February 2018

The Sessional GP

nasgp National Association of Sessional GPs

Supporting sessional GPs to improve patient care

In our 99th edition, Kate is no so sweet on sugar; Judith has us whacking mouldywarps, Rachel has some advice about the new European data protection laws, Nigel pits pensions against mortgages, Emma explains some of the reasons why GPs work Down Under, Sara on the current climate for GP locums and Louise on faltering growth in children.

pension paradox

WHY ARE PENSIONS ANNUALISED ON DAYS WHEN LOCUMS AREN'T ENTITLED TO DEATH IN SERVICE?

By Sara Chambers @sara71chambers

The emerging implications of the 365-day annualisation of pensions for GPs within the 2015 pension scheme become even more bizarre when you factor in that GP locums within the NHS pension scheme are not entitled to 365-day death-in-service benefits, argues NASGP's Sara Chambers.

As we near the end of a pension year and many of us digest the implications of annualisation, it's welcome to get some perspective from our financial advisor contributors on just how valuable the NHS pension remains compared to private pensions and other longer term investments, even if you do end up being subjected to an extra bill for annualisation.

This is some solace, but only some, and only if you look at pension provision in a silo, isolated from the rest of what's happening to GPs.

Because pension provision is part of the package of being a GP, and other parts of that package are under threat: working in an over-stretched service which places us in positions of “enforced underperformance”; the culture of rising litigation; the fear of being found personally (or even criminally) liable for system failures; and rising indemnity costs, along with uncertainty about how occurrence-based cover that adequately supports individual practitioners will be provided in the future.

On the matter of annualisation, there is some ‘equality’, in that as this applies across the entire NHS workforce (all employee pension contributions tiers are based on notional whole-time equivalent income), then it should arguably also apply to GPs too.

However, and a BIG however, the break in service rules that are now applied when a GP changes from a Type 1 or Type 2 Practitioner to a locum are a major problem, especially in the current climate of significant GP recruitment and retention problems, by reducing the attractiveness for GPs to offer flexible, sporadic locum support or take on new roles, and risking the unanticipated consequence of further reducing GP capacity. This needs monitoring and addressing.

Already NASGP is hearing from GPs who were doing the “right thing” by offering extra locum cover, or taking on a salaried or partner role, and are now finding that they are affected by annualisation. In some cases, the extra pension cost they are paying is more than the extra locum pay they received.

And the usual response NASGP hears is “I won’t do extra locum work again” or “I wouldn’t have taken the job if I’d known.”

Finally for GPs working solely as locums, there is the extra irony that if they have a “break in service” they will have to apply their daily rate to 365 days a year. But some of the NHS pension benefits do not apply to them 365 days a year...no death-in-service benefits are paid to your family if you happen to die on a day when you’re not booked to work.

If our government is serious in any way about GP retention and recruitment, and better still, making best use of the existing pool of flexible GPs, a whole, “joined up” approach to the experience of being a grassroots GP is fundamental to any plans.

Sara Chambers
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start planning now for next year's tax

THERE'S A LOT YOU CAN DO IN ADVANCE.

By Liz Densley @honey_barrett

It's not long until the end of the tax year - what should you be thinking about?

- Have you used your full ISA allowance?
- Are you or your spouse wasting any of your personal allowance?
  - If you are a basic rate taxpayer and your spouse is not using their personal allowance, you may be able to claim marriage allowance.
  - If your spouse provides bookkeeping or admin services to your locum practice, could you pay them a market rate for the work done?
  - Is there any advantage in using a company owned by you and your spouse to provide locum services? (Be cautious about this, and take professional advice before committing yourself)

