

# this week

**SUDDEN DEATH AND TRIATHLONS** page 422 • **IG NOBEL AWARDS** page 426

**"In a workforce crisis, you can't have people unable to work because of an administrative error. It beggars belief,"**  
—Zoe Norris, chair of the GPC's sessional subcommittee



MATT SAYWELL/BMA

## IT glitch forces GPs to cancel shifts

Locum doctors are being forced to cancel scheduled clinics at GP surgeries because of an IT glitch that has led to their "erroneous removal" from the national performers list, GP leaders have warned.

The problem has caused staffing problems at practices and meant that locum doctors are missing out on income, said the BMA. It first reported the issue to NHS England and the private firm Capita, which manages the list, last year, but has recently noticed a worsening of the situation.

GPs wishing to practise in England must be registered on the national performers list to prove that they are suitably qualified and they have passed other relevant checks. Typically, GPs can be removed from the list only by notifying the list service provider or if action has been taken against them to suspend or remove them from the list.

But in a dispatch sent to local practices this month Norfolk and Waveney Local Medical Committee said that it had become "increasingly aware that performers across the country are being removed from the performers list without any reason whatsoever." It added, "We are aware of situations where this has resulted in locum GPs having to cancel sessions and not work for a period of time while the matter

is investigated and resolved. We would urge all locum GPs and practices to check each GP working in the practice is showing on the national performers list and set up a system for regular review and at the notification of a CQC inspection."

Ian Hume, lead on primary care support services for the BMA's General Practitioners Committee (GPC) and chair of Norfolk and Waveney LMC, said that the problem was due to "a recognised glitch" in the IT system. "It is extremely frustrating that it has not been resolved," he said.

Zoe Norris, a locum GP and chair of the GPC's sessional subcommittee, said that she had received reports of locum doctors "randomly disappearing" from the performers list. "In a workforce crisis, you can't have people unable to work because of an administrative error. It beggars belief," Norris told *The BMJ*. "We also know there is a shortage of locums in a number of areas. It is a massive problem for a practice to then try to find someone at short notice if your locum is suddenly removed from the performers list."

NHS England had not commented when *The BMJ* went to press.

Gareth Iacobucci, *The BMJ*

Cite this as: *BMJ* 2017;358:j4336

### LATEST ONLINE

- Cerebral palsy investigations are "poor quality," says watchdog
- Few novel antibiotics are in the pipeline, WHO warns
- Influential report backs overhaul of US dietary guidelines process



# SEVEN DAYS IN



REX/SHUTTERSTOCK

## Triathlons are most risky for men over 40

Deaths and cardiac arrests during triathlons are not rare, with most occurring during the swimming segment, concludes a case series reported in the *Annals of Internal Medicine*.

The researchers found a total of 107 sudden deaths, 13 cardiac arrests that responded to resuscitation, and 15 trauma related deaths during triathlons in the US between 1985 and 2016.

They found that death or cardiac arrest occurred in about 1.74 of 100 000 triathlon participants—which is higher than earlier estimates and higher than reported for marathon running, which has a reported incidence of 1 per 100 000. The risk was three times as high in men as in women—2.4 per 100 000 compared with 0.74 per 100 000. In men the risk increased with age and was much greater among those aged 60 years or older (18.6 per 100 000).

The authors said that participants should be aware of the risks and should have adequately trained before taking part. They also said that middle aged and older men should be screened for any underlying cardiovascular disease.

Jacqui Wise, London [Cite this as: BMJ 2017;358:j4326](#)

## Brexit

### NHS not ready to take on pensioners living in EU

UK health services do not have the resources to care for the 190 000 British pensioners currently living in other EU countries if they have to return, peers have been told in their inquiry into Brexit and reciprocal healthcare. The Nuffield Trust's Mark Dayan said, "For us, the biggest concern is to retain access to S1 [the certificate of entitlement to healthcare in another EU country] for British pensioners already in the EU. The NHS is not in a position where it can deal with a large influx of people who have a perfect right to use the NHS."

## Public health

### Intensive lifestyle change for people at high risk of diabetes

Anyone in England with a fasting glucose concentration between 5.5 and 6.9 mmol/L should be offered a place on an intensive lifestyle change programme, but priority should be given to those with readings between 6.5 and 6.9 mmol/L, says NICE. Anyone aged over 40 (except pregnant women), people aged 25-39 of south Asian, Chinese, African Caribbean, or black African

origin, and people from other high risk ethnic minority groups should be offered a diabetes risk assessment.

### Drive to identify high blood pressure

Public Health England has asked the 44 sustainability and transformation partnerships (STPs) to work closely with pharmacists and other agencies to increase the diagnosis of high blood pressure and atrial fibrillation. PHE has estimated that up to 9710 heart attacks and 14 500 strokes could be prevented over the next three years in England if everyone with high blood pressure was treated effectively, saving up to £274m. STPs can find estimates of events averted and potential savings at <http://bit.ly/2xeMEq5>.

## Alcohol dependence

### No evidence that drugs can help control drinking

There is no reliable evidence for using the drugs nalmefene, naltrexone, acamprosate, baclofen, or topiramate to help control drinking in patients

with alcohol dependence or alcohol use disorder, a review of 32 randomised controlled trials in *Addiction* has found.

Lead author Clément Palpacuer said that the data showed that "we don't yet know" whether the drugs are effective. "Researchers urgently need to provide policy makers with evidence as to which of these drugs can be effectively translated into a real harm reduction strategy."

## GP income

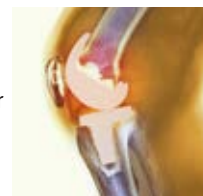
### GPs' earnings fell on average in 2015-16

GPs in the UK earned £90 100 on average in 2015-16, a drop of 1.2% from 2014-15, when they earned £91 200, figures from NHS Digital show. Among GP partners, those working under a GMS contract earned an average of £99 500 in 2015-16, up 1.8% from the previous year. Those working under a PMS contract earned an average of £106 000, 1.9% down from the previous year. Salaried GPs' average taxable income was £55 800, down 1.5% from 2014-15.

## Surgery

### Joint replacements rose by 8.6% last year

A total of 242 629 hip, knee, shoulder, elbow, and ankle replacements were carried out between 1 April 2016 and 31 March 2017, a rise of nearly 21 000 (8.6%) on the previous year, show figures for England, Wales, Northern Ireland, and the Isle of Man. Revision surgery was rare up to 13 years after hip replacement (less than 5% of cases) but rose from 4% among older knee replacement patients (median age 69 years) to 10% among those under 55.



## Drug pricing

### US drug maker sues Ireland for not funding drug

PTC Therapeutics is suing Ireland's Health Service Executive over its decision not to fund ataluren for two boys with Duchenne muscular dystrophy. The executive was advised by the National Centre for Pharmacoeconomics not to fund the drug, given an annual estimated cost of €414 000 (£365 000) a child. The maker said that its final offer was lower than this, being based on a "confidential discount."



