the point of view of staff and supplies, and are also targets for Russia's offensive. Many sick people who are left in cities are too afraid to seek help and will need care sooner rather than later. We will see some of these as refugees in the coming months, which brings us onto the third issue, UK refugees.

From experience, it is likely that much of the workload of caring for the health needs of refugees will fall on primary care, mental health, maternity, children's and dental services. The scale of demand will become clearer as the weeks progress, but we should not expect the crisis to resolve quickly.

The fourth issue is the potential threat from retaliation. Aside from disruption to oil and gas supplies, this is most likely to come in the form of cyberattacks. The NHS is preparing for this possibility and it is critical that we all remain vigilant for unusual emails and activity. We should also be ready to move to paper and pen if such an attack occurs, and it is worth everyone thinking through the solutions if phones, computers or printers don't work or if PACS systems or digital health records go down.

Lastly, the NHS is working with the various parts of the system to withdraw from Russian supplies. Many of you will have seen that some trusts are very reliant on contracts from Gazprom for their energy and while everyone is working as fast as they can to cut such ties, it is not something that can be easily done without patient care being affected. Day by day, global companies are withdrawing from Russia and this will have an impact on the availability of some supplies.

Cover me – medical students

I have been specifically asked whether the RCP can do any work to support medical students, as has happened in previous conflicts. Many medical students in Ukraine are from other countries and around 400–500 are from the UK. We would expect those from the UK to return here and they will need support, which I am exploring with various parts of the system. It is unclear whether native Ukrainian medical students wish to come to the UK, and I have been in touch with one leading medical school in Kyiv to see what the possibilities are. As most readers will know, all men aged 18–60 will have to remain to support the war effort.

Any medical student arriving from Ukraine will be traumatised by what has happened and will have development needs, due to differences in training and experience. We should do our utmost to support them. I know that some UK medical students will be worried about what effect such an influx would have on their own training, but that is a surmountable challenge.

I'm on fire – nuclear attack

When shelling of Chernobyl occurred a week ago, the implications for a large-scale radiation incident crossed the minds of many. I am reassured that the risk remains very low, but have also learned much from our own haemato-oncology experts about the UK's preparedness for such an incident.

After 9/11, it was proposed (by an RCP fellow) to the European Society for Blood and Marrow Transplantation that a Nuclear Accident Committee should be established to optimise the 350 transplant centres and their satellite hospitals, with 3,000 trained doctors and 10,000 beds as a resource for managing huge radiation incidents up to and including a nuclear detonation. Paradoxically, transplantation is not key to survival, but transplant clinicians have the skills, infrastructure and drugs on hand to be immediately operational. Three beds per unit would be 3,000 beds without disruption to the units involved. With exacting triage, we can identify within 1 day the victims who need specialist treatment and are 'saveable'. They are well for 3 days, but mortality is almost 100% after a week without correct management.

I have never stopped to think about such things before (and am amazed that I was gullible enough as a callow youth to believe in the 'Protect and survive' propaganda of the time). I am very relieved that others in our profession have thought and acted. Let us all hope that such planning never needs to be put into action.

On the situation of Ukraine, I need to state unequivocally that we stand by our fellow doctors of all grades in Ukraine and surrounding countries who are working to deliver healthcare to those who need it at huge personal risk. They are the best of us.

Born to run – COVID-19 infections

The resurgence of infections since the relaxation of COVID guidelines is now striking and has come as no surprise to anyone who has even a slight interest in the epidemiology of this pandemic. Whether this rise in infections will become a big peak or a mere 'hump' in the prevalence curve remains to be seen. As I write this, infections in the UK are rising at 56% per week and hospitalisations at 17% per week. The latter will surely increase further, as will the resultant pressure on other services. The fact that ITU admissions remain low is obviously a good thing, but any increase in hospitalisations will have a knock-on effect on our ability to manage non-COVID patients, as we have seen over this winter.

Importantly, cases are rising in the same way throughout the country and in all age groups. This is not due to a new strain (which always shows a regional/age variation initially) and so can be put squarely at the door of behaviour change.

BA.2 has become the dominant variant, making up 83% of cases that have been 'typed' as of a week ago. It has an estimated 80% growth advantage over BA.1 so its dominance is not surprising, but it has not yet removed its sibling completely from the running. There is no evidence at all (yet) that vaccination is less protective against BA.2, and I wonder whether the resurgence of cases may also result in a resurgence of vaccination rates in some groups.

Infections and hospitalisations are raging in Hong Kong and our thoughts go out to colleagues and friends there. It looks like infections may have peaked but low vaccination rates, especially among older people, have resulted in an overwhelming number of admissions. The global pandemic remains just that.

Dancing in the dark – death rates

The 'paper of the week award' goes to the analysis of death rates by the (imaginatively named) COVID-19 Excess Mortality Collaborators in *The Lancet*. There are two things to say before I get into the fascinating detail of the paper. Firstly, I was alerted to the paper by a tweet from Adam Kucharski, whose book *The rules of contagion* I have just finished. It is an excellent read, and his explanations about how viruses and social media posts spread will make you think again about what you thought you knew – for example, that the Broad Street cholera epidemic was dying out well before the handle of the infamous pump was removed. Secondly, when I have written about COVID-19 death rates before, I get a large postbag of comments. Deep breath then …

It is a long paper but worth the time, as it turns some accepted 'wisdom' on its head. In the simplest terms, the authors used reported COVID-19 death data from 74 countries and compared them with excess mortality for those countries. As you can imagine, there are lots of reasons for excess mortality (heatwaves, for example) and they had to correct for this using something called 'least absolute shrinkage and selection operator' or LASSO for short (I would like to see a TED talk on that). The analysis identified that there is a considerable lag in relevant data, and therefore the daily publication of death rates is probably only worth the webpage it is written on. The discussion section talks about this in more detail as death rate data, when accurate, can have uses from a public health point of view.

The headline result is that, up to the end of 2021, there have been 3.07 times as many COVID-19 deaths than have been reported, 18.2 million rather than 5.94 million. The difference varies hugely between countries, and there is a rabbit hole of a table with countries and sub-regions that gives amazing detail. The UK can at least say that its published data fit well with predicted data (ratio of 0.97 compared with 1.37 for the USA). Many of the countries with a much higher 'real' death rate are predictable based on their health infrastructure and reporting systems, but one also has to wonder about how politics interfered with reported death rates. There are some surprises – Japan had 6.02 higher excess mortality and Denmark 3.18 higher. Fig 2 in the paper is a map that gives a good overview. The irony that Russia has one of the highest death rates is not lost.

This means that, if the league table of COVID-19 death rates gets redrawn, the UK's reputation as being one of the worst performers during the pandemic no longer stands. UK death rates according to this study are the 29th worst in Europe and ninth worst in western Europe. It also shows there was no significant difference between the four home nations. None of this, though, should allow anyone to sleep easier over the pandemic and our response. The study confirms that around 169,000 people died in the UK from COVID-19 in 2020–21. That is nothing whatsoever to crow about.

Better days – elective vs urgent care

Urgent and emergency care remains remarkably busy in the NHS, as shown by the latest set of data published last week. The impact on emergency departments and acute medicine units is taking its toll and the press release by Royal College of Emergency Medicine president Katherine Henderson puts it very well – repeatedly publishing worsening figures helps no one, and we need to see action from politicians and the NHS leadership. Increasing COVID-19 cases will only aggravate this situation.

In the context of such pressures, it is hard to see how the elective recovery plan is going to be able to succeed and I hope that attempts to get waiting times down are carefully thought through and supported. At a meeting last week, I heard one consultant describe how they had been asked to reduce follow-up outpatient appointments by 20% across the board. Such policies are doomed to fail.

You have to wonder if we are fighting a losing battle with waiting times. A chart published by the Nuffield Trust on Friday showed waiting times from the inception of the NHS. It looks like an exponential curve to me and by my eye, we may have half the adult population on a waiting list by the end of 2026 if the curve continues.

High hopes – RCP elections

As things would have it, in 2026 my successor as president will be handing over the reins. But we need to elect them first.

Voting opened on 9 March for fellows, in good standing, to make their choices from the candidates standing for election as president, clinical vice president and elected councillors. Online voting will remain open until midday on Monday 11 April 2022 and fellows should have received an email from Civica Election Services with details on how to vote. We've set up a 'meet the presidential candidates' webpage (behind the login), which hosts our first

ever video of the hustings for president, as well as the candidates' written answers to questions posed by the membership. This is available for both members and fellows to view.

The email is from 'CES' and you can click on the 'Vote now' link in the top right part of the email to the side of my unsmiling face. This will automatically fill in the relevant numbers needed to access the voting paper. There is a short video from me and just to reassure the neurologists, I do not have a vertical gaze palsy – the autocue (laptop) was above the camera as we filmed it.

You can find out more about College Day, which will take place on Monday 11 April 2022 and includes the special general meeting of fellows for the election of the president.

Brilliant disguise – politics

We have been fairly active politically in the past week. Thank you to all members who have written to their MP about the #StrengthInNumbers campaign for better workforce planning in the Health and Care Bill. Last week we had some real success, with the House of Lords voting our amendment for regular assessments of how many staff we need now and in future into the bill. Despite strong cross-party support for the amendment, the government is almost certain to try and remove it when it goes back to the Commons for approval. It is still important that as many of us as possible write to our MPs to make it clear that these assessments have strong backing and are a critical foundation to understanding how many staff the NHS needs in the long term. Download the updated letter template.

The secretary of state (SoS) for health and social care, Sajid Javid, was at the RCP at Regent's Park to give his vision for the NHS on Tuesday. View his speech – it starts at 4:22 – or you can read it in full. It is good that the SoS chose the RCP to give this important speech, but rest assured I will continue to challenge him that his vision will only be achieved with a sufficient and adequately rewarded workforce.

and finally...

In the video I recorded for the election website, I finish by saying 'whoever you vote for, please vote' and given the visit of the SoS last week, I've been thinking a lot about politics and how the RCP should interact with politicians. I've written a leading article on this for *Commentary*, coming out in the next week.

The essence of the final paragraph of that article bears repeating here. Given what we are seeing in Ukraine, we should never forget to value the freedom that we have in a democratic society. We may not like those who wish to lead us, but at least we get to vote for who we want and those leaders come with promises, rather than missiles, bombs and invading troops.

28 March 2022

Two years on from the first UK lockdown, COVID-19 is the gift that keeps on giving and the war in Ukraine continues to send shockwaves across the world. It all stops making sense at times, but I will try and summarise where we are at on both as well as some lesser matters of the moment.

Road to nowhere – COVID-19 cases

The number of COVID cases continues to rise and has reached record levels in Scotland. Although there is a week's lag, the ONS data remain the gold standard for an overview of the national picture. The percentage of the population testing positive for the week ending 19 March was 6.4% in England and a staggering 9.0% in Scotland. Case numbers in Scotland do seem to be levelling off, thankfully. While the graph of case numbers is heading up, the one for 'social distancing' is heading down with only 28% of the population now saying they always or often maintain social distancing. The ONS lifestyle charts are illuminating with a slowly increasing group (currently 9% of the population) saying life has returned to normal. I would wager none of those work in the NHS.

Hospitalisation rates of patients testing positive for COVID-19 are unsurprisingly also climbing, and while 55% are coincidental infection, these numbers are stretching the NHS to extreme levels. Scotland is, obviously, feeling this the most but other parts of the UK are also struggling, such as the south west. This is manifest by increasing crowding in emergency departments (it is hard to believe they could get much more crowded). Combined with staff sickness, the demand has put ambulance services on the edge. One solution that has been tried in some parts of the UK is the creation of 'jumbulances', so named as they are acting as large ambulances. These are temporary structures outside EDs to hold patients to free up the wheeled parts of the ambulance service.

One such 'jumbulance' outside a hospital in the south west has less charitably been termed a 'shed' as it can only accommodate five patients. In a moment of irony, the person delivering the structure designed to help with demand injured their back in the process and needed to be reviewed in the ED.

Burning down the house – staff sickness

Alongside this, as always with increasing community and hospital infection rates, there has been an increase in staff sickness absence across the NHS. I attended a meeting last week where 20% of the audience was unable to attend due to having COVID. I also know of many clinicians who have avoided infection for the past 2 years only to succumb now as restrictions have been relaxed. To anyone off with COVID at the moment, I wish you a speedy and full recovery.

The latest UKHSA technical briefing (we're at number 39 now) includes PCR data on the healthcare worker SIREN cohort (Figure 21 in the briefing), which show this rise in staff infection rates clearly. The briefing also includes useful data about reinfection and shows that reinfection with BA.2 or AY.4.2 is not uncommon even after Omicron infection and can occur after only 3 weeks. This is a little worrying and makes one think about the benefits of antibodies.

Last Thursday the ONS released data that show 99% of the adult UK population now have antibodies to COVID-19 and the shape of the antibody prevalence graphs show this is mostly related to the booster programme and the Omicron wave. That infections are increasing in all age groups, though, indicates the important factor in protection is more a matter of how many antibodies.

This raises the question of whether healthcare workers should have a further booster. The decision to recommend a fourth dose for people over 75, care home residents or those with a 'severely weakened immune system' (basically those who

were clinically extremely vulnerable in the first wave) was made by the Joint Committee on Vaccination and Immunisation (JCVI) and announced last week. The rationale is based on evidence of lower immunogenicity from vaccination in older individuals and the results of the OCTAVE study which showed that those with certain conditions mounted a poor immune response to the initial two doses. Thus, the fourth dose for all these groups should be thought of as analogous to a third dose for everyone else.

The data show that three doses in healthcare workers with 'normal' immune systems continue to provide extremely good protection against severe illness and hospitalisation. As yet we have no data to show that a fourth dose for healthcare workers would prevent infection and, given all the above data and the ability for BA.2 to reinfect people with recent Omicron or Delta, I guess it is a reasonable policy. However, there remains unease among the clinical community as to the risks of acquiring COVID and we all hope this surge in cases passes quickly.

Wild wild life – variantwatch

The UKHSA is changing its description of variants – those of us used to 'variants of concern' (VOC) and 'variants under investigation' (VUI) will have to get used to just having VOCs. Furthermore, those VOCs will specifically be variants that are currently emerging or circulating, and which have confirmed or predictable detrimental changes in biological properties (changes in transmissibility, severity or immune evasion) compared with the current dominant variant(s) and a growth rate potentially compatible with maintaining transmission and/or displacing the current dominant variant. In short, VOCs will have to be pretty concerning to get the title.

I also note that more recombinant variants are appearing with the rather novel nomenclature for the three identified so far of XD, XE and XF. XD and XF are both BA.1/Delta recombinants and XE is a BA.1/BA.2 one. XE is a bit of a concern as it is growing at a faster rate than BA.2 – around 10% faster by current estimates. I guess there is no surprise such recombinant variants exist, nor will have evolutionary advantages, but they continue to prove the pandemic is not over.

What a day that was – 2 years on

On the exact 2-year anniversary of the prime minister's televised instruction to lockdown, I was in precisely the same place as I had been when I heard his words live that fateful evening. This led me to do some reflecting about all that has happened in the past 2 years and what I have learned. I could easily fill a book on the topic but your time is somewhat limited so I thought I would share some, but certainly not all, draft 'chapter headings'.

The NHS (and other healthcare systems) will never be the same again both from the impact of the pandemic on the workforce but also the shock to normal 'business' and the integration of respiratory infection control into our lives. The system responded as one to combat a new challenge but the biggest limiting factor in our ability to manage the non-COVID work was almost entirely due to the lack of sufficient workforce. The workforce that was there went (and continue to go) far beyond what would be reasonably expected of it.

We were woefully underprepared for the pandemic and political decision making at critical junctures was slow. We got lucky with the success of the vaccine programme and thank goodness we did. Medical research had an evolutionary jump both in respect to how it is organised but also how it is perceived by the public. The public responded well to lockdown but in the main has become desperate to return to 'normal'. Some parts of society, though, including the most vulnerable, took a disproportionate hit from the pandemic and continue to live in fear.

As the public inquiry gains momentum (and I shudder to think how long it will take and at what cost), all of the above will be examined in depth. I have read innumerable books about the pandemic now and wonder how much true learning there will be. Time will tell.

Life during wartime – Ukraine

I have had numerous emails from members saying they are very keen to offer up their homes for refugees from Ukraine and specifically if it is possible to match with doctors and/or their families. As the system stands it is not. No system for matching exists at the moment beyond social media with its inherent risks, and the current paperwork essentially requires a hosting household to know those to whom they are offering shelter. However, some charities are making progress on matching schemes and I know there are specific discussions about matching healthcare worker households at very high levels.

Many healthcare workers in Ukraine are staying in the country to support the war effort and remaining population. Any who have become refugees have also tended to stay in the surrounding countries in the hope that the war will come to an end sooner rather than later and they can return to rebuild the healthcare system. I think we all share that hope.

In my last bulletin I mentioned medical students and the UK's Medical Schools Council has been doing a lot of work behind the scenes to support both UK-born and Ukraine national medical students. A statement last week makes it clear that Ukraine, rightly, does not want to lose students permanently to other healthcare systems and provides a link to support for any medical students who are now back in the UK. The provision of virtual teaching and support for final year exams are tangible things that we in the UK can do to support our fellow medical schools in Ukraine.