- Have you considered if you should be claiming child benefit? If the higher earner of a couple living together, married or otherwise, has taxable income of less than £60k, this could be worthwhile. Note that where you have disclaimed the allowance because you expected income to be too high, you are able to backdate your claim.
- Have you recorded your Gift Aid payments? Sometimes the timing of these payments can affect whether you keep or lose your personal allowance.
- If you are planning on buying a computer or tablet or other equipment for business purposes soon – buying before your year-end will give you tax relief a year earlier.
- Are you recording mileage properly to maximise your claim for car use? We've worked very closely with NASGP to make sure that the mileage automatically recorded within LocumDeck is correctly categorised to capture all eligible mileage travelling to and between practices.
- If you are considering buying a brand new low emissions car that is used materially for work, buying before the end of the year could give a cash flow advantage. Other car changes probably don't give big enough savings to worry about when it happens, unless you have very heavy car usage.
- Where you have your own company – have you looked at the optimum balance of dividends vs salary?
- If you are salaried, have you checked your tax code?
- Capital gains tax: are you able to use your annual exemption of £11,300? Carefully timed sales of shares/property etc can help reduce your liability. Are assets owned jointly with your spouse so you can each take advantage of the exemption? If you have made losses in the year already, don't deliberately create small gains that would be within the annual exemption, or they'll reduce your losses – leave until the following year if commercially sensible to do so.
- Inheritance Tax reliefs: if you haven't got enough to give away yet, what about your parents? Small gifts of £250 to any number of individuals, £3000 annual transfer (and the year before if not used), gifts in consideration of marriage, normal expenditure out of income. All these reliefs can add up to sizeable sums over the years. With larger estates, PET's (potentially exempt transfers – whereby the donor needs to survive 7 years for it to drop out of account) and Trusts can be useful.

- Prepare to collate your year-end records for your accountant, so your tax can be reviewed early in the year to prevent you paying too much tax in July – and to warn you what you will need to pay the following January.
- Student loan: if you are close to repaying your loan, consider whether it is better to pay it off now, or to switch to direct debit payments so that you don't overpay and then have the hassle of getting it back.
- Finally, if you are considering changing your bookkeeping system (to move on to the NASGP LocumDeck system for example) the new tax year is a good time to start.

Liz Densley is medical specialist Director with Sussex Chartered Accountants, Honey Barrett and secretary of aisma (the association of independent specialist medical accountants). Contact her on 01424 730345 or at liz.densley@honeybarrett.co.uk

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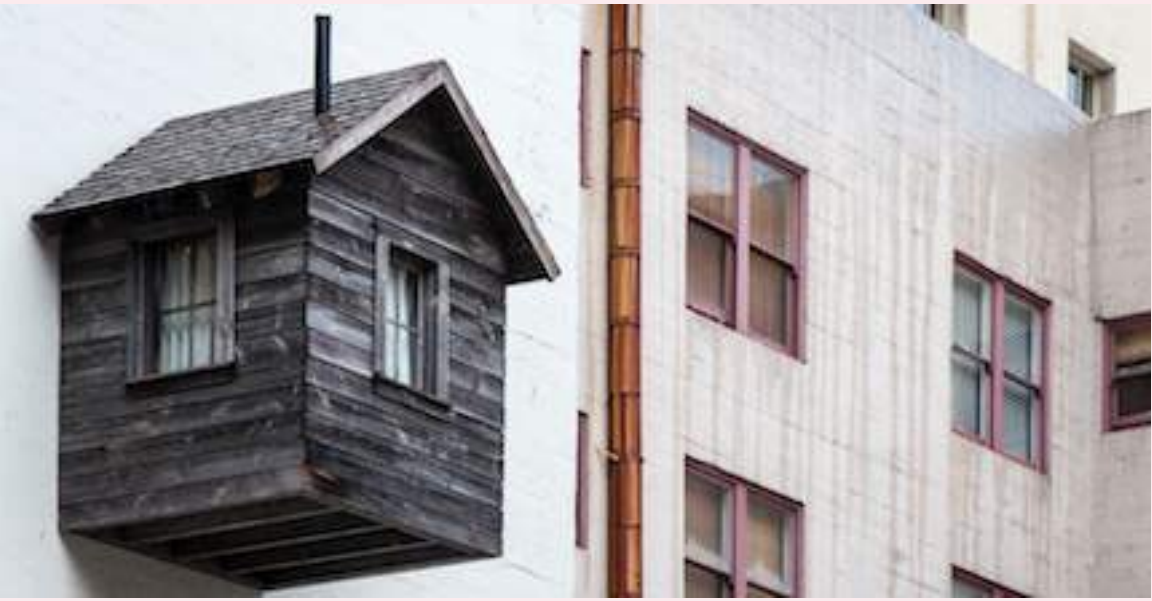
is the property market a good alternative to nhs pensions?