# MEDICINE

## Group B streptococcus

### Antibiotics are advised for preterm labour

Women who go into labour before 37 weeks of pregnancy should be offered antibiotics to prevent transmission of group B streptococcal disease to their children, says new guidance from the Royal College of Obstetricians and Gynaecologists. Group B streptococcus is the most common cause of severe early onset infection in newborns.

## Patient safety

### Trust pleads guilty over death of teenager

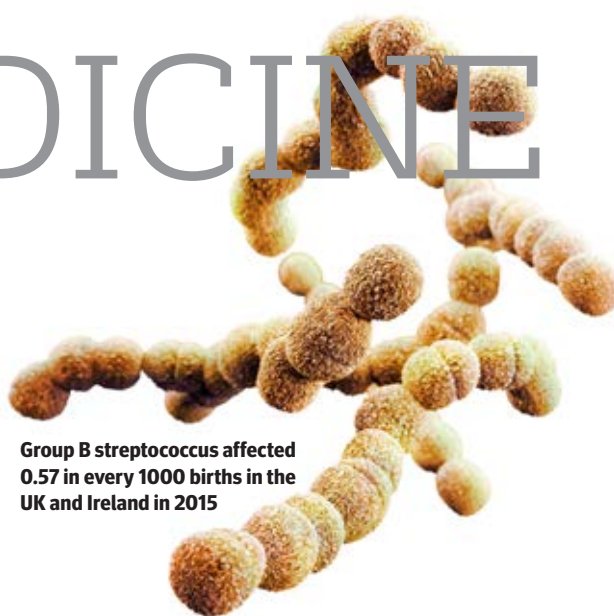
Southern Health NHS Foundation Trust has pleaded guilty to breaching health and safety laws in the death of Connor Sparrowhawk, 18, who drowned in a bath while in its care. The teenager, who had autism and epilepsy, drowned after a seizure at a care facility in Oxford. The trust will be sentenced at Oxford Crown Court on 12 October. A medical practitioners tribunal found last month that psychiatrist Valerie Murphy failed to carry out risk assessments on Sparrowhawk. The case will go back to the tribunal in November.



## Mental health

### "Radical reform" of services is needed

All GPs should have comprehensive training in mental healthcare, says a report by the Centre for Mental Health, commissioned by NHS Employers and supported by Health Education England. It also says that mental health professionals should be given the time and



**Group B streptococcus affected 0.57 in every 1000 births in the UK and Ireland in 2015**

training to consult GPs and staff to respond to more people's mental health needs.

## Hunger

### Global hunger rises to affect 815 million people

After steadily declining for over a decade, global hunger is on the rise again, affecting 815 million people in 2016 or 11% of the world's population, says the UN. The increase of 38 million on 2015 was largely due to the proliferation of violent conflicts and climate related shocks, it says. Some 155 million children aged under 5 were stunted, 52 million were affected by wasting, and an estimated 41 million were overweight.

## Complaints

### Written complaints about NHS rose by 4.9% last year

The NHS in England received 208 400 written complaints in 2016-17, up 4.9% on the previous year, figures from NHS Digital show. There were 75 379 complaints related to GP surgeries, although half were dismissed. Complaints about secondary care rose by 1.4% (from 116 200 in 2015-16 to 117 800 in 2016-17), with 35.3% being dismissed. Lancashire had the biggest increase in complaints (14.6%), while the South Central region had the biggest decline (-6.2%).

Cite this as: *BMJ* 2017;358:j4325

## LIVER DISEASE

is responsible for almost **12%** of deaths in men aged 40 to 49 years and is now the fourth most common cause of years of life lost in people aged under 75, after heart disease and lung cancer —Public Health England

## SIXTY SECONDS ON... THE MOHAWK TRIBE



### THIS ISN'T ABOUT SOME ANCIENT ALTERNATIVE THERAPY, IS IT?

No, absolutely not. It's a contemporary tale of a drug manufacturer trying to ensure that its drug stays on patent.

### INTERESTING—TELL ME MORE

The Irish drug firm Allergan is transferring the patents for its dry eye treatment Restasis (cyclosporin ophthalmic emulsion) to the Saint Regis Mohawk Tribe. The tribe has sovereign status under US law, so the drug firm hopes this will enable it to resist challenges from generic drug makers.

### WHAT'S IN IT FOR THE MOHAWKS?

Money. They get \$13.75m (£10.13m) this year, as well as royalties that could be worth as much as \$15m in subsequent years. Not a bad deal for the tribe, which numbers 13 000 and has an annual budget of £50m. And as the tribal council said in a statement, "We realise that we cannot depend solely on casino revenues."

### A WIN-WIN ALL ROUND THEN?

A win for the Mohawks, particularly for a community that has significant social and health disadvantages. And a win for the drug company, which stands to protect sales worth \$1.5bn last year. But the generic drug manufacturers are not happy. And though the deal is legal, it certainly has a whiff about it. A blog on *Science Translational Medicine* was headlined, "Allergan pulls a fast one."

### ISN'T THIS EVERGREENING?

Evergreening is when manufacturers make drugs in slightly different formulations, such as introducing a fixed dose combination, as a way to extend the patent. This latest play is a new tactic in pharma's ignoble battle to ensure high market share.

### EVERGREENING IS A RATHER BENIGN SOUNDING TERM, DON'T YOU THINK?

It is. Pharma seems to have a history of coming up with colourful terminology. A "patent troll" is someone who tries to swipe another company's patent. I also like the idea of the "drug pipeline."

### SHALL WE CALL THIS LATEST PLOY "MOHAWKING?"

Yes, let's try to patent it.



Anne Gulland, London

Cite this as: *BMJ* 2017;358:j4308



## THE BIG SPEECH

### Duncan Selbie: Health is wealth

Public Health England's chief executive says that getting people into work is in everyone's interests

**I**saw this poster in Freetown, Sierra Leone [which says "Health is Wealth"]. It seems to me that the most important thing that we have been learning is that health and wealth are inseparable and that a thriving economy is good for the health of the people. It is a virtuous circle.

"I want my theme [for the annual conference, last week] to be health and wealth and what we can do to make a positive difference. While life expectancy is important, more important is how long you live in good health.

"As [average] age increases we need people to stay well for longer. For every eight months, at the population level, that [people] stay in work GDP increases by 1%. Staying in the workplace creates wealth.

"The single most important thing that a local authority can do to improve the health of the

people and close the health gap is to get prosperity going.

"One third of working days are lost because of musculoskeletal joint pain and stress in the workplace. That's almost a third of 100 billion working days through things that happen in the workplace and for which we do not yet have a good answer.