I also briefly mentioned the risks of a nuclear incident in my last bulletin. Potassium iodide supplies have been raised as a concern, perhaps due to the use of that chemical in televised dramas. I have had some very helpful advice from senior public health advisers on this topic. Looking at the data, thyroid disease post-Chernobyl in Ukraine and Belarus was mainly restricted to children, and primarily caused by inability to remove radioiodine from the food chain rather than direct external exposure.

Stable iodine prophylaxis has limited applicability, usually only to a relatively short range downwind of a release from an active reactor (most radioiodine products have a very short half-life and are not sustained in the absence of ongoing fission processes). Apparently, sheltering in a standard building is the best way of averting initial risks and will reduce 85% of potential external exposure. Long-term risk management is all about focusing on the food chain. So now you know. The fact that we even need to consider this shows the instability of the world we now live in.

Found a job – elections

I hope by now all fellows have voted in the RCP elections. If you haven't and are worried you haven't received the email, please look for an email from CES or takepart@cesvotes.com in your inboxes, sent on 9 March. If it isn't in your junk/spam inbox and you haven't received the email, please contact membershipqueries@rcp.ac.uk. Importantly, there are no papers being sent out as we are doing our elections entirely online except for those attending College Day.

To help voting decisions, we've set up a meet the presidential candidates webpage behind the MyRCP login which hosts our first-ever hustings for president video recording as well as the candidates' written answers to questions posed by the membership. This is available for both members and fellows to view. And you can find out more about College Day on Monday 11 April, including the special general meeting of fellows for the election of the president.

The RCP has not been the only organisation voting for new Council members and presidents – others include our sister colleges of emergency medicine and radiologists as well as the BMA (other unions are available). Congratulations to Adrian Boyle, who will be the next RCEM president, and Katharine Halliday, who will be the next RCR president. There will be a significant changing of the guard across the colleges this summer.

Last week I received my voting papers for the BMA elections and spent an hour going through the 221 candidates' election statements and then filled in the voting form (which looked more like a winter medical outliers list than a voting form). I would hazard to suggest that it is meaningless to present a list of 221 names for people to rank and if I was involved in BMA Council (don't worry Kevin, that is not on my bucket list) I would start by reforming the election process to make it more manageable. I am staggered that some have been on Council for 3–4 decades and worry more that it all had to be done by post.

I did some 'back of an election pack envelope' calculations on the impact of a paper vote. There were 39 pages of A4 paper and a membership of 160,000. As one tree will produce 10,000 sheets of paper, this amounts to over 600 trees or roughly an acre's worth. The papers state that it is required by law that the election is held by post and my digging suggests that this is due to trade union laws preventing online voting. This is not the BMA's fault but is pretty frustrating.

Stay up late – Medicine 2022

I've spent some time over the past few weeks filming content and preparing for Medicine 2022, which will be taking place on Thursday and Friday this week. Last year our annual conference was completely virtual, so I'm particularly looking forward to the in-person elements happening across both days this year, and, for the first time ever, in two locations.

After spending day 1 at the RCP at Regent's Park, I will be taking the train up to Liverpool and hosting the drinks reception at RCP at The Spine, so hope to meet delegates face-to-face at both sites. Highlights of the conference include: the keynote lecture by CMO Chris Whitty on 'The relative roles of the state, the medical profession and the individual in improving public health'; an interview with the health secretary Sajid Javid about health disparities, workforce and his vision for the NHS; and a session on the immediate future of the NHS with key NHS leaders.

Lighter moments will include the RCP going head-to-head with the Royal College of Surgeons in a University Challenge style quiz and 'Physicians bake!' with the RCP senior officers and their partners (a baking challenge accompanied by discussion on key medical topics such as training as a medic, the pandemic, health inequalities and more).

There's still time to book your place.

Don't worry about the government – workforce campaign

Thank you again to all members and fellows who have written to their MP about the #StrengthInNumbers campaign for better workforce planning in the Health and Care Bill. As you will know from the email that was sent last week on this topic, the bill is due back in the Commons this Wednesday. Government is likely to remove the amendment that was passed in the Lords – but it's not over yet. It's key we continue to make noise about the amendment to encourage government to move on this issue. The RCP will keep making the case for it, and we appreciate the support of members who have raised this with their MP. I'm also grateful to many influential people on Twitter who have raised the profile of the campaign.

If you can manage to do it by Wednesday morning, you can still write to your MP using a template letter we've created to ask for their support on this amendment.

Take me to the river – farewell to the National Guideline Centre

I'd like to acknowledge the significant contribution made by the National Guideline Centre (NGC) team as the centre transitions from the RCP to NICE on 1 April. The NGC was first launched and hosted at the RCP some 13 years ago to develop evidence-based guidelines commissioned by NICE. It is one of the largest guideline centres in the world and through the delivery of hundreds of clinical, social care and service delivery guidelines has achieved international recognition as a global standard for robust and fair healthcare prioritisation. We wish the team every success going forward.

Dream operator – a change of treasurer

Later this week Professor Chuka Nwokolo CBE will demit as RCP treasurer and be replaced by Professor Simon Bowman. Chuka has been a steady hand through the turbulent waters of the past few years and has gently but firmly changed the governance of our finances to those that are needed by a modern charity. The closet has been de-skeletonised and I hope Simon will have an easier job because of it. His forethought to create a 'war chest' made us more ready for the pandemic than we might have been and his drive to decarbonise our investments put us ahead of the field.

I will miss Chuka's humour, his wisdom and (if I'm honest) his occasionally indiscreet ability to tell it exactly how it is. He has been a tremendous support to me over my presidency and has made the job both easier and more fun by his presence. The RCP and specialty of gastroenterology owe him much.

...and finally

I managed a couple of days break last week in Wales (like many I was desperately trying to take some annual leave before the end of the month). The sunny empty beach was a world away from everything that is happening at the moment and it was good to have some downtime.

While it was only a short recharge, I really appreciated how it made me feel and remembered the importance of us looking after ourselves. It is hard to care for others if we are not there because we haven't taken care of ourselves.

11 April 2022

This week's bulletin starts off with some news of hope followed, I'm afraid, with some less optimistic paragraphs. It has been written during a rather busy on-call weekend and so may have some rough edges, for which I apologise. The first news, though, is as fresh as this bulletin has ever seen.

If I was president – election results

Within the past hour the votes for the next president have been counted by Civica and announced to the College Day audience. I'm delighted to say that the next PRCP will be ... David Oliver.

Most will know a bit about David but for those that don't, he is a geriatrician based at the Royal Berkshire Hospital in Reading. He has previously been president of the British Geriatrics Society and clinical vice president of the RCP. He writes a weekly column for the BMJ so is well known to many outside of the world of physicianly medicine.

I will write more about the transition between presidents in a future bulletin but hope that David enjoys the moment. It only gets harder from here!

It was a well-fought election and the voting patterns show how highly all the candidates were rated by the fellowship. It is quite a brutal process to put yourself up for election and never easy when someone else is voted in. I thank all of those who ran for showing such commitment to the RCP in their willingness to stand for PRCP and I wish them all ongoing success in their careers moving forwards.

Killing me softly – COVID and NHS pressures

The current BA.2 wave of the pandemic in the UK does look as though it is peaking/has peaked. ONS data on Friday showed infections in Scotland are falling and they are plateauing in other parts of the UK.

NHS services, though, are in meltdown and it feels like the death of the NHS by a thousand cuts. In my own trust last week we were diverting ambulances for the first time I can remember in my 21 years here. This weekend has been hard to say the least. Talking to colleagues around the country, the sustained busyness of the wards due to delayed discharges, combined with colleague absence from COVID and Easter holidays, are making it hard to cope. One by one colleagues are testing positive and I know the picture in primary care is no better. Hopefully the virus will run out of susceptible people soon and the wave will come to a natural conclusion.

What happens then is the question that those high up in UKHSA, the NHS and (hopefully) the DHSC are thinking about. COVID levels have been high for 9 months now and the NHS has been 'living with COVID' for that time. Many think we will continue to have a plateau of infection with cases not returning to the low levels last seen a year ago. This has substantial implications for the NHS, especially one that wants to increase elective activity by 30% above pre-pandemic levels (he types as that pig flies past the window again).

Currently just under 7,000 (42% of the 16,600) patients in NHS hospitals in England were admitted because of COVID-19, rather than just having a positive test on admission. In a quiet moment waiting to see a patient over the weekend I played with the data over the past 9 months since July 2021. To my reckoning there were at least 3,650 patients hospitalised with COVID on any one day – equating to 4% of the bed base. Surely we need to plan long-term for this increased demand that we didn't have in 2019. Without such capacity the system will never achieve the (aerial porcine) ambitions set for it.

Part of this depends on the workforce and I'm pleased that the #strengthinnumbers campaign continues to make progress. The amendment to the bill running through parliament was passed in the House of Lords last week as part of the 'ping pong' process such bills go through. I only hope the parliamentarians in the Commons will start to see the wisdom in the amendment as well.

We trying to stay alive – long COVID

Last week the ONS also produced an update on long COVID and the number of people who still have symptoms following infection remains worryingly high. The ONS estimates there are 1.7 million people in the UK who are still experiencing symptoms at least 4 weeks after infection, and 784,000 a year afterwards. 19% of those surveyed say that their symptoms limit their daily activities 'a lot'.

We need a bit more detail on the latter to understand how much resource to allocate to those with long COVID. There is no doubt in my mind that many healthcare workers acquired COVID 'in the line of duty' and most trusts are putting a lot of effort into supporting those with long COVID (mine included). Unions and patient groups are calling strongly for long COVID to be classified as an occupational disease, and for specific compensation for those affected. The former is likely to take many years, as proving causality will be a significant challenge given the high prevalence of infections in the community in all waves. The SIREN study suggests that at the wave 2 peak in late December 2020 around 28 per 1,000 healthcare workers were infected. ONS data suggest that at the same time there were 20 cases per 1,000 in the community, ie around one in three cases could potentially be attributed to working in the NHS.

To add to the complexity of proving causality, many other key workers in other occupations are likely to have acquired COVID at work, such as bus drivers and supermarket workers, and may have acquired infection travelling to work. Furthermore, COVID has had broader impacts on worker health apart from just having the infection, including mental health problems. There will be no quick answer to this conundrum.

I think it is important that we understand how many healthcare workers are severely affected by long COVID, although as I understand it there are no hard data on how many are off work and/or limited in their ability to do the job they did before they got COVID. A wise GP colleague reminded me last week that many will have major symptoms from long

COVID but continue to work, as they have no choice and need the income. Hard data would be useful.

Ready or not – Ukraine

Although the rate of refugees arriving in the UK is painfully slow, we are now seeing a steady influx. The NHS has produced a webpage with advice for primary care when seeing Ukrainian refugees. I think this should be read by everyone in healthcare, not just those in primary care, as it contains a few important facts and pieces of advice.

Unsurprisingly Ukrainian is the commonest language spoken in Ukraine (68%) but 30% of nationals speak Russian. Using the latter has obvious cultural sensitivities at the moment, so getting the right translator needs to be done carefully. Mobile apps to help translate are not encouraged as they struggle with health language.

Before the war Ukraine had high suicide rates: almost 30 per 100,000 compared with a global average of 10. Men have a much higher rate than women – 56 per 100,000 vs 8. The psychological impact of the war, as well as that of being a refugee, means that we should have a low threshold when considering risk of mental health problems and should be routinely offering support. Estimates of PTSD range from 30% to 70%.

Vaccination rates in Ukraine for many infections are lower than average so consider infections that you might otherwise not. Multi-drug resistant TB (MDR-TB) is common in Ukraine, which has the 4th highest rates in the 53 countries of the WHO European region. UKHSA recommend routine screening for active TB in those arriving from Ukraine and if you see someone with shortness of breath it needs to be high on the differential. HIV rates are also high and may be higher than measured due to underdiagnosis.

Thinking about TB, there was an excellent article in *The Lancet* a couple of weeks ago about how we should optimise TB care for refugees from armed conflicts and I am grateful to Ali Zumla for pointing me to it. The COVID pandemic has pushed back the global advances in TB care and the war in Ukraine will have dented them further. However, many lessons can be learned from the pandemic and if applied we may be able to achieve the WHO aim to 'Stop TB'.

Two wrongs – trainee (or maybe not) issues

Last week saw the publication of Scarlett McNally's report 'What should we call junior doctors?'. The report is a good read and it calls for abandoning the terms 'junior doctor' and 'trainee' and replacing them with the term 'postgraduate doctor'. It suggests four grades – FY1, central doctor, registrar consultant – as these map to the four tiers we described in our safe medical staffing report in 2018 (always good to be cited like this). The report was commissioned by the NHS and supported by Health Education England – although I note it lacks the branding of either organisation, which is slightly odd.

Rightly, the report acknowledges that this isn't about what doctors want to call themselves, but how others understand their roles. The report followed a 3-year consultation process with over 2,000 people and I have a massive amount of respect and time for Mrs McNally, who is an orthopaedic surgeon on the south coast of England (and was the year above me at medical school, so is definitely in an outstanding group that includes two of the PRCP candidates). I have to confess, though, I am really struggling with the term 'central doctor' and can't get it out of my head that 'postgraduate doctor' is a tautology.

The report specifically recommends that surgeons can refer to themselves as surgeons rather than doctors if they have passed surgical exams and are working in a surgical department. Why not a physician if someone has MRCP(UK) Part 1 and working on a medical ward (he bristles)?

We (the three physician colleges) will ask our trainee committees (which may have to be renamed) what they think they as individuals, and indeed as committees should be called. When it comes to doctors on wards or in clinic I might suggest using 'medical SHO' if they are in the first two years of

internal medicine training or have completed FY2 and are working on a medical ward. That's what people call themselves when they phone me up and I suspect that most of us know what it means. 'Medical registrar' can be used for IMY3 and above.

Take me as I am – neurodiversity in postgraduate doctors (I'm trying Scarlett)

I am a member of the Society of Occupational Medicine (and am very honoured to be so) and thus get their regular eNews bulletins. The latest contained a very useful document 'Evaluating and supporting neurodifferences at work'. Neurodifferences is a term used to describe a range of conditions including dyslexia, dyspraxia, autism, Tourette's and ADHD. Many use the term 'neurodiversity' as many of these conditions have a broad range of manifestations and in some can be of benefit in certain settings.

While at Medicine 2022 I had the chance to catch up with someone who describes themselves as neurodiverse and they made a compelling case for us thinking much more about neurodifferences than perhaps we do. Delays in diagnosis of neurodifferences can often lead to those in training being mis-labelled as 'difficult' or 'introverted' or even 'in difficulty'. However, once a condition is diagnosed it allows for much more targeted training and allows individuals to understand their strengths and play to them. People with dyspraxia may struggle to find their way around a hospital or ward, but are methodical and diligent. People with dyslexia may struggle to filter out background noise, and so need a quieter place to write up notes, but are organised and have better than average non-written communication skills.

Hearing such personal stories has made me completely rethink how I relate to 'doctors in difficulty' both as a supervisor and part of an MDT. You may not agree with the term 'neurodiversity', but when faced with someone who doesn't behave the same way you do, it is worth stopping and asking why that might be.

Gone till November – Medicine 2022

Having mentioned Medicine 2022, it is worth a quick precis for those who could not make it. Over two days we had 1,219 delegates and 101 speakers from 16 different specialties. The most highly rated session (unsurprisingly) was Chris Whitty's talk on the role of the medical profession and the state in public health. However, feedback for both days and both sites was very positive – a big 'thank you and well done' to all those involved in organising it is definitely merited.

We will release some of the content for RCP members over the next few months but most will remain only available to those who registered. It will remain viewable until the end of September 2022 and can count for up to 16 CPD points (something I am personally relieved about as I need to get my CPD diary up to date).

The next major RCP conference is likely to be 'Med+' in November or October but planning is under way as to how we follow-up the success of Med+ 2021 and Medicine 2022.

...and finally

We had our first face-to-face Council meeting the week before last and it was great to see everyone again (a couple couldn't make it as they tested positive beforehand and I think this is a pattern that will persist for many months). The face-to-face nature allowed for many useful conversations either side of the meeting proper.

I've been thinking a lot about climate change over the past year and it cropped up in one such conversation. Someone had put measuring their carbon footprint and trying to reduce it by 10% as one of their PDP objectives for the year. Their appraiser had asked for it to be removed as it 'wasn't relevant'. Climate change denial continues it seems. Maybe we need to make a formal statement that such objectives should be part of everyone's development.

25 April 2022

I hope you have survived the spring holiday season and 4-day NHS weekend that has gone with it. The news that the NHS has been running short of bed linen this week would be worth a quip were it not a sign of how dire things are at the moment. I have been trying to find out why this issue has cropped up – sickness among laundry staff, supply chain issues and too many patients all spring to mind. Maybe someone has been literally cutting hospital corners…

I have been a bit distracted over the past 2 weeks but hopefully haven't missed too much. Here is where I see things as of today.