IS THE PROPERTY MARKET A GOOD ALTERNATIVE TO NHS PENSIONS?



By Nigel Farrar www.legalandmedical.co.uk

As part of a diversified financial portfolio you would expect to see property and pensions represented well, with property normally being your main residence, and some form of pension planning e.g. the NHS pension scheme in the mix.

However, with NHS Pension Scheme contributions as high as 14.5% of pay for some, penalties of c. 5% per year if you want to take benefits 'early', and possible tax charges if your NHS Pension causes you to breach your annual or lifetime allowances, you could be forgiven for asking if you should prioritise property over pensions.

But even contemplating such a swing is fraught with difficulty. In trying to choose between the two, the problem you have is that you are comparing apples with bananas. The NHS pension scheme is a gold plated benefit that is guaranteed to pay you an income in retirement. You contribute to the scheme on a monthly basis, building up benefits over a period of time which is increased by inflation each year. When you take your pension, this is further protected by inflation increases payable for the rest of your life.

Investing in property over time has traditionally been a very good way of getting a return on your capital, but history has also shown things can go wrong. Property crashes and difficulty in borrowing are now in most people's remembrance. Property isn't a cast iron investment. Because it is so familiar to many, inherent risks are often overlooked. What if interest rates make the mortgage repayments unaffordable? What if you end up in negative equity because local prices have fallen since you bought, consuming your equity? If you buy as an investment rather than your main residence only, what if the rental market stalls and your rent no longer covers your mortgage and running costs? What about the tax implications of your capital gain and rental income on a buy to let?

So is the NHS Pension scheme good value for money?

Let's start by comparing apples with apples! Is the NHS Pension the right kind of pension for you?

On the one hand, the new pension freedoms have made personal pensions the obvious, more attractive alternative haven't they? The simple answer is 'no'. The NHS Pension Scheme's fringe benefits are hard to replicate elsewhere. Benefits such as the Ill Health Retirement Pension, Life Cover (death in service, although beware the caveats regarding GP locum work), and uplifts for any spouses pension are not included within a personal pension arrangement and if they were purchased as standalone policies could be more expensive.

To try to illustrate whether the NHS Pension Scheme is still good value for money, here are 3 age dependent examples*: age 25, 35 and 45.

As most are now in the 2015 scheme, I have based all examples purely looking at a contribution within that scheme.

You're 25 years old

(hypothetical - too young to be a GP!)

- Your basic pay is £30,000. Your planned retirement age is 68 (state pension age).
- NHS Pension vs Personal Pension for a 25 year old
- 1 year's NHS Pension contribution will give you an NHS Pension of £2,356.25 per annum (index linked) at age 68.
- To provide an equivalent pension at age 68, you would have to pay 29.2% of your basic pay that year into a personal pension. That's 19.9% more than the 9.3% contribution that you currently pay into your NHS Pension.

You're 35 years old

- Your basic pay is £45,000. Your planned retirement age is 65 (earlier than state pension age and 2015 scheme pension age).
- NHS Pension vs Personal Pension for a 35 year old
- 1 year's NHS Pension contribution will give you an NHS Pension of £1,920.91 per annum (index linked) at age 65.
- To provide an equivalent pension at age 65, you would have to pay 35.3% of your basic pay that year into a personal pension. That's 26% more than the 9.3% contribution that you currently pay into your NHS Pension.

You're 45 years old

- Your basic pay is £80,000. Your planned retirement age is 60 (much earlier than state pension age; early retirement penalties will apply.
- NHS Pension vs Personal Pension for a 45 year old
- 1 year's NHS Pension contribution will give you an NHS Pension of £1,558.74 per annum (index linked) at age 60.
- To provide an equivalent pension at age 60, you would have to pay 40.7% of your basic pay that year into a personal pension. That's 27.2% more than the 13.5% contribution that you currently pay into your NHS Pension.