"Small businesses,

**WORK HAS  
A HEALTH  
OUTCOME.  
IS THAT  
UNDERSTOOD?**

which employ 60% of the workforce (15.5 million people), could adopt some of the practices of big business, particularly around joint pain, moving more, and counselling. It is economic—big business knows that this can bring down sickness absence—and it helps with people being more effective when they are at work.

"In Sierra Leone, the poorest country on the planet, the Ministry of Health and Sanitation understands that health is wealth: that the best way to get income into the people's pockets is to get them into work, and the best way to improve their health is to get them into work. Work has a health outcome. Is that understood?"

Cite this as: *BMJ* 2017;358:j4322

## Adverse birth effects halved by 24 hour glucose monitoring

Monitoring blood glucose levels continuously during pregnancy with an implanted device halved complications associated with hyperglycaemia in babies born to women with type 1 diabetes, when compared with standard finger prick testing, an international trial has reported.

One in two babies born to women with type 1 diabetes may have complications—including premature or stillbirth, congenital anomalies, or being larger than average—resulting from exposure to maternal hyperglycaemia. There has been no reduction in these complications over the past 40 years.

"Keeping blood sugar levels within the normal range during pregnancy for women with type 1 diabetes is crucial to reduce risks for the mother and child," said the lead author of the new study in the *Lancet*, Denice Feig, from the University of Toronto.

"With traditional monitoring, this can be difficult as sensitivity to insulin

fluctuates throughout pregnancy, meaning that accurately adjusting insulin doses is complex. As a result of our findings, we believe that continuous monitoring should be offered to all pregnant women with type 1 diabetes," she said.

The international open label study randomised 325 women with type 1 diabetes treated with insulin to real time continuous glucose monitoring plus standard capillary glucose monitoring, or to standard monitoring alone. Two thirds (215) were pregnant and 110 were planning pregnancy.

Results showed improved neonatal health outcomes in women undergoing continuous glucose monitoring in pregnancy.

The proportion of large newborns for gestational age was halved (odds ratio 0.51, 95% CI 0.28 to 0.90), as were neonatal intensive care admissions (OR 0.48, 0.26 to 0.86). Neonatal

## Soldier with brain injury can have experimental stem cell therapy

A High Court judge has provisionally cleared the way for a soldier disabled by a traumatic brain injury to undergo experimental stem cell treatment at a clinic in Belgrade.

The application by the lance corporal's mother was opposed by the Ministry of Defence, which is responsible for his care, and the official solicitor, who acted for him in the case at the Court of Protection. Both argued that there was not enough evidence that the treatment was safe.

Mr Justice Baker ruled that the 27 year old soldier, referred to as D, lacked the capacity to make his own decisions about medical treatment.

But D was adamant that he wanted the treatment and the judge said that the wishes and feelings of an incapacitated adult were an important factor in weighing up the patient's best interests. He believed that D would be "much more than miserable" if he were denied the treatment.

### Assault

D sustained his injuries when he was assaulted by another member of his regiment and knocked unconscious. His condition substantially improved after extensive rehabilitation but he still has physical disabilities and global cognitive impairments.

D's mother, Mrs B, wants to take him to the Swiss Medica stem cell clinic in Belgrade, after unsuccessfully seeking the treatment in the UK.

Baker heard evidence from the clinic's chief doctor, Igor Bulboh, who accepted that stem cell therapy was "not researched enough."

The official solicitor's expert witness, Gianvito Martino, professor of experimental biology at Vita Salute San Raffaele University in Milan, told the judge that he was unable to find "even a faint trace of the scientific and operative procedures that should be considered as a mandatory prerequisite

hypoglycaemia was also halved (OR 0.45, 0.22 to 0.89).

“Although continuous monitoring is expensive, the extra costs are likely be offset by shorter hospital stays for babies and the reduction in neonatal intensive care unit admissions,” said coauthor Helen Murphy from the University of East Anglia.

She added, “We only need to treat six pregnant women with continuous glucose monitoring to prevent one baby weighing more than average at birth and one neonatal intensive care unit admission.”

Women monitored continuously during pregnancy showed a small but significant reduction in HbA<sub>1c</sub> compared with those having standard monitoring.

They spent more time at target glucose levels (68% v 61%) and less time hyperglycaemic (27% v 32%). But they were no more likely to suffer hypoglycaemia, with 18 episodes of severe hypoglycaemia compared with 21 in the control group.

Women planning pregnancy showed similar improvements in



glycaemic control with continuous monitoring but with greater uncertainty, which the authors said was potentially because of the smaller sample size or greater variation.

Susan Mayor, London

Cite this as: *BMJ* 2017;358:j4294

**The extra costs are likely be offset by shorter hospital stays for babies**

## CONTINUOUS GLUCOSE MONITORING

- Glucose levels in interstitial fluid are measured by a sensor under the skin. “Real time” devices check glucose levels constantly and sound an alarm if rises or falls are excessive, while “retrospective” devices send results to a computer to be viewed later. Sensors last a week. NICE says these devices can be used by people with the severest type 1 diabetes.
- Flash glucose monitoring (Freestyle Libre; Abbott) is a new kind of device that can be prescribed from November. The user uses a “reader” to scan a sensor in the arm, which shows a real time glucose value with an arrow indicating glucose levels rising or falling, and a graph of levels over the past eight hours. Sensors last 14 days. NICE has not yet made a recommendation on it.

to offer a cell based combination therapy such as the one proposed.”

### Further steps

Acknowledging that Bulboh’s evidence was essentially anecdotal, Baker said that he nevertheless accepted that 80% of the brain injury patients Bulboh had treated with stem cell therapy had shown some improvement.

The judge said that he had not found the decision easy and ruled that several further steps must be taken before he gives his final decision. Bulboh and his team must be given a fully

detailed report on D’s condition and must then report on whether he still recommends stem cell treatment for D. Then a comprehensive plan must be drawn up for D’s treatment. If D travels to Belgrade, Bulboh must carry out a full preliminary assessment and submit a report to the official solicitor before the treatment goes ahead, who could bring the case back to court if he had any concerns.

Clare Dyer, *The BMJ*

Cite this as: *BMJ* 2017;358:j4318

## New NHS safety watchdog aims to overcome “blame culture”

A new independent patient safety watchdog for the NHS in England aims to tackle the “blame culture” that critics say hampers the health service in learning lessons to prevent future harm to patients.

The Health Service Safety Investigations Body (HSSIB) is modelled on bodies that investigate air and marine safety, where there is a focus on risks to the public rather than apportioning blame to individuals. It will cover NHS commissioned services in England, including those provided by GPs.

The body, to be given statutory powers under a parliamentary bill introduced on 14 September, will create a “safe space” by banning the disclosure of information it holds in connection with an investigation, except in limited circumstances. The body will also let accredited trusts carry out their own investigations with the benefit of “safe space.”