Free fallin' – COVID cases

In the UK COVID cases are definitely on the decline both in the community and in hospitals. The latter comes as a relief to many. Thankfully, infections in healthcare workers are also falling. I am told that those infection rates have been the highest at any point in the pandemic, topping out a couple of weeks ago at over 110 cases per 1,000 tested who did not have evidence of prior infection (according to the SIREN study – personal communication), which compares with 30 per 1,000 in the first wave. Like most pandemic waves, the virus is now probably running out of people to infect.

New variants continue to arise which will be no surprise to faithful readers of this bulletin. Those travelling to the north east of the USA for the American College of Physicians' meeting in Chicago this week will be a little uneasy at the rapid spread of the BA.2.12.1 lineage in that part of the country. However, it is the emergence of BA.4 and BA.5 mutations in South Africa that is making most variant watchers a bit twitchy. These variants seem to have acquired mutations that enhance evasion of the innate immune system and increase infectivity and are now being seen in large numbers there. It is the presence of the mutation F486V which has people most concerned, as this previously rare mutation does seem to be associated with a significant drop in neutralising antibody effectiveness.

Having said that, as yet there is no increase in hospitalisations in South Africa and, given BA.4 and BA.5 became dominant there 3 weeks ago, we can probably avoid catastrophising for the moment. As always, I caveat this with a 'but the situation needs watching'.

Don't come around here no more – 'wildly contagious' variants

I found an article (with some very good diagrams) published in February in Scientific American which explains why new variants are more transmissible than older ones, or 'wildly contagious' as the headline writer put it (you've got to love medical journalists). I was aware of the increased number of mutations on the receptor-binding domains and the increased stability of spike proteins that Omicron and its successors have, but the loss of the need for both ACE-2 and TMPRSS2 receptors for cell entry as a hypothesis was new to me.

TMPRSS2 is expressed in lung tissue and much less so in the upper respiratory tract (URT). Early mutants needed to infect deeper lung tissue to replicate but newer variants can happily multiply in the upper parts of the respiratory tree, explaining both the change in symptoms being seen (and recently acknowledged in guidelines of when to get tested) and the ease of transmission.

I can attest to this. Exactly 6 months after my booster I succumbed to BA.2 (almost certainly) the week before last with URT symptoms and a remarkably positive, then stubborn second line on lateral flow testing. It still hasn't faded as of this morning (day 13) and my tracheal and naso-pharyngeal mucosa have been given a good seeing to. My T-cells are not quite as brilliant as I thought they were.

Out in the cold – cost of living

Most readers will have seen the effect of the war in Ukraine on their energy bills, and the predictions of fuel poverty over the next winter or more are frightening. These soaring energy prices are already having an impact on some groups of patients, especially those on home ventilation or dialysis.

While oxygen and disposables costs are directly covered in the UK by the government (although rarely to a sufficient degree), the power costs to ensure the equipment works, are not. Costs for powering mechanical ventilators and/or oxygen concentrators are significant and estimated by one Spanish group last year as being up to £40 per month (which now looks conservative). Respiratory medicine colleagues are now hearing stories of patients choosing to turn off oxygen supplies to save money.

This issue is going to need hard lobbying by clinical leads and hospital executive teams to sort and I note that the doctor in charge of the PM's ITU stay in 2020 has raised this issue with him. The British Thoracic Society is working with clinical leads to work with trust chief executives to write to ministers on this issue and I understand the chief scientific officer is also on the case. If you are such a clinical lead and have not yet had a chance to do this, please contact rachael.moses2@nhs.net

It is a(nother) striking example of how poverty widens health outcomes. Respiratory disease – and in particular smoking-related and pollution-related disease – disproportionately affect those least able to afford to improve their social circumstances. It seems likely the cost-of-living crisis will widen this disparity further.

As members will know, the RCP convenes the Inequalities in Health Alliance, which has brought together over 200 organisations to campaign for a cross-government strategy to reduce health inequalities. We're asking members to contribute real-life anonymised examples of patients whose health has been negatively affected by factors such as poor housing, air pollution, deprivation or not being able to afford to eat healthily. We will use these in media and influencing work. You can fill out a short three-question survey.

I won't back down – workforce amendment

As regular bulletin readers will know, the RCP has been pushing several amendments to the Health and Care Bill since it came before parliament for the first time last July. We expect that the bill will finish its final stages this week and then receive Royal Assent to become an Act of Parliament. Despite the House of Lords voting for a second time to strengthen workforce planning in the bill, the Commons is standing firm in its refusal to accept this amendment and looks set to take it out today. To say I am frustrated with this would be an understatement.

The #StrengthInNumbers campaign has been a loud voice in making the case for better workforce planning and I'd like to thank all members who have written to their MP about it. It is really disappointing but the campaign is not over – the RCP will continue to make the case for a fully funded workforce plan that improves recruitment, retention and morale to ensure we have enough staff to meet demand. The bill itself will put ICSs on statutory footing, something the RCP supports, and we can be pleased that we have enjoyed successes with government listening to our calls on health inequalities and clinical research and introducing amendments on these issues that will soon become law.

Into the great wide open – hepatitis in children

Although most physicians will not have come across a case they will not have missed the news of a large number of hepatitis cases in children in the UK. As of Thursday there had been 108 such cases with eight needing a liver transplant. 'Non A-E' hepatitis is well recognised in children but not at this scale or severity.

The conspiracy theorists have been looking to COVID-19 or vaccination. None of the 108 children had been vaccinated so that theory should be

thrown out with vigour and efforts focused on more relevant infections. Where tests have been performed, 77% of cases have had evidence of adenovirus infection and this seems the likely culprit. There are over 80 adenoviruses that are known to infect children and Ad-41 is getting a lot of attention as the most likely suspect – it is typically associated with gastroenteritis rather than respiratory illness. Ad-41 can be hard to detect, so ensuring that samples are sent to reference laboratories will be critical to getting a clear understanding of its role.

The details of cases in Scotland have been published and show that most of the children are between 3–5 years of age. One theory is that the pandemic has delayed children's exposure to viral infection and thus the immune system is exposed at a different stage. We know from previous pandemics that other infections will rise as a population returns to normal activities and mixing more widely, and sadly will need to be vigilant for the re-emergence of other infectious diseases over the next 12 months.

Runnin' down a dream – elections

If you missed it (what were you doing?) the special general meeting for the election of the new RCP president was held on Monday 11 April 2022 as part of College Day. Videos of my address and the announcement of the election result are now available for all members and fellows to watch (behind the login).

As well as electing David Oliver as my successor we have now announced the results of the clinical vice president and councillor elections. I'm pleased to report that John Dean will take over from Sarah Clarke as CVP from the end of July and, given his close involvement with RCP work in the clinical sphere over the past few years, will be able to hit the ground running.

The four elected councillor positions went (alphabetically) to Toby Hillman, Khin Swe Myint, Ajay Verma and Hilary Williams. All four have been instrumental in the RCP response to the pandemic and other challenges that have come our way, so again will be able to bring their shoulders to the wheel immediately. If you want to know more about any of the candidates, the link above gives a detailed biog for each. I welcome them all and am sad that I will only have 6 weeks to work with them in their new roles.

We are still looking for fellows to take up senior roles in the college and are recruiting for two new RCP censors to serve for 3 years from 1 August 2022. The role of censor is an ancient one going back to the origins of the RCP and the royal charter of Henry VIII. Censors have always been concerned with examinations, maintaining standards and education. Over time, the role has developed to participate actively in the workings of the RCP and it offers a real opportunity to provide wise counsel and to help influence and shape RCP outputs. Censors must be RCP fellows, and their current focus is on physician wellbeing, and diversity and inclusion. Find out more about the role and apply – the deadline for applications is 12 June 2022.

All the wrong reasons – GMC taxonomy

A report was released this week that got little (or no) fanfare but may have implications for how all of us interact with the GMC in the years to come. It looks at how the medical register might record what we all do in the form of a taxonomy of medical practice. I need to put my cards on the table here as I was involved in a previous attempt at this many years ago. The exam question then was 'how can patients be assured that the doctor they are seeing has the relevant skills in a particular specialty?'. Together with the medical specialties we came up with a two-tier structure of main specialty (eg gastroenterology) and subspecialty (eg nutrition, inflammatory bowel disease, endoscopy). Unfortunately, the rest of the world of medicine were not keen on such scrutiny and it fell by the wayside.

The University of Newcastle was commissioned to do this work and has come up with the idea of a '10-descriptor list' from a list of 33 roles with a

rather complex looking tree of hierarchical clusters. The roles seem rather simplistic, such as 'prescribe medication' and 'remote assessment' and I am not sure even with detailed reading of this taxonomy any patient would be able to answer the original exam question above.

I don't know what is going to happen next. Maybe we will all have to say which parts of the taxonomy we do or maybe each specialty will have a specific cluster. Given that I reckon I do 31/33 on the list that may be problematic. For the moment, when patients ask me what I do, I will continue to say I'm a gastroenterologist with interests in endoscopy, inflammatory bowel disease and cancer. I think Mr Ronseal would be happy with that.

Feel a whole lot better – fibromyalgia guidelines

We've recently published new guidelines on the diagnosis of fibromyalgia syndrome (FMS). The condition is common – with a worldwide prevalence of 2%. However, it can be challenging to diagnose as the symptoms can vary, can be multiple and may fluctuate. A common experience for patients is for diagnosis to take time and be a drawn-out process, sometimes taking many years.

The new guidance aims to support patient-facing clinicians to consider a diagnosis of FMS. The idea came from wanting to improve the experience and outcomes for a group of patients who can often struggle to be heard. Although the official launch is in Liverpool tomorrow at RCP at The Spine, the guidelines are available to download, along with a diagnostic worksheet and two information sheets.

...and finally

Sitting at home in isolation for days on end has taught me that I am more of a social creature than I thought and that physical contact is important to me (not that sort to those of a furtive imagination!). Having to see my daughter off through a window as she went back to uni without being able to hug her goodbye was tough.

It reminded me that as hospital visiting remains restricted, our patients may feel much more 'alone' than they let on. We are all horrendously busy but taking a moment more of time with them, holding a hand (provided ours are washed!) and being kind remain the markers of great physicianly practice – and I'm not sure any taxonomy is going to be able to describe that.

9 May 2022

This will be a relatively short bulletin as I am currently out of the UK and travelling between various AirBnBs, friends' spare rooms and the occasional hotel. Despite my absence from the UK, the world has kept spinning and events have continued to happen. Here is my view from afar.

Not alone anymore – COVID-19

According to the ONS, infections in the UK have fallen to levels not seen since November 2021. This is a welcome relief and there is a palpable improvement in staffing absences in the NHS and a downturn in inpatient cases. There is some concern around the BA.4 and BA.5 variants which have taken centre stage in South Africa, but according to the latest UKHSA technical briefing issued on Friday, by the beginning of last week only 21 confirmed cases of BA.4 and 19 cases of BA.5 had been detected in the UK. The BA.1/BA.2 recombinant variant XE is much more established with 1,880 cases in the UK and is perhaps more of a worry, although this is still a drop in the ocean compared with BA.2.

If we focus on South Africa, infection levels have increased to 23% of their peak, although hospitalisations are still holding reasonably steady. Laboratory studies emerging around BA.4 and BA.5 suggest that previous infection with Omicron BA.1 will not provide much protection, especially in unvaccinated individuals. More clinical data should be available over the next few weeks. From the experience in South Africa it seems likely, though, that it will be a case of how big the BA.4/BA.5 wave will be in the UK, rather than if there will be one.

Looking around the rest of the globe I see that Taiwan is experiencing an Omicron wave and there are considerable fears about how its health system will cope, due to the lowish levels of vaccination in the over-75s. Taiwan and China are the only two countries that have continued a 'zero-COVID' policy but they are now adopting very different approaches to the pandemic, as discussed in a helpful article in the *Wall Street Journal*. China continues a harsh 10-day quarantine for close contacts and very close surveillance of cases and contacts, while Taiwan has abandoned mass contact tracing and reduced isolation of close contacts to 3 days. Although they are only separated by 100 miles, when it comes to COVID-19 it seems the way they are managing the pandemic is worlds apart.

The WHO has published estimations of excess deaths associated with COVID-19 by country and it comes to a total of around 14.9 million up to the end of 2021. Looking at the data by country, these are much the same as those in the Lancet paper I discussed a few weeks ago. Unsurprisingly, high-income countries have been much more accurate in their attribution of COVID deaths than lower-middle- or low-income countries. The UK had an excess death rate of 109 per 100,000, which compares with a global average of 96. Much has been made of the low excess mortality in China (-2 per 100,000) and Australia (-28 per 100,000) and both have had the advantage of keeping infection numbers low while vaccination has had its chance to reduce the impact of the disease. Both countries' approaches should be reviewed to understand what worked well when planning for future (inevitable) pandemics.

End of the line – the NHS workforce and the COVID backlog

Last week NHS trust leaders were sent a letter suggesting 'enablers' to retain, and indeed increase, the workforce to support the elective recovery. Reading through this letter and the enablers there is much to commend and it must be remembered that the enablers are not just for the medical workforce. However (and it is a big however), there are as many 'disablers' in the system that will offset most of the enablers when it comes to the medical workforce.

The letter rightly identifies that improving recognition of non-clinical activity – and in particular educational and leadership activity – in job plans will improve the quality of working lives, and is likely to reduce burnout and increase retention. Unfortunately, though, increasing contracted hours in job plans is fraught with punitive pension taxation

and we know that on average physicians work 11% above a 'normal' 10 PA job plan. There is not much additional juice in the physician workload tank.

The issue with pensions is assuming a larger and larger disincentive for those in consultant posts. The recommendation in the letter is to remind staff that 'scheme pays' will allow them to delay the payment of annual allowance charges. I don't find such an option in any way attractive and suspect that neither do my colleagues.

It is worth reading the letter to see what you think, especially if you are in a clinical leadership position. There may be some tweaks that will help, but I worry that those tweaks will be a drop in the workforce crisis ocean.

Handle with care – Good medical practice

Over the past week there has been a bit of a social media storm about the proposed wording around 'kindness' in the new GMC Good medical practice guidance which is currently up for consultation. I have written my May *Commentary* leader on the importance of kindness in the role of a physician and feel strongly that being kind is very different from being nice, and that we should all strive to be as kind as we can.

I also recognise, though, that the pressures we are working under at the moment are extreme and that treating all patients with as much kindness, courtesy and respect as we would like can be impossible. Thus, my own suggestion around the phrase related to kindness in the consultation is to change the wording. As I say, I have written more about this that you can read in the coming weeks.

It is important that the GMC get as much feedback around the new guidance as possible. A social media storm is a teacup-restrained thing unless it is fed back formally to those overseeing that guidance. The consultation can be found on the GMC website, although you will have to confirm you are a human to access it. There is irony in that somewhere.

Heading for the light – RCP policies

A short survey will be landing in your inboxes soon to ask for your views on the RCP's policy and campaign priorities for the next 4 years. This is important as it will set the tone for David Oliver's presidency. When we did this at the beginning of my presidency the four areas you, the membership, chose – workforce, health inequalities, research and NHS structures – proved to be exactly the right ones, especially in the light of the pandemic.

It may be that you feel we should keep these or that we should shift focus. Please take the time to respond and help shape the external outputs of the RCP – your input is vital.

Congratulations – The Spine anniversary

It's been 1 year since RCP at The Spine officially opened in Liverpool. With its state-of-the-art facilities, our new northern home has brought the RCP into the heart of a medical and scientific precinct in Liverpool's Knowledge Quarter. Our presence there is helping us to become more involved in the health of the local community, supporting one of our major policy initiatives to reduce health inequality.

The building itself is spectacular – if you haven't yet been I hope to see you at some of the excellent events and activities taking place there over the next few months, including our first regional Update in medicine conference of the year on 19 May. I am really excited to be re-starting the RCP updates again – another sign that COVID is not holding us back. 19 May is also the day that a new exhibition opens in The Spine, the first to be held there. SELFLESS, by photographer Jessica van der Weert, documents the early days of the pandemic with Northumbria and Brent healthcare staff, including some of our own fellows and members. Do take a look if you are in the building – the exhibition is in Liverpool for a month and then moves to London for July.

Dirty world – new RCP exhibition

The new exhibition by the RCP museum team, 'A taste of one's own medicine – medical satire at the Royal College of Physicians' opened last week at the RCP at Regent's Park. The exhibition explores the enduring appeal of satirical images, and how doctors have been ridiculed, reprimanded and maligned for centuries. It is important we laugh at ourselves and the way we are and have been perceived by society over the centuries. The bubble of pomposity should always be burst.

Medical professionals in the past were represented by satirical artists in a variety of uncomplimentary ways, but we don't often get to see how doctors viewed themselves. How would you represent the medical profession? Our cartoon competition invites you to create an artwork to show your view of the medical profession. Find out how to enter for the chance to appear in the exhibition and win exclusive prizes.

...and finally

At the American College of Physicians' conference last weekend we had a global forum where college and internal medicine society presidents compared and reflected on the experiences during the pandemic.