So, is the NHS Pension Scheme still good value for money?

With the examples above, it would take either some extreme investment choices or high contributions to match the equivalent NHS Pension. Not only is the NHS Pension Scheme still good value for money, importantly, a major part of your retirement planning is taken care of for you.

Other considerations worth noting

If you expect to have annual or lifetime pension allowance issues in the future, the excess tax charges that you'll incur will affect the generous nature of the NHS Pension. Financial advice should be sought if you think that these allowances may affect you now or in years to come.

You should also note that, if annuity rates increase, the outcome of the NHS Pension 'value for money' debate may well change. For that reason alone, it's worth keeping up-to-date and regularly reviewing both your retirement plan and your overall financial planning.

So as with most things in life, over reliance on one thing is not advisable. Attempting to choose between pensions of any kind and property is to deny yourself tools that will be of undoubted of use in the unknown future we all face. With the irreplaceable benefits of being a member of the NHS Pensions scheme on offer, plus the ability to partake in the advantages of property with your own main residence without adding complication to your tax situation seems to continue to fit the bill. Any deviation away from this route plan would need very strong arguments and great thought.

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We are looking to recruit a number of General Practitioners, to work in a range of practices - these range from small single handed island practices of 1100 patients, through to single handed practices on Mainland Shetland with 720 patients. Our largest group practice has just under 9000 patients, so there are a range of posts available.

The posts, which are varied offer an excellent opportunity for the appointee to undertake a traditional General Practitioner role in Shetland; where 15 minute appointment times are standard, where there is good interdisciplinary team working and where you will get a chance to influence the direction, e.g. cluster working. Along with our practice teams you will support the delivery of exemplary standards of care, providing daytime general medical services through the week, undertaking a range of duties and dependent upon the location supporting the OOH cover arrangements.

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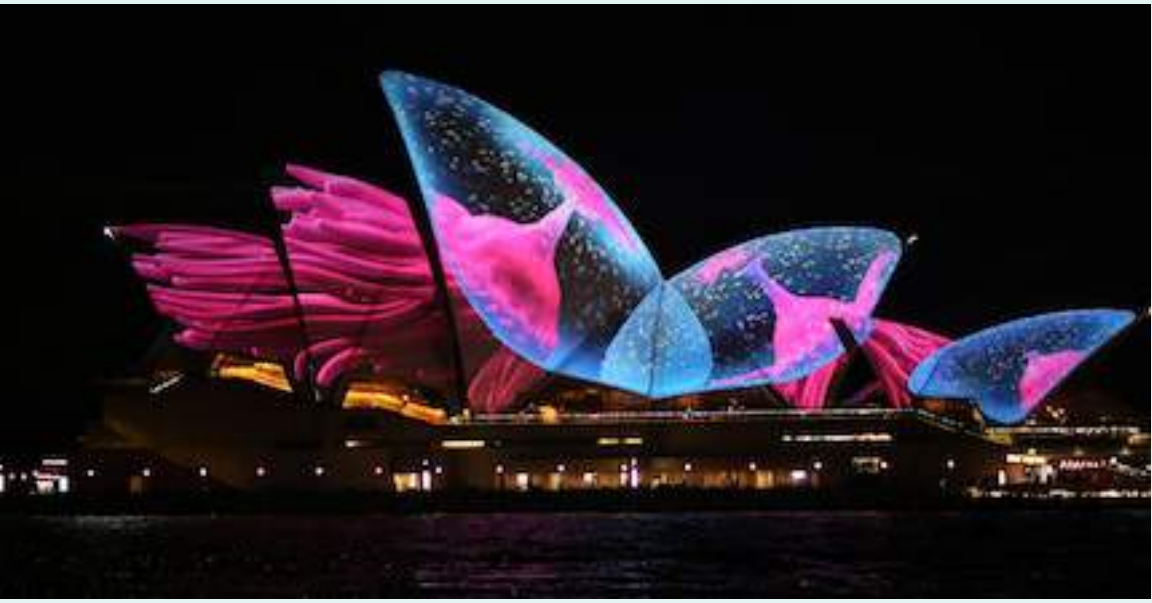
This is a beautiful part of the world with a satisfyingly different lifestyle from the metropolitan centres. The diverse nature of Shetland's culture, the stunning scenery, the wildlife, the local dialects as well as the spread of different islands all make for greater professional and personal challenges. Shetland is a world where wildlife is truly wild - otters and seals play in quiet coves and the air is full of the sound of wild birds crowding the jagged cliffs in huge and noisy colonies. There are regular sightings of killer whales and superb displays of rare sub-arctic flora.