The draft bill gives the new body power to enter premises and seize material if the NHS organisation refuses to hand it over and to sanction organisations that fail to comply with requests.

“Safe space” is intended to encourage NHS staff involved in an investigation to speak freely, knowing that the information they provide will not normally be passed on. “Recent inquiries have revealed that staff need to feel more confident that the information they give to safety investigations will not be used unfairly,” says a fact sheet provided with the draft bill.

Exceptions to the non-disclosure rule include disclosure to the police of any evidence of a criminal offence and to the General Medical Council if evidence raises a question of serious professional misconduct.

Clare Dyer, *The BMJ*

Cite this as: *BMJ* 2017;358:j4306





## CHILDREN'S ACCESS TO MENTAL HEALTHCARE

Children and adolescents in England face barriers when seeking help for mental health problems, with access and waiting times for treatment varying across the country, a report by the think tank the Education Policy Institute has found. The institute sent freedom of information requests to all 67 providers of child and adolescent mental health services providers in England in April 2017 and received 57 responses (response rate 85%).

### 1 REJECTIONS

Over a quarter (26.3%) of referrals of children and adolescents to specialist mental health services were not accepted in 2016-17, up from 21.1% in 2012-13. The report estimates that this represents 50 000 young people.

### 2 VARIATION

Some providers turned away less than 5% of referrals, while others turned away over half. Providers in the south of England (excluding London) rejected the highest proportion of referrals (34%), while London had the lowest rejection rate (19.3%).

### 3 WAITING TIMES

Children and adolescents waited a median time of 39 days in 2015-16 to be assessed, down from 33 days in 2016-17. Similarly, the average waiting time to be treated in 2016-17 was 56 days, down from 67 in 2015-16. The longest waiting time for treatment to start was in London (66 days) and the shortest in the Midlands and East of England (50 days).

### 4 DATA ACCESS

The report called for information on access and waiting times to be published routinely in a standard format. At the moment the only way to get the figures is to request them.

### 5 CAPACITY

The high thresholds that providers applied for accepting referrals of children and adolescents highlight the need to expand specialist services in England, the report concluded. It also said that there was a strong case for national waiting time standards.

Cite this as: *BMJ* 2017;358:j4317



## Two *BMJ* papers honoured in alternative Nobel awards

Two papers published in *The BMJ* have won Ig Nobel awards, which are given for “research that first makes you laugh and then makes you think,” at the 27th annual ceremony on 14 September at Harvard University in Cambridge, Massachusetts.

The Ig Nobel peace prize was awarded to a Swiss, Canadian, and Dutch team at the University of Zurich for showing in a 2006 paper that playing the didgeridoo was a good treatment for sleep apnoea and snoring. The Ig Nobel anatomy prize went to British GP James Heathcote, of Bromley, for research published in 1995 on how ears grow bigger with age.

The event was produced by the science humour magazine *Annals of Improbable Research* and Harvard student organisations. Winners received a document signed by an actual Nobel laureate and a cash prize of a Zimbabwean 10 trillion dollar (£0) note.

Didgeridoo playing for sleep apnoea was discovered by Alex Suarez (above), a patient who couldn't tolerate the usual treatment, a mask that produces continuous positive airway pressure. Playing the didgeridoo strengthened the muscles that keep the upper airways open. In a randomised clinical trial, playing a special acrylic didgeridoo for 20 minutes a day, five days a week, for four months was found to be almost as effective as the continuous positive airway pressure treatment. The study's lead author, Milo Puhan of the University of Zurich, told *The BMJ* that people with sleep apnoea, like people with other chronic diseases, needed to maintain their didgeridoo exercise regimen.

Heathcote's study of 206 patients was undertaken to involve GPs in research that made use of their easy access to patients and that did not take a lot of time, he told *The BMJ*. He found that ears grew by about 0.22 mm a year as a person ages.

#### Benefits of cream

One of the youngest winners ever at the Ig Nobels was Jiwon (“Jesse”) Han, 19, whose paper on the physics of spilling coffee won the fluid dynamics prize. It was completed while Han was a high school student in South Korea and published before he entered the University of Virginia in Charlottesville, where he is now a sophomore.

Han told *The BMJ* that because spilling coffee was an everyday occurrence he thought it would be fun to investigate it. He found that spilling could be suppressed by adding a lot of cream to the coffee, changing its viscosity and density and making it less likely to slosh. Walking backwards also worked, as did holding the cup with a hand on top, like a claw. Even better, as he demonstrated at the ceremony, was to use a lid.

A paper on the internet meme about the liquid nature of cats won the physics prize for Marc-Antoine Fardin of the Laboratoire de Physique at the École Normale Supérieure de Lyon. “Solid is the state in which matter maintains a fixed volume and shape; liquid is the state in which matter maintains a fixed volume but adapts to the shape of the container,” Fardin wrote. He told *The BMJ* that he thought he could use the paradox to highlight questions in rheology, the study of flow. Using photos from the internet, he



## OTHER IG PRIZE HIGHLIGHTS

Among the other Ig Nobel prizes were:

- Cognition prize, which went to researchers from Italy, Spain, and the UK for showing that many identical twins could not tell themselves apart in photographs
- Biology prize, to Japanese, Brazilian, and Swiss researchers for discovering that a cave insect had a female penis and a male vagina
- Obstetrics prize, to Spanish researchers for showing that a fetus reacts more strongly to music played through a tampon-like device in a woman's vagina than to music played on her belly
- Medicine prize, to French and British researchers for using brain scans to measure the extent to which some people are disgusted by cheese
- Nutrition prize, to researchers from Brazil, Canada, and Spain for the first report of human blood in the diet of the hairy legged vampire bat.

showed that cats could appear to be solids while jumping and standing but that over longer timescales they could appear to be liquid, such as when they curled into an empty wine glass, bowl, or sink. He concluded, "It's a question of time. If you wait long enough, cats are liquids." He added that he likes cats but doesn't have one now because his apartment is too small.

### Holding a live crocodile can affect gambling behaviour

The excitement caused by holding a live, metre long crocodile, even if its jaws are taped shut, can affect gambling behaviour, according to a study that won the economics prize for Matthew Rockloff and Nancy Greer of the Institute for Health and Social Science Research, Central Queensland University.

People who had a gambling problem and had a positive reaction to holding the crocodile were likely to increase the size of their bet in a simulated gambling game, while those who had a negative reaction to holding the crocodile decreased the size of their bets. "Most people think their gambling decisions are under their control, but their decisions are also driven by excitement itself," Rockloff told *The BMJ*.