The personal accounts by many were moving and one speaker was moved to tears as they recollected the trauma of looking after patients with the deadly combination of COVID-19 and limited resources. I know that speaker was surprised by the strength of their emotional response and I do wonder how much the stresses of the past 2 years have been internalised by us all and are awaiting an outlet.

I've taken some time to catch up with old friends over the past week and it has been therapeutic to talk through the difficulties of the pandemic with trusted people outside of the NHS. I would recommend it.

23 May 2022

I'm back from my travels outside of the UK and now travelling inside it. The first in-person regional update since pre-COVID times was in Liverpool last week and it was brilliant to see so many colleagues enjoying learning and meeting together. I also had to stand up in front of them in the traditional 'open forum'. This week's bulletin gives a good taste of the topics of the day that we talked about.

Me and my monkey – a new infection to worry about

Monkeypox has been stealing the health headlines from SARS-CoV-2 and there is much noise in the media. As I type this there have been 20 confirmed cases in the UK but the latest updates from the UKHSA will give the most up-to-date numbers.

I first learned about monkeypox when I visited the High Consequence Infectious Diseases (HCID) Unit in Newcastle a year before COVID-19 hit, and Matthias Schmid got me to don the full biohazard suit to experience what it felt like. So I was a little twitched when I heard that the virus had appeared on UK shores again. ID and GUM colleagues have reassured me that I do not need to worry too much about this current outbreak. There has been a steady trickle of cases of monkeypox over the past decade in the UK (the last was in Wales in June 2021) but this current outbreak is the largest outside of Africa for a long time and the community spread of infection has been described by some respected experts as 'concerning'.

Monkeypox is, unsurprisingly, a poxvirus and related to variola virus (the cause of smallpox), vaccinia virus (which helped us eradicate smallpox) and cowpox (Jenner fans will be getting excited as we approach a major anniversary of his life). There are two main types arising either from the Democratic Republic of Congo (DRC) or from West Africa respectively. All of the current cases detected are identified as the West African clade through a specific PCR and thankfully it is the milder of the two

– DRC monkeypox is a much more lethal and scary form of the disease. It is thought to be spread by rodents in forested parts of Africa but is transmitted to and between humans and primates.

The disease caused by West African variants is relatively mild with pyrexia, malaise, lymphadenopathy and rash the main clinical features. The rash is variable but typically starts on the face and neck and can affect the whole body including the genitals. It often becomes vesicular and looks a bit like chickenpox, with similar crusting and potential for scarring. There are some images of the lesions on the UKHSA site but given how common such lesions are in other systemic viral infections and skin infections, clear (and consistent) public health messaging, access to clinics where diagnostic tests can be performed and contact tracing of close contacts are going to be the best ways to identify cases and reduce the spread.

Monkeypox is spread predominantly through close contact with infected clothing, skin, shared utensils and bed linen and potentially large droplet transmission via the respiratory route. While it is not a sexually transmitted disease, it can certainly be transmitted by close contact while having sex. The mortality of West African monkeypox is around 1 %, but as large outbreaks have tended to occur in Nigeria in pre-pandemic times it is likely this is a substantial overestimate due to under-ascertainment of cases. With early identification, the availability of ITU support and potential treatment for severe cases, we would expect this to be much lower in the UK.

The UK guidance for managing this outbreak of cases has taken a highly precautionary approach and the four UK public health agencies are currently reviewing the evidence and guidance and working with the World Health Organization. The updated principles for management will be available on the UKHSA monkeypox page and for England, will link across to the NHS IPC manual. 21-day isolation for closest contacts is currently advised. The NHS website has information for patients which is also worth reading in case a patient asks you anything about it.

Lastly, on a bit of a tangent, 2 weeks ago I was desperately trying (and failing) to figure out how I could include 'Tweeter and the monkey man' as one of my song titles to go with my Traveling Wilburys theme for the bulletin. Fate is a fickle thing and 2 weeks a long time in medicine.

Eternity – COVID-19

While the media have moved on from COVID-19, the medical community has not and there were still over 700 deaths in people positive for COVID in the UK last week so probably around 300 directly from the infection. This is still a very significant number. Hospitalisations have continued to fall with levels now similar to the middle of July of last year – remember 'Freedom Day'?

The NHS is keen to set out the next steps and 840 days since the pandemic was declared as a 'national incident' in the NHS, the incident grading has been reduced from Level 4 to Level 3 and the advice is to start transitioning to pre-pandemic policies. If you want more detail on incident levels they can be found on page 9 of the NHS England Emergency preparedness, resilience and response framework. In short, though, this change of level devolves planning and control from a central to a regional basis.

The JCVI has also announced that there will definitely be an autumn booster as part of the COVID-19 booster programme. As yet we don't know what vaccine will be used (although the odds are on a non-mRNA based one) but we do know which groups will be vaccinated:

- residents in a care home for older adults and staff
- frontline health and social care workers
- all those 65 years of age and over
- adults aged 16 to 64 years who are in a clinical risk group.

We (the RCP and the medical specialist societies) are continuing to work with the NHS to ensure there are more robust ways to identify the latter group. This remains a considerable challenge and currently identification requires a lot of work from all parts of the system in primary and secondary care, as well as creating confusion for clinicians and patients.

The BMA has published two reports into the government's handling of the pandemic. They look at how well the medical profession was protected and the impact of the pandemic on the profession, and they hold no surprises. The reports have received some press coverage, although I think the National Audit Office report into PPE that was published in November 2020 is harder hitting and likely to carry more weight with the government.

Finally on COVID-19, the National Institute for Health and Care Research (NIHR) has produced a helpful summary of all the research they are supporting into long COVID, which is worth a peruse.

It's only us – workforce

I have been in several meetings over the past week concerned with workforce and there have been a few significant moves on this political chessboard since my last bulletin.

On the positive side, the British Thoracic Society has published its calculations on the needs for the respiratory workforce moving forwards. This is good in many ways, not least because it involves all parts of the workforce and not just doctors, but also that any additional data we have strengthens our case when making arguments to those in Whitehall.

And those arguments are needed. Close on the heels of the rejection of our and others' proposed amendment on workforce to the Health and Care Act, we learned (at various meetings) that the legislation for the regulation of physician associates will not be put before parliament until the summer of 2023. This means that even if the GMC works at an unprecedented speed it seems unlikely that there will be a register in place before early 2025 – at least a year later than we were expecting. This is a big blow and we have already started meeting with the relevant parts of government and the system to see if the process can be accelerated.

At the RCP Council meeting last week we heard from Nigel Trudgill (previous director of the RCP Medical Workforce Unit – MWU), Sarah Logan and colleagues about the work they have been doing on key workforce issues, including modelling of consultant demand and supply. This is due to be published soon but it will come as no surprise to many that the retention of doctors through their careers has a massive impact on consultant numbers. That shortage has been shown in stark terms by data published last week by the MWU.

A staggeringly low percentage of consultant physician appointments were successfully filled in 2021. At 48% it is the lowest figure ever and a big reduction from the already low level of 57% in the previous 3 years. Predictably, most jobs advertised were in acute medicine (197), geriatric medicine (166) and respiratory medicine (149). The NHS is screaming out for more consultants, but like the money in many people's wallets, there is not enough to meet our needs.

Come undone – the cost of living and public health

The high levels of inflation, energy and fuel costs are having a direct impact on the population's health and to investigate this further we recently commissioned YouGov to look into this. The results were published last week and according to the poll, over half of the British public (55%) feel that their health has been negatively affected by the rising cost of living. A quarter of those affected also said that a doctor or other medical professional had confirmed it. Of those who reported their health getting worse, 84% cited increased heating costs, 78% the cost of food and 46% transport costs.

We are only at the start of the cost of living crisis and while I am keen the government does something to try and to reverse the impact on health, I'm not impressed with their efforts so far, which have included delaying the publication of a tobacco control plan and a U-turn on the legislation on BOGOF (buy one get one free) offers in supermarkets and the 9pm watershed for advertising junk foods. I guess at a very strong push I understand how BOGOF might superficially seem to help the cost of living, but the real reason supermarkets do it is to increase total sales and the work by Which? and others over the years has shown this clearly.

There is certainly no evidence at all that a ban on junk food advertising until 9pm will impact on cost of living and we need to rally against reversals using this as an excuse. The levelling up agenda is becoming tilted by industry, and political leopards are showing that they cannot change their spots. We are in for grim times.

Bodies – the national medical examiner's report

The national medical examiner has published a report on his activities in 2021 and while it seems a little inward looking at first, the work of others comes to the fore in the latter half.

An impressive 194,074 deaths were scrutinised in 2021 by medical examiners across England and of these, 10% were referred for case record review or clinical governance review. Given that there are about 550,000 deaths in England and Wales per year (half of which occur in hospital) there is still some way to go but certainly good progress is being made.

All those involved in the system from relatives to coroners have seen a slicker and more responsive approach to death and this has to be a good thing. We will need more medical examiners and our sister college the Royal College of Pathologists has been leading the training. By the end of 2021 it had overseen the completed training of 1,427 doctors as medical examiners. That is impressive given the constraints of the health system over the past 2 years.

Let love be your energy – support for non-clinical activities

Medical examiners are paid for their time and most hospitals are happy for clinicians to take these roles. Some hospitals, though, are less happy about clinicians taking on roles outside their organisation. A quick conflict of interest declaration – this includes work for the RCP. The most senior leadership of the NHS gets the importance of such work, even if local managers and exec teams may not. For England, this has been demonstrated by the publication of a letter from those leaders including Amanda Pritchard (CEO NHS) and Chris Whitty (CMO England) to CCG leads and trust chief executives encouraging them to allow people time to do work for the wider NHS.

Negotiating job plans can be a fraught business and the pressure to get elective waits down and deliver urgent and emergency care has never been higher.

Spread your wings – education matters

I was pleased to see that my 'Royal College Challenge' teammate Ananthakrishnan Raghuram has taken over the role of chair of the MRCP(UK) regulatory subcommittee, which helps quality assure the MRCP and specialty certificate exams. He and the committee are looking for more members and if you are interested you can find out more about the role. This is an important new committee and vital to ensure that the exams do what they need to improve patient care.

The RCP Education Directorate has been working in partnership with Birkbeck, University of London to deliver new and innovative short courses for modern clinical leaders. The first will focus on organisational change and strategy and leading a diverse workforce.

This 30-credit module is designed for senior clinicians seeking to enhance their skills and knowledge to be effective leaders of change in the modern-day medical workplace. The course will provide the opportunity to develop the leadership skills to enact organisational change compassionately, ethically and informed by the best evidence. You can find out more in a short video I recorded outlining the benefits.

Life thru a lens – pictures say a thousand words

Last week was a busy one at The Spine as we also opened SELFLESS, a photography exhibition sharing powerful images and stories of healthcare colleagues at the start of the pandemic, and unveiled the names of those who have generously

donated to the O'Donoghue Wall. If you are in the area, both are worth a visit.

The SELFLESS exhibition is strikingly emotional with photos of healthcare workers and patients by Jessica van der Weert encompassing the worst and best of those early weeks of COVID-19. If you are not able to get to Liverpool in the next few weeks, the exhibition will move to London in July.

...and finally

I had the honour of representing the RCP at the recent Royal Australasian College of Physicians meeting in Melbourne and, as well as meeting many great physician colleagues from that part of the world, was able to catch up with a group of FRCPs for a dinner organised by the wonderful and generous Dr Roger McLennan.

Although many miles separate us, it was clear the things that drive us to do medicine are the same the world over and our desire to improve patient care is a strong uniting force. I left the meeting inspired again and reminded that we are able to recharge each other's enthusiasm by the simple act of spending time together.

6 June 2022

The Platinum Jubilee weekend has been a bit of a distraction from all the bad news of late and if nothing else it has allowed us all to gauge what the UK thinks about its monarch (I think she's wonderful), the royal family as a whole and, perhaps most tellingly, its prime minister. It is time, though, to take down the bunting, put the BBQ away (it may be a busy week for acute medics and gastroenterologists) and refocus on medicine. And in particular a very un-fun trio of zoonotic infections.

The more I see – monkeypox

The number of cases has increased substantially since my last bulletin and the prolonged bank holiday weekend means that UK data are probably a little bit out of date. From a global perspective the latest WHO data estimate that there have been almost 800 cases identified in 27 member states that would be considered 'non-endemic' for the infection. For the UK, that number stood at 302 on 5 June. The growth curve for UK cases seems to be slowing according to the data, which is good news. But as all armchair epidemiologists know, a week can be a long time in an infection outbreak.

We (the RCP) hosted a webinar for clinicians last Monday evening with the UKHSA and I am really grateful to the brilliant Susan Hopkins for organising and chairing the panel of speakers. The webinar is currently available to view on demand and it is an hour of your time that will go very quickly and hopefully answer any questions you may have – you'll need to be quick as it's only scheduled to be available until Wednesday due to the fast-moving situation. My take on the main messages of the moment are as follows.

Sexual health teams are the main point of case contact if you think you have a patient with the disease. The first cases in this current wave of infections were picked up in early May by eagle-eyed GUM and ID physicians in London (who must be commended) and the GUM community

has responded brilliantly to this outbreak. Most cases have occurred in men who have sex with men. It is not an easy disease to catch and the main route is direct contact, although there may be large respiratory droplet spread. The rash, while resembling chickenpox, is often in unusual places such as the mons pubis and therefore relying on our clinical skills is important – if it looks like chickenpox or varicella zoster (and we all see many cases each year) in a low-risk group, it almost certainly is. We should beware of cases in immunocompromised or pregnant individuals although, thankfully, we haven't seen any in these groups yet.

It is also important to remember that monkeypox is a pretty stable DNA virus and very different from the ever-mutating RNA virus that is SARS-CoV-2. So unless the disease becomes endemic in the UK (hence the warning for people with the infection to keep away from pets and animals), we should not see recurrent waves. There is much work going on to try and understand why this current series of outbreaks has occurred and if there is a 'gain-of-function' by the virus.

The other good news is that there are treatments and a vaccine for monkeypox (the CDC website is helpful here) which were developed for the treatment of smallpox. Oral antivirals include tecovirimat and cidofovir, although there is little data on their effectiveness against monkeypox. The use of either should be left to infectious disease colleagues working in the HCIDs and at the moment they are favouring tecovirimat. Vaccine supplies are low, but more is being produced and the vaccine is estimated to be around 90% effective at preventing symptomatic infection in contacts.

I recommend an insightful piece in *The Lancet* by Ali Zumla and colleagues about the key issues around the current outbreaks of monkeypox cases outside of endemic areas. NHSE/I are keeping us up to date on the monkeypox response in a letter to the system, with details of the risk stratified clinical approach which aligns with the UKHSA principles for control paper.

The farmyard connection – COVID

We would all like this bulletin not to have to mention our most well-known zoonosis and I hope that will happen soon. However, I am well aware from talking to respiratory colleagues about the ongoing toll of COVID cases on their workload, both from acute infections and also through the burden of long COVID. Hospital cases continue to fall – there are currently around 5,500 in the UK, of which 36% have the infection as the primary reason for admission. Community cases also continue to fall according to the ONS, with rates in the UK at around 1 in 70, depending on the nation. The ONS data also show long COVID cases are approaching 2 million, which is a concern.

There have been some changes to the policies for COVID-19 treatments for non-hospitalised patients and for those with hospital-onset COVID-19 to include additional groups identified in an independent advisory group report as potentially eligible. In other words, which patients should get antivirals and nMABs for COVID-19. Figure 1 in the IAG report gives the list of conditions and is worth a glance over to make sure you discuss this with your eligible patients. The changes will take effect from Monday 13 June.

Summertime – flu season in Australia

Every summer, the UK infectious diseases community keeps a watchful eye on the flu season in Australia as it is a reasonable (although not infallible) predictor of what is coming our way the following winter. The news is not good as flu case numbers are rising early and steeply compared with 2017 and 2019, which were big flu years there. Figure 4 on the latest Australian government surveillance report is worth a look.

We had a small blip of flu this spring in the UK but cases seem to be falling consistently alongside COVID cases. The UK surveillance reports are long and full of fascinating detail if you want a respiratory rabbit hole to explore.

The bottom line is that we should expect a significant flu season this winter and should prepare ourselves and our patients for a vaccination push. I know I warned of this a year ago and was woefully inaccurate, but in my defence the arrival of Omicron resulted in ongoing respiratory precautions by the public and healthcare workers alike which will have reduced flu cases substantially. Such behaviours/measures seem highly unlikely this winter – at least we should hope they are not needed.

Really saying something – workforce

Something went under the radar the week before last which I think readers will find remarkable in many ways. It occurred at an evidence session in front of the Health and Social Care Committee chaired by the MP, author (I've not read it yet) and born-again NHS workforce advocate, Jeremy Hunt. Evidence was being given on workforce plans by Navina Evans, CEO of Health Education England (HEE); Em Wilkinson-Brice, acting chief people officer for NHS England and Danny Mortimer, CEO of NHS Employers – all three of whom are great people albeit in very difficult roles.