For more information on this opportunity and how to apply, please visit **www.aspenpeople.co.uk/nhsshetland**. For a confidential discussion, please contact Lorraine Porteous, Associate Director on 0141 212 7555.

the move down under

IT'S BECOME MORE POPULAR, BUT IS IT FOR YOU?



By Emma Cook @transitionmedic

Having successfully placed over 100 GPs from the UK and Ireland into general practice posts in both Australia and New Zealand, Emma Cook from Transition Medical has come across a myriad of reasons why GPs want to both leave their current posts, and also why they've taken up their new posts 'Down Under'.

Despite a deep-seated loyalty to their native healthcare systems, especially the founding principles of the NHS, many cite unfavourable changes to the NHS, as well as a considerable increase in both their administrative workload. Others have had a life-long dream of living and working overseas, with Australia and New Zealand providing the perfect climate and lifestyle to fulfil that dream.

Once settled in their new overseas post, we then start to hear heartwarming feedback about their experiences of the professional benefits:

- Ease of transition; with UK qualifications or experience from a comparable country, the transition into general practice in either Australia or NZ was relatively easy. There are, of course, differences in the healthcare systems, but the day to day clinical practice has been quite similar.
- A wider scope to practice clinical interests, with the majority of clinics being well set up for minor injuries and surgery, occupational assessments, skin cancer clinics and chronic disease care. One of our GPs had always been frustrated in the UK because she hadn't been able to explore her interest in respiratory illness, but when she arrived in New Zealand she found enthusiastic support to set up her own specialist clinic within the practice.
- The workload is generally less intense than their experience in the UK, with the focus being much more on spending time with patients in clinic, with some GPs typically having 15 minute appointment times, and usually no home visits or telephone consultations. All this with the addition of less paperwork!
- Earning potential, with UK GPs in New Zealand earning around $160 - $200K NZD, which at the moment equates to £85K - £105K, and in Australia earning upwards of $250k (£140k), with many GPs earning much more than this.

Finally, with Australia and New Zealand being consistently at the top of global lifestyle indicators, we also get to hear a lot of feedback about the UK GPs have settled into their new way of living. As well as experiencing a higher quality of life, we also get to hear about the superb education and health care systems, not to mention the stable economic and political environment, clean and safe surroundings along with a fantastic climate allowing for that enviable outdoor lifestyle. One of our GPs moved to South Australia a few years back with his young family, where his kids are thriving. They've loved exploring and have made lots of new friends, so much so that they've now applied for permanent residency and are about to lay the concrete foundation for a new home they're building in Adelaide. A dream fulfilled.

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Emma Cook is the managing director of Transition Medical. In her next article, Emma advises on how to find the right overseas job for you, and then make yourself more appealing to a practice.