Janice Hopkins Tanne, New York

Cite this as: *BMJ* 2017;358:j4303

# Consider steroids for acute sore throat, says *BMJ* review

The evidence is weak but points to the need for shared decision making, reports **Gareth Iacobucci**

This week *The BMJ* publishes the latest article (p 452) in its Rapid Recommendations series, which aims to accelerate evidence into practice and answer the questions that matter to clinicians quickly and transparently.

The latest review examines the evidence for the use of corticosteroids for treating sore throat, one of the commonest reasons for primary care appointments.

## Guidance

International guidance on corticosteroids for sore throat varies, but a trial published in April 2017 indicated that they might be effective. After a systematic review (p 437) that included data from the new trial, the authors make a weak recommendation to use a single dose of oral corticosteroids in patients presenting with acute sore throat. The recommendation applies across ages but excludes patients under 5 years old.

The authors emphasised that shared decision making is needed, highlighting that corticosteroids did not help all patients, according to reported outcomes, and that patients' preferences varied substantially.

The team noted that steroids somewhat reduced the severity and duration of pain, by one day, but that time taken off school or work was unchanged. They also emphasised that harm seemed unlikely from

one dose of steroid. In addition, they noted that steroid treatment was inexpensive and likely to be offered in the context of a consultation that would have taken place anyway.

The recommendations raise several issues for GPs' consideration, including how they should incorporate them into their usual management of patients with sore throat and whether they should change current practice.

Bert Aertgeerts, a GP and professor at the Academic Centre for General Practice at the University of Leuven, Belgium, and one of the authors of the review, told *The BMJ* that the new recommendations were "consistent with current guidance" but added, "If you look at the modest reduction of symptoms and the large variability in patients' preferences, the most disruptive thing about this is the shared decision making between patients and GPs."

## Weak evidence

Although the paper makes only a weak recommendation of oral corticosteroids for patients presenting with acute sore throat, Andrew Green, clinical and prescribing lead for the BMA's General Practitioners Committee, expressed concern that they may lead to an increase in unnecessary appointments and potential overtreatment.

"GPs have spent years advising patients that

normal sore throats are a minor price to pay for the joy of being alive and should not require professional help. The perception that there is a prescription-only treatment available will encourage attendance, and within a system like the NHS this will inevitably deny consultations to patients with genuine needs."

But Aertgeerts said that he did not expect an increase in the number of patients seeing their GP as a result of the



**THE MOST DISRUPTIVE THING ABOUT THIS IS THE SHARED DECISION MAKING BETWEEN PATIENTS AND GPs**

recommendations, although he hoped they would encourage GPs to adopt a more collaborative consultation style.

"If we want to make shared decision making a 'real deal' between the family physician and their patient, then we have to follow our patients. I think the paternalism that we have had for such a long time as GPs has to go away."

● RESEARCH, p 437

● RAPID RECOMMENDATION, p 452

Gareth Iacobucci, *The BMJ*

Cite this as: *BMJ* 2017;358:j4333









## THE BIG PICTURE

# Passion for life

"I promised myself that only after the birth of my first child would I proceed with the mastectomy. I wanted to know and feel what breast feeding is all about."

These are the words of "Sharon," who two years ago elected to undergo a mastectomy and reconstruction after discovering, on the death of her mother, that she had an 85% risk of breast cancer.

To help raise awareness of others also living with a high risk of hereditary cancer, Sharon took part in the Venus Project, an artistic collaboration between the photographer David Scheinmann and BRACHA, Israel's support organisation for people who carry the BRCA mutation.

Scheinmann's images of Sharon and nine other BRCA gene mutation carriers, survivors or "previvors," were taken in and under water to allow freedom of movement to suggest cathartic and ethereal states.

The exhibition is at the Rosenfeld Porcini gallery, London, until 26 September.

Alison Shepherd, *The BMJ*

Cite this as: *BMJ* 2017;358:j4315



# Rising to the many challenges of terror

After another UK hospital declared a major incident, as a result of a tube bomb, **Anne Gulland** reports on the lessons doctors can learn from how those in London and Manchester have dealt with this year's attacks

Last week London's St Mary's Hospital had to declare a major incident after a terror attack on an Underground train at Parsons Green. The explosion once again highlighted the challenges for doctors and medical teams—hospitals in London and Manchester have already been tested by four major terror attacks in 2017: Westminster Bridge, Manchester Arena, London Bridge, and Finsbury Park mosque.

The Parsons Green victims mainly sustained burns, but each of the attacks have presented different challenges. The Westminster Bridge attacker rammed a vehicle into pedestrians, and most patients brought to hospital had blunt trauma. At London Bridge, the attackers used both a vehicle and knives and many patients presented with stab wounds. In Manchester the attacker detonated a device loaded with shrapnel and patients presented with complex, multiorgan injuries.

At a conference at the Royal Society of Medicine in London earlier this month, doctors who treated those patients shared what they have learnt. The NHS was widely praised for its response; however, Duncan Bew, a trauma specialist at King's College Hospital in south London where many of those injured in the Westminster and London Bridge attacks were treated, told the meeting: "We cannot rest on our laurels. Because we have done well in this incident, it doesn't mean we'll do well in the next one."

## Before a major incident declaration

Early reports of a terrorist attack often say that a major incident has been declared, giving the impression that some magical switch is flipped and a well oiled emergency plan kicks in.

Malcolm Tunnicliff, clinical director for emergency and acute care at King's College Hospital NHS Foundation Trust, says the reality is different. The first inkling he got of the Westminster Bridge attack on 22 March was when he was waiting to start a shift in the trust's emergency helicopter and he heard traffic over the radio about an incident.

"The first patients were a normal trauma call. We were getting very little information—patients were being sent through and we didn't have a sense of what was going on until about an hour later," he says.

At the London Bridge incident, which took place just after 10 pm on a Saturday (3 June), King's again received patients before a major incident was declared. In the parlance of the emergency services, police officers "scooped and ran," picking up two injured colleagues without treating them on the scene. "The first we knew was when police officers were banging on the door of resus," says Tunnicliff.

**"We didn't have a sense of what was going on until about an hour later"**

**MALCOLM TUNNICLIFF**



Most Westminster Bridge patients had blunt trauma injuries—but each attack presents different complexities

Susan Beards—a consultant in intensive care and anaesthesia, and medical director at University Hospital of South Manchester NHS Foundation Trust—says there was a delay in the major incident plan being enacted after the bomb at Manchester Arena, with patients arriving at the emergency department unexpectedly.

## Communication updates needed

Beards told the conference that staff contact lists were out of date and some staff did not answer their phones because the hospital's number was listed as "number withheld" in caller ID.

"The switchboard was inundated with calls from the public, and some staff couldn't get through. We had an emergency email address for the hospital command and control centre but not many people were aware of it," she says.