Dr Evans was being quizzed on the impending 'Framework 15', HEE's plans for the workforce over the next 15 years. Mr Hunt, reasonably, was keen to see if the plan would include a clear statement of the numbers of healthcare staff needed. To be fair, the previous versions of Framework 15 have not included any number predictions – something that I've pointed out on many occasions to politicians (including Mr Hunt) when they've said, 'don't worry, HEE will tell us the numbers in Framework 15'. This latest iteration will be no different and the HEE CEO was visibly uncomfortable when being pushed on it by Mr H. The lack of a clear answer then led Mr H to say that he thought the plans all sounded 'a bit bulls****y to me'. My jaw rather dropped.

The whole session can be watched on the parliamentlive.tv channel – the segment starts at 11.29 and the fruity use of words is at 11.45 (or, if you prefer, you can read the transcript). At least you can never say that politics in the UK is boring.

The pressure of life – emergency care pressures

Our sister college of emergency medicine, RCEM, has been doing a lot of work collecting and analysing the trends in urgent and emergency care and was in the headlines last week on NHS bed numbers. It estimates that we need another 13,000 beds in the UK and notes that currently we have the second lowest number of beds per 1,000 population in Europe (2.42), the third highest decline in beds since the year 2000, and that there has been a 23% fall in mental health beds since 2010/11. Read the full report.

The RCEM is calling for an additional 4,500 beds by next winter which are clearly needed if you look at the powerful charts in their winter flow project. The problem, coming back to the fruity topic of workforce, is that without the staff to look after patients these beds will lie empty or be unsafe. The workforce challenges in health and social care will be a long-lasting legacy of this government if it is not careful.

The predicted increase in retirements from the NHS seems to be happening with a 28% increase in April compared with last year. I know of many colleagues who see retirement as their only option having been backed into a pension tax corner. Saying 'I told you so' sounds really hollow at the moment. I live in hope that the Treasury will pull the solution out of their hats, a bit like a marmalade sandwich.

It ain't what you do (it's the way that you do it) – integrated care systems

Now the Health and Care Act is written in statute, integrated care systems (ICSs) and their key parts, the IC boards and IC partnerships, can start the hard work of trying to deliver improvements to local health systems. If you are still at a bit of a loss as to how this will all work, The King's Fund has produced a short animation to make it all easier to understand.

As part of the new NHS world, all the chief executives of the 42 new ICSs have worked with one of their number, Claire Fuller, to make some recommendations to improve working as they find their feet. This work has been called 'the Fuller stocktake' as it looks at what has and hasn't worked with previous iterations of care, especially with respect to primary care (hence its full title, Next steps for integrating primary care).

I think there are lots of useful things in this report and the buy-in of all 42 ICS leaders is critical in ensuring that moving forwards there is a more consistent working approach between primary care and the other parts of the system. Claire Fuller is a very impressive individual and is to be congratulated on achieving such a united vision. I am biased, though, as I was her brother's best man and had many a cup of tea in the family kitchen growing up. Her mum is a force of nature!

Personal connections aside, I would recommend reading the report as it seems very likely this will be the direction of travel, and secondary care physicians need to be aware of how primary care will work in the new systems. More than ever, we need to be working closer together.

If you want to read even more about the future of ICSs, the NHS has produced a roadmap on how specialised commissioning will work in the new systems. This is quite complex (no surprise there), but the bottom line is that accountability and control will remain with the centre of NHSE/I rather than with the ICSs. This is probably the right thing, especially given that the experience of commissioning such services is limited in the wider system.

Our lips are sealed – have your say

There is just over a week left to have your say on how the RCP should influence the way healthcare is designed and delivered in the UK. In 2018, members chose four policy and campaigns priorities to guide the external influencing work of the RCP. It is now time to revise these priorities – please take the survey by 15 June to help ensure we are prioritising the right things. The survey results will be used to refine our priorities and decide how we will achieve each one. A final plan will be shared with members before Professor David Oliver takes over from me in September 2022 (in less than 100 days!).

There is another survey I wonder if you might consider looking at. Jake Parnian, a medical SHO (his term, not mine) at St George's Hospital, is inviting RCP members and fellows to participate in a research project on climate change and healthcare in the UK.

The study seeks to understand healthcare workers' perceptions of climate change and health, to gauge awareness of sustainability initiatives currently operating within the UK, and to analyse the perceived effectiveness and engagement of such initiatives.

The anonymous survey should take no more than 5 minutes to complete. Interested participants will be invited to participate in a short telephone interview after the survey is completed. This is not compulsory, and there is no obligation to leave your details for interview. Climate change and health is, as you know, a key issue for us all. Even if you don't think so, having your views on how the service should adapt is important.

Just do it – stopping smoking

To mark World No Tobacco Day last week, Professor Sanjay Agrawal, clinical lead for the NHS tobacco dependency programme and chair of the RCP's Tobacco Advisory Group wrote a blog about the benefits of quitting, which is a good read. Sanjay has been a powerful advocate on this issue since taking over from Prof John Britton as our lead. Another force of nature I admire.

The telephone always rings …and finally

We all like to think we are unique and until recently I was the only Andrew Goddard working in my hospital. No longer it seems and (having survived the potential crossed wires of having a brother in the same department for the past 15 years) confusion is

beginning to reign as folk use my NHS email address in error. Worse than that, my IT access was blocked last week in a case of mistaken identity which led to a frustrating unanswered call to IT support and an inability to sign my digital letters.

I guess I have done well to avoid this for so many years and now have a deep respect for those called David Smith or David Jones (the two commonest men's names in the UK if you didn't know). I will have to change my email address … if only I could think of a nickname that nobody else uses.

20 June 2022

Once again I started this bulletin in a theatre coffee room during the antisocial hours of a weekend (those on calls come around way too fast). It was a busy weekend, so this bulletin will be a bit shorter than normal and has been written 'in haste'. My hospital is full and the medical admissions unit seems more popular than ever, but at least I feel wanted and I know I am not alone. Here is what is happening in the world of medicine.

Eye in the sky – NHS services

Given how busy the NHS feels at the moment, I was interested to see the performance data for England in April and May 2022 published at the end of last week. These publications contain a huge amount of data, so I would recommend the Nuffield Trust summary and analysis as an easier way to digest where we are at. The charts are excellent too.

In short, things are looking grim. In emergency departments, 27 % of patients waited over 4 hours before admission, transfer or discharge, and over 122,000 spent over 4 hours on a trolley in May. Ambulance response times remain at historically high levels and all hospital waiting lists have increased, bar for those patients waiting over 104 weeks.

On another Nuffield Trust page, there are some fascinating data on the size of the elective backlog in February 2022 by integrated care system (ICS – the new unit of comparison) in England. My ICS is mid-pack, but looking at the list does nothing to dispel my bias around health inequalities in our country.

At the risk of sounding like I work for them, one further Nuffield Trust article I saw a week or so ago is worth a read. It specifically looks at the performance of the NHS in Wales and includes some charts for comparison across all the devolved nations. Patients in Wales have to wait longer than

those in England and the article explores why this may be. It is a bit to do with geography, a bit to do with demographics and a lot to do with funding.

You're gonna get your fingers burned – COVID-19

There is a definite uptick in cases and hospitalisations (32% in the past week). The BA.4 and BA.5 variants are one significant driver of this surge (portrayed beautifully in the variant charts) and are set to displace BA.2 as the main variants in the UK soon. Viruses with the letters BA seem to have more success with taking off than planes at the moment.

Many people have said this is a significant new wave of COVID-19, but I think it is too early to say how big it will be and how significant an effect it will have on admissions. Looking at the European data, BA.2 continues to dominate and even in those countries, such as Portugal, where there has been a significant spike due to the new variants, hospitalisations are low.

Given the increase in cases, it therefore seems a little counter-intuitive that the guidance for mask wearing and other infection control measures in UK hospitals is being relaxed. These changes were implemented in English hospitals after a letter received 3 weeks ago and are being rolled out steadily. My hospital started this morning, and I was in Leicester last week where they have been following the new guidance for a week. It was odd wandering down hospital corridors with everyone not wearing masks.

I get the need to try and return to a more 'normal' life, and confess that I will be more than happy not to wear a mask in our departmental offices. I do know, though, that many of my immune-compromised patients are still petrified of coming to the hospital and worry that if there is a significant wave of hospitalisations at any point, getting members of the public to put their masks back on will be quite a challenge.

Gemini – monkeypox

Monkeypox cases continue to increase worldwide but case numbers in the UK seem to have peaked, which is good news. As I have said before, this is due to the great work of genitourinary medicine (GUM) and infectious disease physicians in their response. Most cases have been in the MSM population and 68% of cases have been in London. Unsurprisingly, the outbreak is having a massive effect on the ability of GUM clinics to see their usual patients and as these services will be critical in the rollout of a vaccination programme, this impact will continue. Thought will need to be given by healthcare leaders to ensure that GUM services are fully supported moving forwards, to prevent a surge in other infections.

The monkeypox vaccination programme will be rolled out over the next few weeks. The plan is to use a 'ring vaccination' policy that has been used previously for smallpox – close contacts and their own close contacts are vaccinated, thus creating a 'ring' of vaccinated individuals around a case. Vaccine supplies are low but more is coming, so those areas where there have been most infections will need to be prioritised as well as staff working with these patients. Unlike COVID-19 vaccines, the monkeypox vaccine needs –20°C freezers and is being given 'off-label', so has to be given by appropriately regulated healthcare professionals. All of these logistical challenges can be overcome, but the supply of vaccine will be the main rate-limiting step.

What happens to the outbreak from here remains a topic of much speculation. Three possible scenarios exist: the outbreak dies out; monkeypox becomes endemic; or it grumbles along for a few months (there must be a formal epidemiological word for this, but you know what I mean). The latter seems the most likely at the moment.

Lastly, the World Health Organization is looking urgently at renaming the virus to prevent stigmatisation of parts of Africa, as we saw for

China in the early days of COVID-19. The lack of association with monkeys in human outbreaks also makes the moniker misleading. 'hMPXV' is the term that many scientists having been using, but it is a little clumsy and I wonder how easily the publicly understood name will be shaken off.

Silence and I – Clean Air Day

During my time as president and registrar of the RCP, I have been fortunate to be involved with the work the RCP has been doing on air pollution. Last Thursday was Clean Air Day and to mark the occasion, we (the RCP) published a progress report on this work to communicate the adverse effects of air pollution on health. We also wrote to members to highlight key resources, including those that will help healthcare professionals have conversations with patients.

On Friday we hosted a roundtable that brought together the chief medical officer for England Professor Chris Whitty, officials from the Department of Health and Social Care, campaigners and royal colleges to discuss progress on air pollution. This was ably chaired in London by the incoming PRCP as I was only able to join virtually from the hospital – I listened intently but kept quiet, given the great job David was doing.

The meeting was a great success, but looking at the photo of the event that was tweeted afterwards I realised that I loomed rather large on the projection screen in the room like Big Brother in a scene from 1984. I promise not to do this once I demit.

Step by step – a greener NHS

Tomorrow I am giving a talk at the British Society of Gastroenterology (BSG) meeting in Birmingham (trains allowing) on the 'NHS in 2032'. Trying to predict the future is not easy, but one thing I am confident about is that the NHS will be 'greener'.

Last week I was speaking at another meeting, the European Healthcare Design conference, alongside the NHS chief sustainability officer Dr Nick Watts. Nick, if you have not met him or seen him speak, is a force of a nature (which seems apt when talking about climate change) and has already had a transformative effect on the NHS and its plans for a more sustainable future. He has written a blog about the plans, which includes case studies on how trusts and their staff are helping to progress them through new innovations.

The NHS is the world's first health system to commit to reaching net zero carbon emissions by 2040. As part of that commitment, all NHS trusts in England have now developed green plans to set out how they will reduce their own environmental impact and help the NHS improve public health. These have not been published yet (that I can find), but should be over the next few weeks.

Old and wise – pulmonary rehabilitation

Over the past 10 years I have attended many RCP lectures, and would therefore hope I am wiser as well as older. One of the best talks I have ever heard at an RCP Update in medicine was by Professor Nick Hopkinson on pulmonary rehabilitation (PR) about 5 years ago. Until that point I had not realised the importance of such services in the lives of patients with chronic lung disease. Respiratory disease affects one in five people and is the third biggest cause of death in England. PR offers a structured exercise and education programme that significantly benefits patients and reduces hospital admissions.

This week is Pulmonary Rehabilitation Awareness Week in the UK. The campaign links closely to the work of the RCP's audit and accreditation programmes and their contribution to high-quality PR. Our clinical lead Professor Sally Singh has written a blog about how she started in the field and why PR continues to be a highly valued intervention for people with chronic respiratory disease.

The expansion of PR services is one of the key commitments in the NHS Long Term Plan, which aims to increase referral rates to PR from 13% to 60% by 2023. By expanding PR services over 10 years, 500,000 exacerbations can be prevented and 80,000 hospital admissions avoided. If PR is something you know little about, I would strongly recommend Sally's blog.

and finally…

The talk I am giving at the BSG mentioned above has been mentioned in dispatches from the BSG, but a typo (or at least I hope it is a typo) changed the interpretation of that update. Referring to the talk, it suggested that the challenging brief on the future of the NHS should make BSG members 'examine the President and decide what we want to change'.

I'll leave you to think whether 'present' or 'president' is more appropriate.

4 July 2022

Since my last bulletin there have been some seismic events that have thrown the political systems on both sides of the Atlantic into turmoil. The US Supreme Court decision to reverse Roe v Wade will set back women's health in the US over half a century, and the plummeting of support for the UK government and industrial action by many groups implies the next few months will be anything but stable.

Meanwhile the NHS slowly slips into terminal decline and various infections resurface to threaten a susceptible and weakened population across the globe. Let's start with our old friend SARS-CoV-2.

It's all over now (not) – COVID-19

Case numbers continue to increase, as do hospital admissions. BA.5 is now the dominant strain and is pushing its siblings BA.2 and BA.4 aside. Many of us have seen an increase in colleagues coming down with COVID-19 and the pressure is back on rotas. There is no evidence, though, that this strain is any worse (from a severity point of view) than recent ones in vaccinated individuals, which is reassuring. Impending school holidays may help truncate the amplitude of the wave, but there have been few obvious behavioural changes in society in response. If only we could learn from what has happened in the pandemic so far …

Last week, the prime minister accepted the terms of reference for the COVID-19 inquiry. This means it has now been formally established under the Inquiries Act 2005 and can officially begin its work. Baroness Hallett, chair of the inquiry, has outlined seven promises that will underpin how she will run the inquiry. These include placing people who have suffered during the pandemic at the heart of proceedings and a commitment that interim reports will be published with recommendations. The promises also make clear that the inquiry will be 'firmly independent' and state explicitly that Baroness Hallett will not 'tolerate any attempt to mislead the inquiry'. I wish her luck with that.

Baroness Hallett will set out her approach for the next stage of the inquiry's work in July. Public hearings will begin in 2023. I know that many RCP members are really interested in this inquiry, so we will have a dedicated page on the website to keep members updated on progress.

Regular readers will know that I have had an interest in the role of vitamin D in the management of COVID-19 and I failed to update readers in the last bulletin that the much-awaited multicentre RCT in Spain, known by some as the 'CARED trial', has been published in PLoS One. Alongside other trials, this confirms that a single high dose of vitamin D3 has no effect on mortality, ITU admission or other outcomes in mild–moderate COVID-19. It still seems reasonable to ensure that those at risk of either severe outcomes or of vitamin D deficiency should have supplementation, but the notion that vitamin D3 is a golden bullet for COVID-19 has hopefully been put to rest.

Oh no, not you again – polio

The day after my last bulletin, the headlines were topped by the detection of polio in the UK, 40 years after its 'eradication'. Given the passage of 2 weeks, it is useful to reassess where we are.

If you ever want a good short review of any infection that we vaccinate against in the UK, it is worth going to the 'green book' (actually more of a 'green titled website' these days) which is the go-to reference for GPs. On polio it usefully states that the last case of naturally acquired polio in the UK was in 1984 (so 38 years for pedants) but there have been cases of 'VAPP' – vaccine associated paralytic poliomyelitis – since then. VAPP occurs when the live vaccine administered in oral vaccines mutates to be more like the wild type, thus allowing direct effects on the nervous system. It is very rare and since 2004, when the risk of live polio was considered less than the risk of VAPP, the UK moved to the injection of inactivated polio vaccine.

Other countries continue to use oral vaccine and where polio remains endemic it is an effective way to protect populations, due to acceptability among children and their parents. Anyone receiving vaccine will secrete virus in their stool, and if it does mutate in the gut this too will be secreted, risking infection of others. Some individuals secrete virus over a long period of time and such an individual could explain the current situation in the UK.

As I've mentioned before in this bulletin, UKHSA have been piloting the analysis of sewage water for evidence of many pathogens, including 'vaccine derived' polio. Short bursts of positivity are to be expected from people coming to the UK who have had oral vaccination, but the concern now is that levels of infection have not fallen as they normally would. We know where the positive sample was found (Beckton sewage works) but the design of the London sewage system is not a simple dendritic one and tracing the infection would have foxed even Sherlock Holmes, given it is the largest works in Europe, serving around 4 million Londoners.