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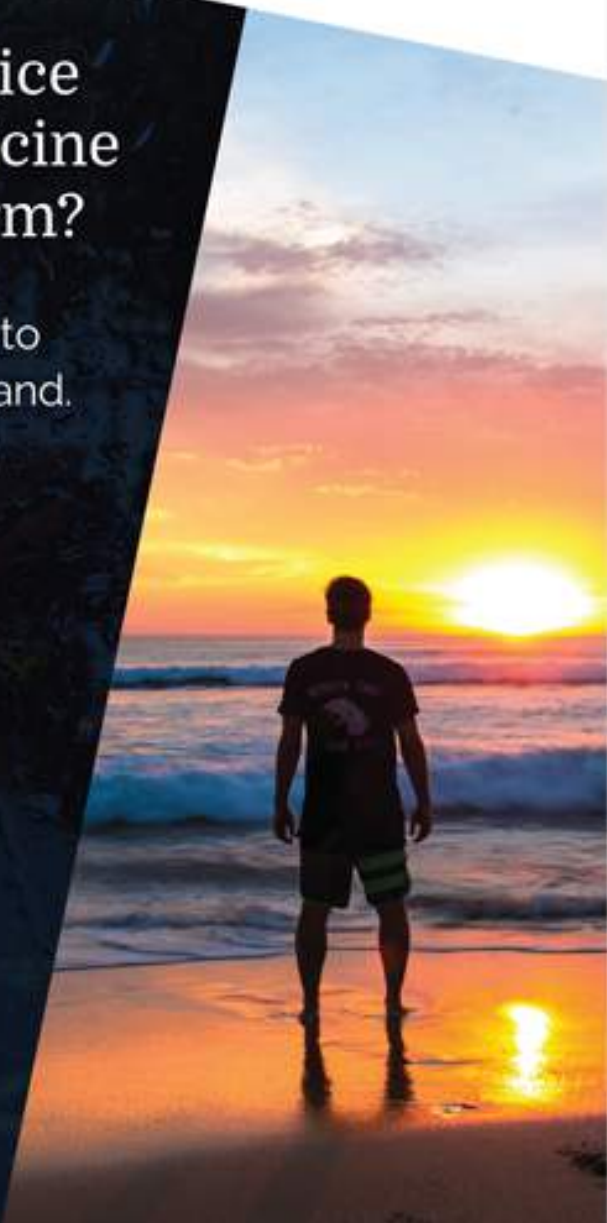

the new GDPR and sessional GPs

THIS NEW EU DATA PROTECTION LAW HAS IMPLICATIONS FOR ALL GPS

By Rachel Birch @MPSdoctors

Data Protection law will be changing in a few months. Dr Rachel Birch, medicolegal adviser at Medical Protection, answers some commonly asked questions about the new legislation, with particular emphasis on how it may affect sessional GPs.

1.When does the GDPR come into force?

On 25 May 2018, the EU General Data Protection Regulation (GDPR) will come into force and will have a direct effect in every European country. It will supersede existing data protection laws, including the UK Data Protection Act 1998.

It has been written to reflect the increasingly digital world and will allow people to take greater control of their own personal data.

2. Will it be affected by Brexit?

The UK will still be in Europe on 25 May 2018 and data controllers will have to comply with the GDPR from that date.

In order to prepare for the post-Brexit period, the UK Government has published the UK Data Protection Bill. This will be debated in Parliament and may be subject to numerous amendments prior to any law being finalised. However, as the UK will wish to continue to do business with EU countries, then the data protection laws are unlikely to change much in the UK post-Brexit.

3. Who does it apply to?

The GDPR applies to all individuals and organisations who have day-to-day responsibility for data protection. Therefore it applies to all sessional GPs, whether employed as salaried GPs in a practice or doing locum sessions in a variety of different practices.

Practices themselves are defined as "data controllers" of patients' personal and sensitive personal data and must be fully compliant with the GDPR.

4. What are the main changes?

The Information Commissioner's Office's (ICO) has published guidance "Preparing for the General Data Protection Regulation (GDPR) – 12 steps to take now".

a) Consent and legal processing: The GDPR sets a very high standard for consent in relation to the processing of personal data. Consent must be freely given, specific and informed. It should constitute an unambiguous indication of the patient's wishes, by a clear affirmative action to the processing of his/her data. Pre-ticked boxes will not count as consent and there must be a positive opt-in process, separate from other terms and conditions. There should be an easy way for patients to withdraw their consent.

However, rather than relying on consent to process patient's data, practices are likely to be relying on another appropriate legal basis for the processing of data. The ICO has published specific guidance on this.

In general, a GP practice will be providing a service to the patients. Therefore, since it is necessary to process that data to provide the service, then the practice may choose to rely on that legal basis rather than consent.