Many of the speakers used WhatsApp, an encrypted instant messaging tool, to communicate with groups of colleagues but were uncertain if they were breaking professional codes. Joshi George,



**"Switchboard was inundated with calls, and some staff couldn't get through"**  
**SUSAN BEARDS**



**"Because we have done well in this incident, doesn't mean we'll do well in the next one"**  
**DUNCAN BEW**





consultant neurosurgeon at Salford Royal NHS Foundation Trust, told the conference that WhatsApp was useful for working out how many staff were needed on the night and who could be available.

"It's not an officially sanctioned form of communication but it worked well on the night. Going forward we need to look at a way of regulating this," he says. WhatsApp is seen as very secure, with even the government unable to break in to spy on potential suspects. However, according to information obtained by *The BMJ*, three doctors were investigated by the General Medical Council between January 2015 and June 2017 for using WhatsApp to discuss work.

Some forms of communication can be distracting, says Tunnick. During the London Bridge attacks staff were inundated with messages from friends, family, and colleagues and were given incorrect information, particularly about reports of a second attack in Vauxhall. "You have to be disciplined. This is where the value of a hospital ambulance liaison officer comes in as they are giving you the correct information," he says.

### Triaging—and re-evaluation—is key

At the scene of a major incident paramedics triage patients according to three categories: patients classified as "P1" have life threatening injuries and need immediate treatment; "P2" patients have serious injuries and need urgent treatment; the "P3" category is for walking wounded.

However, says Tunnick, a patient's condition can deteriorate or even improve on the journey

to hospital. Some of the patients injured during the London Bridge attack had been drinking alcohol or taking drugs, adding an extra layer of complexity to diagnosis.

The first patient Tunnick saw had been stabbed in the back of the head but because he seemed well had been categorised as P3 and sent to minor injuries. However, after it was discovered that he had an expanding haematoma in the neck he came back for immediate intubation before going to theatre. "Patients won't be triaged correctly—that's no one's failing. That's just medicine," he says.

Unlike London, which has trauma centres such as King's or the Royal London that can cope with all major trauma, Manchester has three hospitals that operate as a collaborative trauma centre. George says: "If you have a chest, abdominal, and brain injury there is no one place where that can be treated. We have three different hospitals that form a collaborative trauma centre. That's a problem, particularly when you have injuries from shrapnel. Shrapnel does not respect tissue boundaries."

**Trauma specialists dispute the London Evening Standard headline: "We made our own luck"**



DANIEL SORABJ/AF/GETTY

## DOCTOR'S EYE VIEW: "IT WAS A HORRIBLE SHIFT, BUT AN INSPIRING SHIFT"

Owen King first realised something was happening at Manchester Arena at about 11 pm. The specialist registrar in anaesthesia was taking a break from his shift and flicking through social media when he read the first reports of an incident.

About an hour later, a major incident was declared at University Hospital of South Manchester, and staff were told to expect between 10 and 20 casualties. They did not know the nature of the incident—was it a crush or a crash at the nearby railway station? King and colleagues started to prepare the theatres and call in as many people as possible. "We were a bit like a sports team before a big match: we were running through our pre-game rituals, checking our kit," he says.

When the first patient arrived King, four years into his specialist training, was the most senior anaesthetist in the department—something that was beginning to worry him.

George pays tribute to the paramedic crews. "It was testament to their ability that we had very few secondary transfers. They triaged very well because they knew which injuries could be treated in which hospital. We only had four secondary transfers, and in the next few months we will be looking at those particular patients to see what we could have improved on," he says.

Chris Moran, national clinical director for trauma for NHS England and professor of orthopaedic trauma surgery at Nottingham University Hospital, says that in future it might be better to triage patients into just two categories: walking and lying wounded. "The situation is dynamic and repeated evaluation is essential. P2 can become P1 very quickly," he says.

### Should you return to normal so quickly?

The night after the London Bridge attack, King's had eight major



Many of those killed and injured in the Manchester Arena attack were children

The paramedics looked like they had been through hell, he says. "It wasn't until later that I understood why."

His first patient was conscious and the image of her dirty, tear streaked cheeks remains with him. "Her injuries were strange—like little holes. It was shrapnel flying through her limbs but at the time I had no idea. She also had skin and

**"Everyone was on edge, scared, but everyone got on with the job"**  
OWEN KING

tissue stuck to her that didn't belong to her," he says.

He remembers the surgeon pulling hexagonal fragments from the patient's body and swearing as he found more terrible injuries. He remembers the scrub nurse crying. "Everyone was on edge, everyone was scared but everyone got on with the job," he says.

"It was an exhausting night. I had nothing left and by morning I was running on adrenaline. It's still very hard to talk about. It was a horrible shift, but it was also a very inspiring shift."

trauma calls, including a patient with an unstable neck fracture and a rupture of the spleen. Rebecca Bott, a general surgery registrar at King's, who was on call on the night of the attack, points out: "Ongoing trauma doesn't stop because there has been a major incident."

But some doctors feel their hospitals returned to business as usual too quickly. At Salford the major incident alert was stepped down the day after the bombing, but George believes that the hospital should have cancelled all elective operations for the next two weeks.

"It might even take three to four weeks to know for sure that you have finished all the operating that needs to be done. We underestimated the impact the incident would have on the normal service," he says.

Beards told the conference that in her trust 139 hours of additional operations were performed after the

Manchester attack—equivalent to an extra two weeks of operating time. Her trust cancelled 78 elective cases.

Moran urges hospitals not to declare a major incident over too quickly. "People think because the scene has been cleared and all casualties have left that means a major incident is over. The ambulance service can begin to step down, but for hospitals the incident is nowhere near finished. Hospitals take a huge hit during these events—they should have a divert on for 10 days and take local cases only.

"Do you have to continue business as usual? Couldn't St George's take on some cases for King's?" he asks.

### Be proud of your performance

The *London Evening Standard* newspaper described the survival of all 48 patients from the London Bridge attack as a "medical miracle"—something Bew disputes. "That's a wonderful thing to hear, but I don't think it's true. In lots of ways we made our own luck," he says.

The hospital is well prepared for major incidents, and treating patients with penetrating injuries is, unfortunately, a fact of life in south east London since 30-50% of patients presenting to the emergency department on any given day have stab wounds. Some 27% of patients self present so the hospital is used to people arriving unexpectedly and can respond quickly.

Tunnick says that getting a buzz from working in a major incident is not something to be ashamed of. "It's not bad to feel energised—it's almost what we're trained to do. We're delivering a response to an event that is not ordinary. All of those involved with emergency services and ongoing care should feel energised and good about what they're doing. Some of our staff find that difficult to cope with," he says.

Bott describes working on the London Bridge incident as "massively rewarding. It's energising and it does give you a buzz," she says.