Importantly, no cases of VAPP have been identified yet, nor has the source been located. We need to remain vigilant, ensure that children are vaccinated and have a high index of suspicion for polio in anyone presenting with a flaccid paralysis whatever their age. In short, brush the dust off the tendon hammer for anyone with severe myalgia or muscle weakness – loss of reflexes is typical in the evolving case.

Not fade away – global pathogens

There isn't too much new to say about monkeypox. UKHSA produced an informative epidemiological update on Friday, at which point there were 1,185 cases identified in the UK with 77% in London and all bar five being in men. Cases continue to be identified but the vaccination programme is now being rolled out and the rate of new cases seems to be slowing.

Flu in Australia seems to have peaked, although it is too early to be sure if this is a false summit. Case numbers are the highest for over 5 years with more than 147,000 cases notified already this season – and the season started a good 6 weeks early. This is why there has been some concern expressed by Dame Jenny Harries yesterday about an early flu season in the UK.

Not to be outdone by re-emerging viruses, an old bacterial foe reared its head again this weekend – diphtheria. I was sitting on my sofa watching England throw away a lead against Australia in the rugby when the news pinged into my feed about a paediatric case in the Australian state of New South Wales (NSW). In one of those odd synchronicities, next to me on the sofa was my best mate, who is a paediatrician from NSW. NSW is quite big, so I don't think he was too worried for his own patients, but the news and re-emergence of the disease may be helpful should any readers have friends/patients asking: 'Do I really need to vaccinate my child against DTP?' I note a second case has now been identified in the past 24 hours.

If you have forgotten your medical school lectures on diphtheria, the NSW factsheet acts as a good booster or (and I should be on commission) the green book is excellent.

(I can't get no) Satisfaction – the NHS

Like an eagle, the Health and Care Act has landed. In many places the most obvious manifestation of this was a ritual of taking the name-plate of the local 'CCG' off the door and replacing it with a new shiny one for the 'ICB'. If you are still confused as to what is going on and the cartoon I linked to a few weeks ago was a bit too simplistic, the NHS Providers explainer is a good summary of the different parts of the Act. The BMA summary is another take if you want a slightly more negative one.

Whatever the rights and wrongs of the Act, it is now in place and we have to learn to live within the new structures it creates. In a metaphorical representation of moving to a new way of doing things, I see NHS England moved out of Skipton House (next to the lethal Elephant and Castle roundabout) last week. To anyone who has sat waiting in the massive light-filled atrium or at a meeting in the dark windowless committee rooms, it is the end of an era.

The NHS celebrates its 74th birthday tomorrow so there will be a bit of national comms activity around this. I guess it is a time to focus on the achievements of the past year in the NHS, but I haven't met many people who feel like celebrating. Let's hope the 75th will have something to sing about.

Start me up – digital healthcare

Digital technologies continue to be heralded as one of the key solutions to all the ills of the NHS at the moment – be it workforce or waiting lists. Regular readers will know of my hate/hate relationship with digital technology in my hospital. You can therefore reasonably assume that I listened to the secretary of state's speech on digital healthcare last week with more than an ounce of cynicism (possibly a UK government approved imperial unit). The fact that I couldn't attend the event live, as my invite arrived with 4 hours' notice, didn't help.

The SoS outlined the government's plan for digital transformation and this speech was fairly similar to one he gave 2 weeks beforehand on the government's 'Data saves lives' policy. In short, the plan is to: increase the use of electronic patient records in the NHS and social care (the latter in particular) thus allowing more connectivity between providers; increase use of the NHS App to make it the main point of access to NHS services, as well as 'personalised' medicine; and there will continue to be a focus on new technologies and remote monitoring.

In his speech the SoS referred to his love of electronics as a child, taking the family television to pieces and the House of Lords raising suspicions that X-rays were a hoax when they were first used. Both are engaging anecdotes in a speech, but I think it will take more than engaging stories to ensure the digital revolution is delivered and that those patients without access to the internet are not left far behind.

Lastly on digital, the RCP is embarking on an exciting new project to redevelop the website from the ground up. This aims to give us a modern, eye-catching and easy to use website, with better search functionality and new features. For us to best design a new website that meets the needs of our members and fellows we need to know what you want and expect from the RCP website. To help us with this, please fill in

the short survey. Your feedback will help us create a website that has user experience at its core.

I'm moving on – changing of the guard

I was pleased to see the Faculty of Physician Associates (FPA) announce the results of its elections for president and vice president. Jamie Saunders, a practising physician associate (PA) in haematology at Guy's and St Thomas' NHS Foundation Trust, has been elected as president.

Chandran Louis, a practising PA in urology at St George's University Hospitals NHS Foundation Trust and a PA lecturer at St George's University of London, has been elected as vice president.

Three candidates stood for FPA president and Jamie won with 436 votes. He will succeed the current FPA president, Kate Straughton, and I look forward to working with him, albeit briefly. Kate has been a superb advocate and leader of her profession and will be much missed. I know that the handover between Kate and Jamie will be thorough.

Talking of handovers, if you are interested in how David Oliver will do things when he replaces me, we are running an 'In conversation with the presidents' event on 27 July. Registration for this event is now open; it will be livestreamed from London on RCP Player 6–7pm. David and I will have a structured discussion chaired by Saffron Cordery, NHS Providers interim CEO. I hope that discussion will focus on the future rather than the past.

You can make it if you try – diversity

One of the areas I have tried to improve in my time is that of diversity within the RCP. When Ben Summerskill did his review for us 2 years ago he was rightly critical of the lack of data on our diversity and we have been working to try to obtain this. It is not easy, as many people are reluctant or too busy to reply to data monitoring requests. However, we now have a summary of senior RCP diversity data and have published it on the website.

It would be brilliant if we could have better data for all the membership; as it stands we only have data for 9%. The form is quick and easy to fill in and can be found on the MyRCP home page, with the option to choose 'prefer not to say' (right hand column under 'account').

Not fade away – Clinical Medicine

Some good news from last week: our *Clinical Medicine* journal's impact factor has more than doubled from 2.66 to 5.41.

While most medical journals' impact factors have gone up (as this new release covers the COVID period), we've moved up relative to other journals in the 'Medicine, General and Internal' category (which includes *The Lancet*, *New England Journal of Medicine* and the *BMJ*) and are now #45 out of 172 titles. We have a long way to go to match *The Lancet's* 202.7, although to be fair we are not aiming to.

While we've never focused strongly on impact factor (as the majority of our readers are practitioners who will apply what they read in the clinic rather than necessarily citing us) we're pleased at this evidence of our increased reach and would like to thank all our board members, reviewers, authors and readers for their support and hard work during COVID.

...and finally

I will often close the bulletin with an occasionally amusing story from my week, but cannot do that today. I was very saddened to hear of the death of one of our most promising trainees last week. Dr Vaishnavi Kumar was an alumna of the 2021–22 cohort of the Chief Registrar Programme and will be greatly missed. My thoughts go out to her family, friends and colleagues.

It has reminded me that asking if colleagues are 'OK' is more than an okay thing to do.

18 July 2022

I am writing as the temperatures outside begin to rise in the UK and they are likely to be approaching 40˚C as some of you read this. Temperatures have also been rising in political circles as the candidates for the Conservative and Unionist Party leadership compete to win hearts and minds. I'll discuss both climate and political changes shortly but need to start with some important news.

Take a step back – David Oliver withdraws from PRCP role

I am sad to have to report that, due to health issues, Professor David Oliver has withdrawn from becoming RCP president in September. There is a full statement on our website but suffice to say my thoughts go out to David as this was an impossible situation for him and a very difficult decision to take.

We are constrained by an act of law to elect our president on the Monday after Palm Sunday but the bye-laws we amended in 2020 do give us some options when it comes to deciding who can/should replace David. RCP Council will be meeting later this week to talk through those options and members can rest assured that we will not leave the RCP leaderless for any time as we move into a turbulent period in UK politics.

Promised you a miracle – who will be the next PM?

It is a quirk of UK politics that a prime minister can be 'elected' by around 0.2% of the population (the Tory party have around 180,000 members) and thus choosing that individual and living with their beliefs and values rests with a group that is not particularly representative. Be that as it may, we all have a vested interest in understanding what those beliefs and values are, and I have followed TV interviews and debates with interest.

NHS and social care have barely featured in the debates and given the latest NHS performance data (the busiest ever June) and GP Patient Survey (biggest drop in approval), this is worrying. I hope it doesn't represent a 'perhaps if I close my eyes it will all have gone away when I open them' mentality. Once we know who the two candidates for the vote-off are, I will write to both to make it clear that we want to engage and suggest solutions to those challenges.

Tax cuts have featured a lot in discussions, due to the notion held by many Tory politicians that cuts will boost the economy. The evidence for this position is rather weak/non-existent and if you fancy a deep read into it I would recommend a 2020 paper from the LSE. Whatever tax cuts do happen, it is hard to see them including the NHS pensions tax, which continues to erode the medical workforce like an expanding basal cell carcinoma.

There have been some discussions about the net zero agenda and no one has come right out and said that climate change is not happening (although I do wonder if a couple of them would like to). Given the heatwave we have right now, and the fires destroying large tracts of land of our ex-EU partners, it would be very 'Don't look up' for them to do so.

White hot day – heatwave

The combination of long ambulance waits and the heatwave is a deadly one, and it is no surprise that pictures have emerged of air-con units in ambulances, or that specific guidance has been issued by the NHS to try to prevent patients being inside stationary ambulances for too long. The ambulance waits are due to the ongoing COVID pressures and difficulties discharging patients to the community. We have not faced such a double-hit before on this scale, despite what some commentators are saying about the current heatwave.

Those who have underplayed the significance of this current wave, likening it to the drought of 1976 'which we all survived without too much bother', are mistaken. The highest temperature that summer was 35.9˚C and there was clear evidence of excess mortality. An interesting paper from 2002 confirms

that excess mortality and temperature follows a U-shaped curve with 19°C being the nadir of that curve. We have not tested the far right of the curve like this before and while I too remember the summer of 1976 well, I don't think excess mortality was top of my agenda at that time (a cool can of Top Deck would have been).

Don't you (forget about me) – COVID

COVID may have slipped down the bulletin a little but continues to dominate our lives. The current wave seems to have plateaued in Scotland and shows a promising slowing in the rest of the UK.

However, the large number of hospitalisations because of COVID has put the NHS under great pressure with around 5,000 hospital beds in England being filled with patients admitted primarily with COVID. Another 8,600 patients in hospital have COVID and certainly I have had lots of reports of hospital-acquired infections causing issues in patient flow, as well as staff absence.

Given tomorrow will be the anniversary of 'Freedom Day', it doesn't feel like free is a way to describe bed capacity in the NHS at the moment.

I note that the vaccination criteria for COVID and flu have been confirmed for this autumn and include all adults over 50 years of age as well as all frontline health and social care workers. Hopefully that will lessen the impact that both infections will have.

Glittering prize – get your MRCP(UK) earlier

Most readers of this bulletin have already got MRCP(UK) but for those who have not, or who supervise those in internal medicine training (IMT), there has been a very important change to regulations as to when the exam needs to be completed with respect to applications for higher specialty training.

Previously trainees needed to have completed the exam at the point of starting the post, but Health Education England's Medical and Dental Recruitment and Selection (MDRS) recruitment group has brought forward the date to the time at which the offer is made. This will take effect from the start of 2023 recruitment this November. Assuming offers are made in line with previous years, the exam will need to be completed by around 21 April 2023.

MDRS is facilitated by Health Education England but acts on behalf of all four nations and this move was made to ensure that the medical specialties fit in with all the other specialties (we have been out of synch). We (the RCP) haven't had anything to do with this decision but will continue to ensure that IMT trainees are prioritised to get through PACES in time for the new deadline.

Alive and kicking – workforce

We have released the latest workforce census headlines and they make unsurprising and depressing reading. More than half (52%) of advertised consultant physician posts in England and Wales went unfilled last year – the highest number of unfilled posts on record. Up from 43% before the pandemic and 48% in 2020, this is the highest rate since records began in 2008.

The data also suggest 44% of current consultant physicians will reach retirement age in the next 10 years (taking an average retirement age of 62–63), so the workforce will be further depleted just when demand for care will be increasing. As our population ages, this will likely bring a rise in multiple long-term health conditions.

The full dataset and census report will be published later this year, but these data will give strength to arguments as we prepare for political party conference season.

Book of brilliant things – new ethical guidance

During the pandemic, our Committee on Ethical Issues in Medicine published guidance for NHS staff about the ethical dimensions of COVID-19. Today they have followed that up with guidance on negotiating the NHS 'Road to Recovery' as COVID-19 moves towards becoming an endemic

disease. It covers the difficult and distinctive ethical issues that we will face during this period and beyond, including patient-centred care and decision-making, reducing health inequalities, resumption of 'non-clinical' care practices and taking a nationwide approach.

As I return to full-time clinical practice in September, I will miss the chance to influence the big debates about these topics. However, I'm also very much aware that the prioritisation of which patients should get which investigations or treatments is going to become as big an issue, if not bigger, than it was in the worst days of the first wave of the pandemic

Sign o' the times – outpatients

The pandemic has altered both the demand and our approach to how we interact with patients in an outpatient setting. These processes are ripe for ongoing transformation and NHS England are looking to appoint a clinical director for outpatient recovery and transformation. It would be great if this individual could be a physician, so if you are interested please take a look at the job description.

Much has already been done on how we make outpatient consultations work best for patients and Professor Trish Greenhalgh in Oxford has led a fantastic piece of guidance for NHS England on choosing how to consult with your secondary care patients. This provides a practical and pragmatic individualised approach which is something we were looking to work on with our own Patient and Carer Network. I think, given how good this work is, we can focus on something else.

All the things she said – Turner-Warwick lectures

I'm delighted to announce that we (the RCP) have opened the 2023 Turner-Warwick lectures for entries from trainees. These lectures have been going since 2018 and celebrate the work of many to a wide audience. Winning trainees will be able to reach beyond their specialty and present their lecture to a wide range of specialists and future collaborators. Winners will also be presented with a plaque and feature in our annual Turner-Warwick lecturer scheme yearbook. As well as those opportunities, previous winners have commented on how the scheme has provided them with a sense of pride and helped build confidence.

For consultants and SAS doctors working with trainees, it is important to note that most trainees apply to the Turner-Warwick lecturer scheme because a senior colleague recommended it to them. Please help us support trainees by passing this message on. The deadline for submitting applications is 4 October 2022.

...and finally

While my thoughts in the past few days have been focused on the succession of my own position, I have also been reflecting on others who are stepping down from RCP duties.

I attended my last-ever Trainees Committee and New Consultants Committee meetings last week. The former was the last one for the current co-chairs Rachel Jones and Michael Fitzpatrick, and I have been lucky to have them by my side over the past 3 years. Looking around the Dorchester Library at the Trainees Committee and around the Teams screen at the new consultants one, I was left feeling so inspired by the calibre of those who were there and that the future of the RCP is in safe hands.

1 August 2022

I hope that many of you read this bulletin late if it means you are on holiday and getting some well-deserved downtime. The thought of a bit of a break is certainly keeping me going as we don't seem to be getting much of a reprieve from politics or NHS pressures. After this July the concept of 'winter' pressures will have been subsumed into the history books.

I have been enjoying all the sport on at the moment and the positive light being shone on the Midlands via the coverage of the Commonwealth Games. I'll comment on the footy later.

Food for thought – COVID

I've tried to avoid headlining with COVID for a few weeks but the recent release of a paper in *Science* pretty much proving that the Huanan seafood wholesale market in Wuhan was the site of first human contact is such a brilliant piece of detective work it deserves the top slot. Not only does the paper present several modern-day 'John Snow Broad Street' type maps to make the case, it goes into even further detail to locate the source to several stalls in the south-west corner of the market, analysing the possible mammals that could have been the zoonotic link.

That list includes many animals that I had never heard of, let alone knew were edible. Raccoon dogs and masked palm civets top the list as likely vectors in the virus spill over from Rhinolophus bats which carry SARSr-CoVs. It is an eye-opening paper and the clear evidence of the dangers of close human/animal interactions makes the theory that the virus was leaked from a lab (by accident or design) dead in the water. Those who remember the title sequence from the 70s TV series 'Survivors' will be reassured.

In the UK the current wave has definitely turned a corner and COVID cases and hospitalisations are falling, albeit stutteringly in some parts of the country. A temporary respite seems likely for a couple of months, but we should expect cases to climb again in the autumn. Reinfection, once thought to be unlikely, has become common with emerging variants and while mortality rates with recent variants are lower (for many reasons), there is significant morbidity associated with such reinfections.

Recent research in the large (5.7 million) veterans affairs (VA) population in the USA has given us useful insights into the clinical impact of reinfections. It shows that each reinfection – and a small number (246) had had four or more reinfections(!) – had a cumulative risk of mortality and hospitalisation by an amount similar to the first infection. This study includes a group of patients that is not typical of the general US population (you can read a good review of the VA population), being older and sicker, but perhaps isn't too far from those we have been seeing in UK hospitals since the BA variants emerged. The study is also a pre-print.