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## Simon Wessely: “Mental health awareness weeks make my spirits sink”

The first psychiatrist president of the Royal Society of Medicine worries that public over-awareness of mental ill health will sink an under-resourced service, he tells **Sophie Arie**

One of the UK's most prominent psychiatrists has called for an end to mental health awareness campaigns. It “massively expands demand” for stretched NHS services and may be convincing well people they are ill, warns Simon Wessely, who until June was president of the Royal College of Psychiatrists.

“Every time we have a mental health awareness week my spirits sink,” says Wessely, who then in July became the first psychiatrist to be president of the Royal Society of Medicine. “We don’t need people to be more aware. We can’t deal with the ones who already are aware.”

Wessely remains concerned about the over-reporting and under-resourcing of mental illness, and the lack of integration between mental and physical health services—despite NHS England head Simon Stevens’s affirmation last month that mental health is now “front and centre” of the NHS agenda.

“I’m really worried that we will overstretch and demoralise our mental health services if all we do is raise awareness but don’t provide more people, better circumstances, better support, and less burden of regulation,” he told *The BMJ*.

### Too much awareness

Recent years have seen a major drive by government, the NHS, and mental health charities to change attitudes towards mental health and to raise its profile in line with physical health. In a crescendo of media coverage, royals and celebrities have opened up about their own struggles.

Despite having welcomed Prince Harry’s interview about his mental health in April, Wessely believes we can have too much of a good thing: too much awareness. He particularly questions surveys in which most students report mental health problems.

“We should stop the awareness now. In fact, if anything we might be getting too aware. One wonders what’s happening

when you have 78% of students telling their union they have mental health problems—you have to think, ‘Well, this seems unlikely.’”

If we have made progress on the profile of mental health, then the same cannot be said of the resourcing of services against a background of increasing demand (see box). Theresa May has pledged to “end the burning injustice of mental health and inadequate treatment” and this summer the government announced a £1.3bn plan to expand mental health services by recruiting enough nurses, therapists, and consultants to treat an extra million patients by 2020-21.

Yet some noted that this would only begin to replace over 6000 mental health nursing posts that have been closed since 2010, and the Royal College of Nursing warned that it would be hard to train enough people within the timeframe set.

“The worry is that they will get a lot of pretty cheap [people]. They will have to be cheap, not that well trained, inexperienced

people who will do nice touchy feely stuff—but they're not going to be able to manage the difficult stuff," says Wessely.

### Integration would make the difference

Wessely, whose main role is regius professor of psychiatry at King's College London, believes that what would make the most difference, in terms of breaking down stigma and improving services for patients, is proper integration of mental and physical health services. "I'd give up parity between mental and physical health any day if I could have integration," he says.

What patients most want is for mental and physical services to be together, he says, because it is when staff work together that they understand each other's—and the patient's—needs better.

But, however logical that may seem, with mental health trusts separate from physical health the system set up under the Health and Social Care Act of 2012 does not make it easy to offer this kind of integrated care. When psychiatrists see patients who also have physical health problems, and vice versa, they cannot share their notes because the computer systems are separate and behind firewalls.

Although the government has said it wants to integrate services better, Wessely says that its much vaunted Improving Access to Psychological Therapies (IAPT) programme, introduced in 2008 to provide cognitive behavioural therapy services to people with anxiety and depression, has instead created a sort of "third way," independent of both primary and secondary care.

The success of IAPT, which in January hit the government's target of 50% recovery for those who complete a course of therapy, is being overplayed, he says, and the figures "massaged" because of the government's need for treatments that show quick results.

### "Pest control": stigma among doctors

That mental health has become "fashionable" in recent years has not made it more appealing to medical students, Wessely notes (see box).

Stigma within the medical profession is a big part of the problem and in terms of changing their attitudes the "public are ahead of us," he says. Peer pressure and family pressure are two of the main reasons students state for not wanting to specialise in psychiatry.

## MENTAL HEALTH SERVICES IN NUMBERS

**10** The number of percentage points by which the growth in consultant psychiatrist numbers is lower than growth across the total consultant workforce

**12%** The fall in the number of NHS mental health nurses between 2010 and 2017

**20%** The proportion of doctors undertaking core psychiatry training in 2013-14 who did not progress into higher specialty training

**23%** The increase between 2013-14 and 2015-16 in ambulance call outs to patients with mental ill health

**26%** The increase between 2012 and 2015-16 in the number of people being sectioned



Wessely, who qualified at Oxford and trained at the Maudsley Hospital in London, where he is still a consultant, knew he wanted to go into psychiatry early on. But he remembers countless times when colleagues spoke with derision about the specialty and suggested that he was too good a doctor to go into mental

health. Some believed there was nothing wrong with mental health patients, some believed they were all "sabre wielding" and dangerous, and others believed anyone who is interested in psychiatry must be mad themselves.

"I vividly remember neurologists at Queen Square [the National Hospital for Neurology and Neurosurgery in London] would always say, 'You seem a decent enough chap. I can't understand why you want to do psychiatry.'"

"My senior house officer was quite upset a few weeks ago when she turned up at the emergency department and someone said, 'Oh look, here's the pest controller.' It's terrible. That happens a lot."

### Stopping the rot

While concerned about the risks of making the public too aware of mental health, Wessely is passionate about tackling this stigma within the medical profession and finding ways to get medical students excited about psychiatry.

As president of the Royal College of Psychiatrists, Wessely launched its Anti-BASH (#BantheBash) campaign to try to end the stigma within the profession. "I spent a lot of effort on that. We've stopped the rot. Recruitment of psychiatrists was going down and now it's levelled out."

He rejects as "nonsense" the idea that psychiatrists are themselves the most guilty, within the medical profession, of prejudice against some forms of mental illness.

"We are not part of the global conspiracy of making everyone into a mental health problem. We do the opposite," says Wessely. "We really are the people who try to maintain some form of boundary between sadness and depression, between eccentricity and autism, between shyness and social phobia."

"We will say, 'Look, this isn't a psychiatric problem,' because we are acutely aware of the dangers of overmedicalisation of what are normal emotional problems."

An expert in post traumatic stress disorder, Wessely's work helped established the principle that victims of trauma should not see a psychiatrist or counsellor immediately because it can cause problems for the majority who will recover with time.

"You might sometimes see that as unsympathetic. It's based on having a view that we do not want to treat the world."

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# Shared medical appointments

A promising response to escalating demand for healthcare

**D**emand for healthcare is escalating, owing to ageing populations and increasing case complexity.

Healthcare systems globally are facing unprecedented and rising deficits, with the prospect of punishing cuts to essential services. Consequently, new models for providing safe and effective care for patients while reducing healthcare costs are urgently sought. One such innovation is the shared medical appointment (SMA).