Reinfection increases the risk of long COVID which should be a worry to us all. The NHS has just released the next plan for improving long COVID services which makes for slightly scary reading. The autumn booster programme will be a critical part of the defence for people over 50 and healthcare workers.

You could meet somebody – monkeypox

Since my last bulletin the WHO has categorised the current outbreak of cases as a 'public health emergency of international concern' (PHEIC) as cases globally passed 16,000 in 75 countries with five deaths. For reference, COVID-19 was declared a PHEIC on 30 January 2020.

The UKHSA updated its technical briefing on monkeypox on Thursday last week and the graphs (Figure 1) and transmission dynamics show the outbreak is slowing down in the UK and that the public health measures (education and vaccination) are working. Gay and bisexual men who have sex with men remain the most at-risk group with only 22 infections in women out of the 2,487 current confirmed cases where gender information

was available (see last week's epidemiological overview). London remains the commonest region for infections but its dominance is reducing. The briefing is well worth a read.

Also worth a read is the UKHSA's monkeypox communications pack, which is a slide deck for stakeholders and partners containing a good overview of the disease, FAQs and answers to those questions.

One in ten – workforce

Last Monday saw the publication of the Health and Social Care Committee's latest report on workforce, snappily titled Expert panel: evaluation of government's commitments in the area of health and social care workforce in England.

The report has been put together by the committee's expert panel, chaired by former RCP president Professor Dame Jane Dacre. For clarity, it's worth noting that this is not the final report of the committee's inquiry into *Workforce: recruitment, training and retention in health and social care*, which has been running in parallel. The expert panel and its evaluations are independent of the committee, but the committee sets the panel's remit. This is the fourth evaluation the panel has conducted, following previous reports into maternity, mental health and cancer services.

The panel examined seven key commitments made by the government with respect to the health and care workforce, which were split into three policy areas and given a CQC-style rating (inadequate, requires improvement, good, outstanding). In doing so, the panel considered whether each commitment was met overall, whether it was effectively funded, whether it achieved a positive impact for patients, and if it was appropriate in the first place.

The panel also gave the government an overall rating across the seven commitments, which was (unsurprising to anyone working in the NHS) **inadequate**. They noted that workforce shortages had an impact on the delivery of each commitment, and that a running theme throughout all their evaluations has been a lack of workforce planning which has led to workforce shortages and had an impact on patient safety.

I think the use of CQC ratings not only grabs the headlines and brings workforce issues to the fore but also makes the point that workforce issues have a direct impact on patient care and safety. Much of the debate about the NHS recently (especially by those seeking to be PM) has not made this point strongly enough.

In their evidence sessions the panel were told that there are around 12,000 vacancies in hospital doctor posts or roughly 1 in 10. I suspect that is an underestimate given the failure to appoint consultant physicians in 52% of attempts in 2021. I think the NHS workforce will become a significant issue in the UK government elections in 2024.

The earth dies screaming – air pollution and dementia

I am hoping that the heatwaves of the past couple of weeks and the impending droughts will have focused minds on climate change (although once again worry that our political leaders are more interested in short-term votes rather than long-term survival). Air pollution remains a very important health issue for the RCP and I was interested to see the latest report from the Committee on the Medical Effects of Air Pollutants (COMEAP) on the relationship between air pollution and dementia.

Like many such reports it is quite long but it does include a fascinating review of how pollutants might get into the brain and the role of the 'nose-brain barrier' (page 163 if you are interested), ie the way the olfactory bulb acts as a potential back door avoiding the blood-brain barrier.

In short there is not enough evidence yet to say how much air pollution contributes to dementia or which pollutants are most important. Suffice to say the evidence is good enough to say there is a definite link, and it seems the impact on the microvascularity of the brain is the most likely mechanism.

Get along without you now – new faces

My earlier references to the 70s might make some (older) readers think this section title means I am looking to become the next Derek Hobson. Thankfully not. As well as the news last week that Dr Sarah Clarke will become the new PRCP on 13 September when I ride off into the sunset, this week sees many other new RCP appointments taking up their roles.

Our new censors Dr Ruth Law, Dr Rajaratnam Mathialagan, Professor Tom Solomon and Dr Jo Sykes take up post today for a term of 3 years. The office of censor is a senior and ancient one going back to the origins of the RCP and our royal charter. Originally they issued licences to practise (and could put people in prison if they wanted), and were the college's examiners. While things have changed a little, their role has always been concerned with the examination, the good conduct of members and fellows, and maintaining standards and education. At any time, there are at least four (as well as the education and training vice president, who is also known as the senior censor) and the new cohort brings the number up to eight.

Our new councillors Dr Toby Hillman, Dr Khin Swe Myint, Dr Ajay Verma and Dr Hilary Williams will all bring fresh perspectives and expertise to our Council. I'm a little sad that I won't have the chance to work with them in their new roles.

Known to many already in his role as RCP improvement clinical director, Dr John Dean takes over from Dr Sarah Clarke as our new clinical vice president today. One of John's first tasks in the role will be to speak at an NHS England webinar on 4 August. The webinar will launch a series of virtual wards clinical summits and John will be sharing his perspective on the opportunities and challenges ahead for clinical teams delivering virtual wards or hospital at home services. He'll be joined by national medical director Prof Steve Powis and others from NHS England. John has been collecting views from many teams around the UK involved in such services in preparation for the webinar. I know the concept and real-life experience of virtual wards raises a mixture of feelings among members and so please share your thoughts and suggestions to help shape the content for the series of summits, which will commence in the autumn. John is happy to be emailed directly: john.dean@rcp.ac.uk. One thing I can promise is that the summits will not be in a 'hackathon' format.

And finally on the topic of new faces, we welcome Jamie Saunders today as the new Faculty of Physician Associates president and Chandran Louis as vice president.

Huge thanks to everyone who has just completed their term – your contributions during the most 'interesting' of times have been enormously valued by me and all of the RCP officers.

Red red wine – annual review and report

The one question I've been asked most often in the 21 years I've been lucky enough to work at the RCP is 'what does the college actually do?'. We've just published a short online annual review looking back at the RCP's key achievements in 2021. It covers highlights of our work under our new strategic priorities of educating, improving and influencing and is a good way to get an overview of all our work, especially as we move on from the impacts of the first year of the pandemic.

If you're interested in even more detail, you can also download our annual report and financial statements. I know there are still some who think the RCP is just one big wine cellar, but I hope both the review and report will reassure people that is not the (wine) case. We do apparently have a cellar somewhere but I have never found it … something I will try to do before I demit.

and finally…

Last week I presided (presidents do that) over my last fellowship ceremony and last two membership ceremonies. All were wonderfully celebratory affairs and I caught up with trainees and consultants I have bumped into in various roles over the years.

These ceremonies are always 'medicine is brilliant' affirming days and I will miss them more than almost anything else at the RCP. Looking around the Dorchester Library at those ceremonies was very reassuring as it reminded me that the future of medicine is in very safe hands.

As for last night's football, it was a massive moment for sport and the women's game (which I have been following more since I learned one of the RCP Global team played for Wales). Mrs G agreed that last night's win was a good allegory of our marriage: the men's team have been promising (in the medium of song) to bring football home since 1996, but the women's team got fed up with waiting and did it themselves.

15 August 2022

August usually feels like a quiet month with fewer people around in both the hospital and the RCP. 2022 is determined to be different. NHS data show that while there may be fewer doctors in the hospital, the demand for services is unrelenting. UK and global politics haven't got much quieter either and cybercriminals have been targeting the NHS. A drought has been declared in much of England and energy prices are spiralling up. One of the few positive things I can say is that at least the current COVID-19 wave is ebbing.

Hospital song – 'winter pressures'

Last week the NHS in England announced its 'winter plan'. This is to be welcomed as it shows that there are people trying to plan ahead. The published plans themselves are more of the same old, same old, though, and the only reasonably new idea is to create 7,000 additional beds. These won't really be beds as such, as the use of virtual wards will be the source of many of them. The wards may be virtual but the staff to run them are real and as I said in response to the plan it is people that we lack. I wonder how many of these 'beds' we will manage to create.

Lots of physicians have worked hard to create virtual bed services already (some for many years), and these are now beginning to be counted and declared in bed numbers. Therefore, large numbers of additional virtual beds will be quite challenging to achieve, although there is local funding available to support the development of these services. Having said that, there are definitely still patients who occupy physical hospital beds who would be appropriate for such services, so there is certainly more to be done.

Anyway, 7,000 is unlikely to be enough and as I mentioned in a previous bulletin, the Royal College of Emergency Medicine has estimated we need almost double this number at 13,000. If there is a big spike of COVID-19 and/or flu even this may not be enough.

The NHS has also published the latest performance data for the year up to July. Compared with the slight optimism of the winter plan it is a dark and foreboding set of data. Yes, the number of people waiting over 18 months for treatment has fallen (and to be fair this was the commitment made in the COVID-19 recovery plan) but waiting lists have increased otherwise and now stand at 6.73 million in total. Ambulance response times, cancer treatment times and 12-hour trolley waits are at their worst ever.

The Nuffield Trust QualityWatch site has already plugged these data into its graphs, which are well worth a look. Those at the bottom of the page show that despite admissions from emergency departments being lower than in 2019 it is flow that remains the problem. Capacity in social care will continue to be the main limitation on how hospitals can cope with demand at the front door. No one politically is talking about this and the NHS has very little ability to influence it.

The publication of waiting times data should be an opportunity to reflect on how much work has gone on by so many to achieve reductions and care for the large number of patients represented on the list. I think it is important to say a big thank you to everyone for their seemingly never-ending efforts in this regard – so thank you. Any positive feelings such reflections may bring are swiftly washed away by certain media outlets, though. If you are suffering from hypotension you could always visit the Daily Mail website to see its take on the situation – the NHS would be fine if only we were more efficient and spent less time worrying about inclusivity and diversity. Long-term readers may remember that a few years ago I tried to live my life by following the health and diet advice in that paper for a year. I gave up after 3 months due to the large number of conflicting recommendations every day. 'Quelle surprise', I hear some say.

Still fighting it – workforce

Like a stuck record I will continue to go on about physician workforce, and the lack of it, until something happens which either means that I cannot speak or do not need to. The annual UK census of consultant, higher specialty trainees and SAS doctors – conducted by the RCP, RCPE and RCPSG – provides a unique insight into the physician workforce and how it is changing. I declare a conflict of interest as I helped run the census for 6 years, but this is probably one of the best ways we have of showing what is going on in the physician workforce and what the next few years will hold.

The full census results will be published in September this year. In the meantime, you can watch a new video presentation by Dr Sarah Logan, director of the Medical Workforce Unit, for an overview of the key findings from the 2021 census. The video is 21 minutes long and contains a large number of worrying stats, not least that 1 in 5 consultants intend to retire by 2025. Around 45% of physicians report that they have rota gaps in their teams each week and we should not be surprised that many are at risk of burnout.

I note the junior doctors committee at the BMA are bringing forward plans to ballot their members about strike action. There is no doubt that retention of our trainees is absolutely critical for the future and that pay is an essential part of how doctors of all grades feel valued by the system for which they work. We also know that the number of doctors on a team makes a huge difference to workload, flexibility, feeling part of a team and the ability to have protected time for training. I really hope discussion about the lack of workforce numbers comes to the fore when strike action is being debated in the public arena as I suspect that the next 6–12 months will be a decisive period for determining the role of doctors in the NHS.

Don't change your plans – inter deanery transfers

One issue which commonly causes problems for trainees is the ability to move between deaneries. Following a lot of work by our Trainees Committee and education and training vice president, a new system to facilitate such inter deanery transfers (IDTs) has been created.

The new criterion 5 (application for IDT without

needing a reason) is confirmed. There has also been standardisation across the nations for eligible annual review of competency progression (ARCP) outcomes. Health Education England's update gives further information but it is really important to note that according to the timeline for submission of documents there is not much time to apply for the next round. Applications must be submitted by 12pm on Friday 26 August. There hasn't been much publicity about this so if you have colleagues/trainees who are looking to transfer please bring it to their attention.

Landed – Linacre fellow

One person who is making a form of deanery transfer is our current Linacre fellow Dr Jo Szram, who has been appointed as dean of Health Education England Kent, Surrey and Sussex Deanery – many congratulations Jo. This means we are now seeking our next Linacre fellow. If you are an RCP fellow with a passion for medical learning and development, please consider applying for this exciting leadership role. You'll work directly with the RCP registrar and with college tutors throughout the UK to represent the work of the RCP and produce the annual college tutor and associate college tutor conference.

Jo has agreed to stay in post while we recruit and throughout a handover period. Find out more about the role and watch Jo talk about the benefits of being RCP Linacre fellow. The deadline for applications is 18 September 2022.

Where's Summer B.? – the heatwave

As we come out of the second major heatwave of the year and drought is announced across large swathes of the UK, data are now emerging on the impact of the first heatwave 4 weeks ago. There were 10,978 deaths in England and Wales in the week ending 22 July 2022 with 1,680 excess deaths to what would be expected for that week, or 18.1 % above the 5-year average. COVID-19 was implicated in 745 of these, although only mentioned on the death certificate in 62 % of the 745. Strikingly, the increase in deaths that occurred at home (private residence) was 31 % above the 5-year average. As there were no other major infectious disease epidemics or environmental events for that week it seems reasonable to infer that about 1,200 people may have died from the effects of the heatwave (or at least had their death hastened).

A blog on the ONS website by Sarah Caul explains why such a simplified conclusion is flawed and as death certificates rarely if ever cite 'heatwave' as a factor in the chain of mortality we will probably never be sure. The U-shaped mortality curve with temperature I mentioned in my bulletin back in July makes it pretty clear that heat was likely to be a factor in these deaths. Climate change is real, and I remain appalled that a potential future prime minister thinks that getting rid of solar farms is a good idea.

Gone – IT issues

The first heatwave did cause considerable problems with unplanned server loss which affected one central London trust in particular (and the effects are still being felt). I'm told Google planned for the heatwave with pre-arranged server closure once 30 degrees Celsius was passed, due to known server issues above this temperature. Something else that will need to be thought about moving forwards.

Further IT outages have been seen in the past week following a cyberattack on the Adastra software used by many NHS bodies in Scotland, 111 and mental health. Psychiatry colleagues tell me they have really struggled with clinical noting due to this and although the exact reason for the attack is not confirmed we need to be ready for more such attacks as the world becomes a more unstable place.

I suspect when the secretary of state was calling for a hackathon to improve ambulance services this was not what he had in mind.

There's always someone cooler than you – AGM

The RCP's annual general meeting (AGM) for fellows will take place from 5–7pm on Tuesday 13 September 2022. This year's meeting will be hybrid with fellows able to attend virtually or in person at the RCP at Regent's Park in London. It will be preceded by the Linacre lecture and followed by a dinner.

This AGM marks the end of my term as president and will include the ceremonial handing over of the reins (as well as robe and caduceus) to Dr Sarah Clarke.

Booking is now open for in-person attendance (behind the website login) where there is also information on automatic registration for virtual access, how to raise advance questions and the programme for the day.

Talking of fellows, I wrote a blog recently reflecting on my time as an RCP fellow and encouraging physicians to propose younger colleagues for FRCP. After an incredibly challenging couple of years, we're asking all RCP fellows – whether you've been one for decades or are newly elected – to take 30 minutes to continue to strengthen the college and its relevance to health services across the globe by proposing two excellent colleagues worthy of recognition.

Proposals are now a joint application with candidates and all parts must be submitted by 5 September 2022 in order to be considered for RCP fellowship this year. So do please take the time to start your proposals now.

Best imitation of myself – ECSACOP fundraiser

As well as my concerns for workforce I hope most readers will be aware of my strong support for the East, Central and Southern Africa College of Physicians (ECSACOP). If we have problems with our workforce supply, they are nothing compared with those faced in that part of Africa. On average, there's just one doctor per 250,000 people in this region, so it represents one of the most underdoctored parts of the world. Founded in 2015, ECSACOP aims to double the number of physicians being trained in the region by 2030 and is supported by the RCP through our Physicians for Africa fundraising initiative.

As part of that, before I became PRCP and as part of the celebrations for the 500th anniversary of the RCP I did a 2018-mile cycle ride to help raise money for ECSACOP. Our fundraising development officer Ewa Gabarz has taken up the baton (if you can do that between bike and foot) and is busy training for a marathon to raise funds to support medical trainees in ECSACOP.

Ewa is aiming to raise £1,300, the cost of supporting one trainee doctor through 4 years of medical school. ECSACOP's mission is to improve standards for healthcare throughout the region and it has delivered amazing results with its network of training centres. With your help we can further those gains, one trainee at a time. If you can, please support ECSACOP by donating on Ewa's JustGiving page.

The luckiest … and finally

I'm writing this bulletin from the Welsh coast and have enjoyed having a few days in my favourite place with my family. As I left the hospital before heading along the M54 I bumped into one of my longest standing patients. I asked how they were and they reported all was fine for them but their partner was on CCU having had a cardiac arrest. Prompt bystander CPR had saved the day and when they awoke on ITU they were, thankfully, their normal self.