## Group appointments

First proposed by Noffsinger,<sup>1</sup> shared medical appointments were conceived as a clinical encounter in which patients receive healthcare, from one or more health professionals, in a group setting. This includes patient education and counselling, physical examination, and clinical support. Patients attending shared appointments usually share a key attribute, such as medical condition.

Sharing elements with traditional patient education groups, shared appointments uniquely incorporate clinical interventions, such as history taking, examination, and clinical management. During appointments of about 90 minutes, up to 12 patients can share experiences, interact with facilitating professionals as a group, and receive one to one care. Variations on this model have the clinical component delivered in a group setting, with patients able to listen and contribute to other consultations, or as private one to one consultations held in parallel with group work.

Kirsh et al proposed several causal mechanisms for the beneficial effects of shared appointments.<sup>2</sup> The group setting promotes self management through learning from others' experiences<sup>2</sup>; it allows more equitable relationships to develop between patients and professionals, engendering greater trust, while enabling professionals to learn from



patients how best to support their needs. Patients and professionals gain from having more time in the consultation. Interestingly, these mechanisms map closely to the theorised "curative factors" of group psychotherapy that inspired shared medical appointments.<sup>3</sup>

Investigating the effectiveness of shared appointments is not without methodological challenges, but the body of research is growing. The strongest clinical evidence is in diabetes, where shared appointments result in improvements in HbA1c and blood pressure.<sup>4</sup> Studies have, however, successfully used SMAs in many other conditions and settings, in primary and secondary care, including care for cancer survivors,<sup>5</sup> high use of medical care,<sup>4</sup> pain management,<sup>6</sup> substance misuse,<sup>7</sup> health screening for elderly people,<sup>8</sup> and chronic heart disease.<sup>3</sup> Technology, including video conferencing, has been used for patients in rural areas or those with mobility difficulties.<sup>9</sup>

Researchers have considered a range of patient related outcomes of SMAs, suggesting they can facilitate effective information giving, improving patients' knowledge about their condition and its management,<sup>3,5</sup> and leading to more effective self care.<sup>10</sup> Patients participating in SMAs report fewer symptoms<sup>10</sup> and express greater satisfaction with and perceived access to care<sup>3,11</sup>; quality of care and of life are also more highly rated.<sup>10</sup>

## The body of research into the use of SMAs is growing

Healthcare system outcomes were central to Noffsinger's proposal, and subsequent studies have supported the ability of SMAs to improve access to care,<sup>3</sup> while reducing the use of routine as well as emergency healthcare.<sup>3,4</sup> However, evidence of impact on overall healthcare expenditure is conflicting, with both higher and lower costs resulting from introduction of SMAs in different studies,<sup>4</sup> and widespread adoption is likely to prove costly, at least initially, in terms of development and implementation.<sup>5</sup>

## Consulting challenges

Most literature focuses on the advantages of shared appointments, but challenges clearly exist in this mode of consulting. Chief among these is likely to be the issue of confidentiality. In addition, the established model of doctor-patient consultation is deeply ingrained: both professionals and patients may be reluctant to engage with shared appointments, and just as they will not be appropriate for all conditions or settings, they will not be for everyone.

As the number of studies remains small, more research is needed to define the most effective model of SMAs—and how and where they may be most usefully implemented—and to evaluate their effectiveness in improving care and reducing costs.

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# Tougher charging regime for “overseas” patients

Migrants with mental health needs will be hit hardest

**M**ajor changes to regulations on charging overseas patients for English NHS services came into force on 21 August, with further alterations due on 23 October.<sup>1</sup> The changes make care provided by NHS hospitals and local government, and in private facilities paid for by the NHS, chargeable, with limited exceptions.

The greatest impact will be felt by mental health and community trusts, which until now have been exempted from charging. The government argued that these changes were minor and necessary “to drive a culture change in the NHS to embed identifying and charging overseas visitors and migrants not eligible for free NHS care.”<sup>2</sup>

## Sharing data

Consistent with a recent memorandum of understanding between NHS Digital, the Department of Health, and the Home Office,<sup>3</sup> the changes also require those delivering services to NHS patients to collect, match, and share data across government agencies. This process is facilitated by the Home Office, which now flags charging status on NHS systems: a green banner for eligible patients, an amber banner when a decision is pending, and a red banner for patients likely to be chargeable. Providers must charge upfront for all non-urgent care for patients identified as required to pay and notify the Home Office if they incur NHS debt, accompanied by some personal, non-health data to assist immigration enforcement.

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Additionally, the changes make those who pay the so called “health surcharge” (a fee levied on visa applications for people from outside the European Economic Area coming to the UK for six months or more) ineligible for free assisted conception services. Although the changes offer little financial benefit to the NHS, they were deemed desirable “to reduce the pool of individuals eligible to access highly sought after NHS funded acute care trusts . . . and thereby benefit UK society.”<sup>2</sup>

## Questionable benefits

But will they really benefit UK society? We do not believe so. Firstly, they are likely to push migrants away from seeking community and mental healthcare. The experience after the Grenfell Tower fire was telling: some migrants refused care from the NHS because they feared it would harm their status or alert immigration enforcement.<sup>4</sup>

Not all migrants and visitors are required to pay for their care even if they haven’t paid the surcharge. Staff will need to understand the full set of exemptions for vulnerable patients and those detained—10 full pages of the guidance. Healthcare staff, now including those in mental health trusts, will need to take steps to identify patients eligible for exemption. But we know that many staff lack the confidence and training to do so effectively, especially around

exemptions for people who have been subject to human trafficking.<sup>6</sup> This burden falls on a mental health service that already requires an additional 21 000 staff.<sup>7</sup>

Furthermore, a recent report from the National Audit Office identified some trusts are paying more to administer the system than they are recovering and cited ongoing objections by healthcare staff and their representative organisations to checking entitlements.<sup>8</sup> Staff are concerned that involvement with immigration enforcement betrays the ethics of healthcare practice<sup>9</sup> and about the additional workload in an already overburdened healthcare system. Such objections seem well founded, with even the government referring to the system as “chaotic.”<sup>4-11</sup>

Published freedom of information requests suggest that many acute trusts still have no overseas patient management team and are making charging mistakes.<sup>12</sup> Mental health trusts are likely to be equally unprepared, and mistakes in mental health may have dire consequences for adults and children who are already highly vulnerable.

It is difficult to avoid the conclusion that these measures are not really about raising money for a beleaguered health service but rather about contributing to the government’s agenda to “create a hostile environment” for migrants.<sup>13</sup> Importantly, the problems could increase rapidly if restrictions expand to cover everyone from the EEA after Brexit. Enforcing the charging of migrants in this way may also sensitise the public to charging in the healthcare system, while laying the groundwork for further privatisation in the future.

The government has fundamentally misrepresented the nature of the changes. Alternatives should urgently be considered.

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**Some trusts are paying more to administer the system than they are recovering**