It made me remember that things can change in a moment and we should make the most of life, our friends and family while we have the freedom to do so. A glass of wine with said friends and family awaits.

30 August 2022

The August bank holiday has passed, welcome rain returned to many parts of the UK and autumn is on the way – although many of the trees have already shed leaves in an attempt to survive 2022. British political action and inaction have marked much of the past 2 weeks, and there have also been some devastating announcements about energy costs.

Standin' in the rain – cost-of-living crisis

I try not to get overly political in this bulletin but the announcement of a new price cap for UK household energy bills from October (£3,549, up from the current figure of £1,971 with future rises likely) on Friday was met with horror by most commentators as this will have a huge impact on the poorest in society. Together with other causes of the cost-of-living crisis, including inflation and rising food prices, this winter will be extremely difficult for many and it seems likely that some people will be unable to afford heating and risk hypothermia if it is a cold one. Having spent recent bulletins focusing on the right-hand side of the U-shaped temperature-mortality curve because of heatwaves, the left-hand side has become suddenly much more relevant again.

The deafening silence and lack of even a draft plan by the government is bewildering, especially as this price cap figure was easily predictable (and indeed has been by some for at least 2 months). The formula for calculating the price cap is publicly available and thus there has been plenty of time to come up with ways that financial support could be given. The ideas laid out by the PM candidates have been evasive at best, and neither seem to have a convincing strategy. They both seem more intent on soundbites to please their electorate. Given Mr Sunak's comments about lockdown being over the top, and Ms Truss' on the 'threat' France's president may pose, I am glad I am not part of that electorate. It is not even a Hobson's choice.

The cost of energy will have a direct impact on hospitals and practices (as well as the RCP, unfortunately) and this will reduce funds for patient care, estate improvements and workforce expansion. The NHS in England spent over £630 million on gas and electricity in 2020–21 and prices have doubled since. As if things were not tough enough in the NHS at the moment.

Big wheels – excess mortality

There has been a lot of debate over the past few weeks as to the cause of the excess mortality we are currently seeing, and if you would like to read a compelling examination of the impact of delays in the system, I recommend an article by John Burn-Murdoch for the FT, which he shares on Twitter. In his Twitter thread, John makes the point that many countries are seeing excess mortality compared with 5-year averages even once COVID deaths are excluded, but only England and Wales have an excess mortality once ageing population is taken into account.

He then shows a correlation between the 12-hour emergency department (ED) waits in England and variations in the excess mortality. It is a convincing argument as there is much evidence that longer delays in ambulances and ED (whether you are admitted or not) lead to excess mortality. The shocking images of older patients on the floor with fractures awaiting an ambulance do not require any leap of imagination to see such a situation will lead to worse outcomes. There is also lots of evidence from the Royal College of Emergency Medicine that the published 12-hour waits are a woeful underestimate of the reality of the situation in EDs. The number of patients waiting over 12 hours from arrival is a staggering 14 times as high.

Delays in discharging patients and all-time high bed occupancy rates are clearly an important cause of these long waiting times. Ms Truss' plan to shift funds from the NHS to social care makes some sense, as prioritising social care is more important now than for many years. However, many commentators have pointed out that raiding established NHS budgets is like robbing Peter to pay Paul and it seems highly unlikely that there will be a good outcome.

It's over – COVID-19 testing

Last week it was announced that routine testing of asymptomatic healthcare workers will stop tomorrow. This hasn't been received too badly and the rationale seems sound given the prevalence of infections has fallen recently and there is no imminent new variant in other countries. Having said that, when new variants come they do so at a pace, and I hope that it will be as easy to reintroduce the testing programme.

There is flexibility for individual trusts and NHS organisations to implement asymptomatic testing for high-risk areas (for example, you would imagine it would be prudent for staff on a haemato-oncology ward). The exact wording in the UK government guidance is:

'Local healthcare organisations, with appropriate advice (including from Medical Directors, Nursing Directors or Directors of Infection Prevention and Control), may exercise local discretion to continue testing for specific individuals or cohorts in line with broader infection prevention and control measures, for example to asymptomatically test staff or patients who are at higher risk of serious illness from COVID-19 and/or may be in contact with patients who are at higher risk of serious illness from COVID-19.'

Thus, if you think your clinical team/patients need a local variation please contact your local DIPC.

It (hopefully) goes without saying that vaccination is key if we are stopping asymptomatic testing as waning of immunity will be the most likely predictor of further infections if there are no new variants. It also looks like healthcare workers will be among the first to be offered the new Moderna bivalent vaccine (a Pfizer equivalent has been made but is awaiting the relevant authorisation).

Across the border – BGS hospital at home report

Since my last bulletin in which I talked about virtual wards / hospital at home, the British Geriatrics Society has launched a new report called *Bringing hospital care home*. The report offers a further helpful and succinct summary of what we mean by virtual wards and hospital at home, and the evidence we have and need on the benefits and limitations of providing this alternative to hospital inpatient care for older adults.

There is investment across the UK to expand hospital at home (or virtual wards) for people with acute presentations. Many physicians are leading these services, and it will be important for us all to identify people who can be cared for at home rather than hospital when the mechanisms are in place to do so. A recent article in the *Future Healthcare Journal* explores this in more detail.

As I said in my last bulletin this idea is not a panacea, but it may allow us a retort to some of those on the right wing of politics who see the NHS as a bloated inefficient beast.

Starlight – RCP Launchpad

One of the hardest transitions we have in medical careers is from trainee to consultant and the pandemic, as well as shortening of training, have accentuated this. We've recently 'launched' RCP Launchpad, a new online resource which brings together information, tips and guidance for new consultants and SAS doctors. It covers topics such as applying for and starting a new job, what to focus on in the first 12 months in a role and further career development. A new member-only benefit, the resource also focuses on what to do to prepare for appraisal, how to deal with complaints, information on senior leadership opportunities and more, and will be continually updated.

Sweet talkin' woman – Med+

It is now 5 months since Medicine 2022 and if you are pining for more medical education 'Med+' will be taking place on 24–25 October 2022. Previously known as the acute and general medicine conference, this event will provide essential clinical updates for healthcare professionals and includes a dedicated stream for trainees. The conference will feature sessions on diabetes and endocrinology, pain on the acute take, and lessons from military medicine. Expert speakers include Prof Sir Munir Pirmohamed, Prof Rose Anne Kenny and Dr Andreas Goebel. It's taking place in person at the RCP at The Spine in Liverpool or you can join online.

Turn to stone – a taste of culture

Because of the bin workers going on strike in Edinburgh it is not the most fragrant of cities at the moment, but it is possible to escape the bad humors (both literal and with respect to dodgy fringe events). Members in or near Edinburgh may be interested to visit two items from the RCP museum collection on loan to the National Museum of Scotland in their Anatomy: a matter of death and life exhibition. The RCP has lent a portrait of William Hunter by Johan Zoffany, and a 17th-century print of the Leiden anatomy theatre. For members near to London, two exhibitions at the RCP at Regent's Park are reopening from 5 September: A taste of one's own medicine, featuring medical satire at the RCP and SELFLESS, an exhibition of photography documenting the COVID-19 pandemic.

If you'd like a regular dose of medical history and art, exhibitions and events, sign up to the RCP archive, heritage library and museum newsletter.

and finally...

I have been spending lots of time in 'handover' meetings with Sarah Clarke trying to ensure the transition to her presidency is as smooth as possible. I was very grateful to Jane Dacre for doing the same with me and it does reduce the number of surprises in the first few months. We have been using my email filing system as a way to ensure I don't miss anything major, and it has been a bit of a walk down memory lane. Such walks are never dull and I have been surprised by just how much has happened in the past 4 years (maybe this is post-traumatic amnesia).

My main reflection, though, has been that things that seemed unsurmountable at the time do get resolved and passed into history. All things must pass. Talking of which, my next bulletin will be my last.

12 September 2022

We live in turbulent times and the UK feels a very different place compared to a week ago. Out of respect for the period of mourning following the death of Her Majesty, this, my final bulletin as RCP president, will be a tad shorter and more muted than usual. I questioned myself whether it was appropriate to have a musical theme but given her appreciation of at least one rock band, and the title of the album, decided the Queen would have approved.

Long away – rest in peace ma'am

I suspect we will all remember where we were when we heard the news of Her Majesty's death. I was on a tube and my watch pinged the headline as it caught a scrap of signal at a station. It was obvious from those around me that the news had spread fast and that oddest of things, a conversation between tube travellers, was struck up. That alone says much.

The Union Flag has replaced the RCP flag outside the building and will be flown at half-mast until the Queen's funeral. We have opened books of condolence for members, fellows and staff to sign either in person or online. If you are visiting the RCP in London or Liverpool, you may wish to add a message to one of the books which are held in the main reception at Regent's Park and the RCP reception area on the first floor in The Spine. Alternatively, you can sign an online book of condolence.

Readers of this bulletin will know I have been a great fan of Her Majesty and one of the small things that I am proud of as PRCP was to install a small photo portrait of her on the wall behind my desk. It had always struck me as odd that such a pivotal person in our history and governance was not more openly acknowledged. As our 'Visitor' she had a rather unique role, more part of the organisation than patron. I vividly remember conversations about whether we would need her (or at least her representatives) involvement when we were taken to the High Court over our change in position on assisted dying.

King Charles III will become our new Visitor and I hope our relationship with His Majesty will be as positive as it was with his mother. He wrote a piece for our *Future Healthcare Journal* last year and so knows a fair bit about what we do. We should build on that.

I only met Her Majesty twice, and both times as part of a line-up – as a representative of my school when she visited our town during the 1977 Silver Jubilee celebrations and in 2018 at the RCP's quincentenary. The latter visit demonstrated her ability to make anyone and everyone feel very special and it is one of the happiest memories of my time with the college. I have been given a bit of grief by many for my bow, however, as I was a little over-enthusiastic.

In my mind her dedication to the service of her realm was without parallel and there are few who would work as hard as she has done for us all over her lifetime. I cycled down to the palace early on Saturday morning to pay my respects. Even at that early hour many people were already congregating there, quietly showing their appreciation for her life. Every other person clutched a bunch of flowers and as they lay them at the gates, the pile was quietly and efficiently kept under control by the police and palace staff. Messages had obviously been pinned to the railings over the days since her death but, similarly, had been removed. There was one left, though. It said simply, 'Thank you'. I cannot improve on that.

The millionaire waltz – a new government

Two days before her death, the Queen invited Liz Truss MP to form a new government and in so doing become our new prime minister. In the following 24 hours ministers came and went and, as has happened with monotonous regularity in my time, we now have a new set running health and social care services. It is worth a quick précis of this team

to try and understand what the implications are for us all.

Thérèse Coffey is the new secretary of state (the fourth of my presidency) and importantly, also deputy PM. On the positive side this means that she has the new PM's confidence and thus as a champion of the NHS and social care, this has to be a good thing.

Dr Coffey (our new health secretary has a doctorate in chemistry) has already made some statements on her vision for her bailiwick, most notably her focus on the 'ABCD' of ambulances, backlogs, care, and doctors and dentists (chiropractors didn't make the first cut). While I am pleased that this suggests she understands the medical workforce is in dire need of expansion and support, I await the details before passing any more comment. It is worrying too, that it may be a long time before she gets along the alphabet to N for nurses and P for physician associates. Both those parts of the workforce need focus immediately.

Among the new team, Robert Jenrick is a name and face that may be familiar to some as he was an occasional face at the government COVID-19 briefings. He was shown around The Spine in Liverpool during its construction and is therefore aware of the RCP and what we do. His exact portfolio has not been described yet (nor has it for the other three new junior ministers) but I would expect him to have a significant role in NHS matters.

Caroline Johnson is a Newcastle medical school graduate and a consultant paediatrician (less than full-time one assumes – the hospital website is shy about naming its consultants) in Peterborough. Like Mr Jenrick, Dr Johnson is a senior Tory having been vice chair of the party.

Will Quince and Neil O'Brien complete the new cohort. The former has little track record on health issues but the latter was a strong supporter of lockdowns and campaigned against the downplaying of COVID by some journalists and COVID-sceptics. I hope this bodes well.

All new members to the team are based in the East of England or the East Midlands. All are younger than me but then I have always said age often doesn't correlate with wisdom. Let us see how wisely they care for the care services under their charge.

You take my breath away – COVID-19

As this is my final bulletin, I feel I should include a brief update on COVID-19 and the current variants to watch. Cases in UK hospitals have now fallen below 7,000, which is very similar to the levels 12 months ago. The UKHSA published its 45th technical briefing on SARS-CoV-2 variants of concern on Friday and as always it contains some nuggets for sharing. BA.5 remains the main circulating variant and analysis of the severity of disease suggests BA.4 and BA.5 are very similar to BA.2. Among the variants that are being watched with interest are BA.4.6 and BA.2.75.

In all the political reshuffling of the past weeks little has been talked about in relation to the pandemic and certainly nothing about the sacrifice made by so many healthcare workers. It was, therefore, especially important that our memorial to physicians who died during the pandemic was unveiled by Professor Sir Chris Whitty FRCP in the garden at the RCP at Regent's Park earlier last week. The ceremony was attended by the families of those physicians (we invited as many of the families that we had contact details for) and those who came were moved by the memorial, some to tears. The sculpture, by Nicholas Dimbleby, is a striking piece with motifs reflecting the classical tone of William Harvey House, as well as the modern 'brutalism' of Lasdun's building.

As well as praise, since its unveiling the memorial has had some criticism from patient advocates and healthcare workers concerned that its design, a cascade of shields with some broken at the bottom, would trigger bad emotions and memories of the woeful provision of PPE during the pandemic. Such triggering is unsurprising and when we opened our SELFLESS exhibition of photographs of healthcare workers and patients from the first wave, we debated long and hard about the negative

consequences of such pieces of art. However, families of deceased fellows and members were involved in both the principle of having a memorial and ideas for its design, and we realised that an emotional response was needed for the memorial to have a lasting impact.

The creation of conversations and debate is one of the points of a sculpture. Indeed, since its unveiling I have had numerous conversations with members of the public who have been impressed with the memorial. Many had no idea just how poor PPE provision was and indeed how many healthcare workers have died. The memorial will be in place for decades and hopefully centuries – too obscure a piece could mean that the public forget the horrors of the pandemic and the sacrifices made.

Placing it in a publicly accessible position in the garden has allowed many people to pause and reflect. I know some think quiet reflection is wrong and anger and rage is what is needed. I wonder what our deceased colleagues would want. Talking to their families, quiet reflection and a focus on positive memories was what came across from them.

Somebody to love – cost-of-living crisis and homelessness

The economic support for energy costs that the new government is putting in place will go some way to reduce the impact of the cost-of-living crisis that will worsen over the winter period. However, it will do little to help the poorest in our society and the other variables of food prices and rental costs make it likely that we will see a significant increase in the number of homeless people in the months to come.

It is therefore timely to remind ourselves that NHS trusts have a duty to refer individuals who are homeless or at immediate risk of becoming homeless to local housing authorities. It is worth ensuring your trust has processes in place and, when you have such a patient on the ward, checking with colleagues that this has been done. There are helpful NHS resources available.

Another useful resource is the Streetlink app. If you see someone who appears to be homeless on the streets you can contact them and they will ensure local services are activated. This is available in England and Wales.

Teo torriatte (let us cling together) – climate change

While I understand the reaction of government to fall back on fossil fuel provision and removal of green levies in the current energy crisis, we must be resolute in regaining the net-zero ground we might lose in the immediate future. When I became president, I was convinced of climate change and its risks for our future but did not truly understand the threat it brings. I am now really scared about what the future holds, and watching colleagues and friends in Pakistan having their lives literally washed away in recent weeks has been another reminder of what awaits us all if we do nothing.

Earlier in the year the RCP Council and Board of Trustees agreed that we should commit to reducing our greenhouse gas (GHG) emissions by 50% by 2030. This is not easy or cheap to do but we must lead by example. I had hoped many other healthcare organisations would join with us to do this but they have been slow to do so. A recent 'scorecard' for colleges and other associated organisations in relation to climate change shows we all have much to do. I hope others will follow our example and commit to such GHG reductions.

You and I … and finally

Tomorrow will be my final day as RCP president, culminating in the AGM which starts at 5pm. Fellows will be able to join online and will already have received details in an email from the registrar on Friday of some changes we've made to the AGM programme. These include postponement of the Linacre lecture and cancellation of dinner and pre-dinner drinks. The change of president will take place as planned and we will acknowledge Her Late Majesty's service as monarch and contribution to the RCP.

As I hand over to Sarah Clarke I am confident that the RCP is in good hands. I am also confident that you, the RCP membership, will support her as much as you have supported me. One of her first responsibilities will be to represent the RCP at Her Majesty's funeral. I know she will do us proud.

The job of PRCP is a tough one but the emails and messages you have sent me over the years in response to things I have said in my bulletin have been a massive tonic and help. The RCP is its membership and I hope my bulletins have allowed a closer relationship between us all.

It has been an absolute honour to be able to work with and for you all. As the card on the railings says – 'Thank you'.

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