In relation to special categories of data (formerly sensitive personal data, which includes health data), there are specific provisions that allow data to be processed in order to provide medical care, and in relation to social protection laws.

b) Transparency and fair processing: Practices must inform individuals what they are doing with their data. Privacy notices should be used to inform patients at the time of collecting their data. These could be available on the practice website and as posters in the practice.

The following information must be provided within such notices:

- the data controller's identity
- the data protection officer's contact details
- the purpose of the processing
- the legal basis for processing
- the categories of personal data concerned
- the potential recipients of personal data
- how long the data will be retained
- a list of the data subject's rights
- safeguards that will be used if data is to be transferred to a country outside the EU.

In addition, patients must be informed that they can complain to the ICO if they believe there is a problem with how their data is being handled.

c) Subject access requests: The timescale for compliance with a patient's subject access request will be reduced from 40 to 30 days. Practices will no longer be able to charge, unless the request is manifestly excessive or unfounded. If practices refuse a subject access request, they must tell the patient why they have done that and inform them that they have a right to make a complaint to the ICO.

d) Data breaches: In the event of a data breach affecting a patient's privacy rights (for example, breach of confidentiality), data controllers (practices) will be required to notify the ICO without undue delay, and where feasible no later than 72 hours after becoming aware of the breach. This is in addition to the duty of candour to inform patients of such breaches.

The ICO will have the power to impose higher fines on practices for breaches of the regulation.

e) DPIAs: Data Protection Impact Assessments (DPIAs) are recommended as a way of assessing the level of protection in place to safeguard patients' personal data. Whilst considered good practice in any case, DPIAs will be

legally required where the processing of personal data is likely to involve high risks to the confidentiality of individuals. They are likely to be required when practices introduce new technology, for example a new computer system or a new system of sharing data.

f) Data protection officer: General practices will be required to have a Data Protection Officer (DPO). The DPO's role is an advisory and monitoring role, and cannot be someone who takes decisions about data protection. It is unlikely that the practice manager could take on this role, as there would likely be a conflict between advising on how to carry out processing in compliance with the GDPR, and taking decisions about how that should be done.

g) Patients' rights: Individuals will be given stronger rights under the GDPR, including the right to rectification, the right to erasure, the right to object to processing, the right to restrict processing and the right to data portability. This final right makes it easier for patients to move their information from one data controller to another, and they will have the right to receive certain personal data in a structured, commonly used and machine-readable format. These rights are complex and not absolute. Practices should ensure that they understand when they apply and have a process in place to deal with them, should patients wish to exercise them.

Does the GDPR affect what sessional GPs should do if they wish to follow up on a patient's progress?

Scenario 1

Dr A undertakes regular locum sessions in a practice. She saw a patient with an interesting rash, prescribed treatment and arranged a review appointment with the patient's usual GP. The next time she is in the practice she wants to go into the patient's record to follow the patient's progress.

In line with the GDPR, practices must inform patients what they are doing with their data, ie that the information within their medical records will be used to provide clinical care and for local clinical audit. In general terms, patients usually do understand and accept this.

It would seem reasonable, in line with the GMC concept of "implied consent" (7) for disclosure of information for clinical care or for local clinical audit, for Dr A to review the patient's progress in this way.

Scenario 2

Dr B is doing a one-off locum session in a practice. He sees a patient with an unusual pattern of visual loss and refers the patient urgently to the Ophthalmology department at the local hospital. He wishes to find out the outcome of that referral for his own learning. However, he is not going to be back at the practice again.

The GDPR advises data controllers to consider whether you are using information in a way that patients would not expect. The GMC states that explicit consent should be sought for disclosure purposes that may cause patients surprise.

The patient may not expect that Dr B will be contacting the practice, when he is no longer working there, to follow up on his progress. Therefore it would be best for Dr B to seek the consent of the patient to contact the practice at a later date for this purpose. Consent could be verbal (and documented in the medical record) or signed on a consent form.

Key messages for sessional GPs

Data protection is the responsibility of everyone within a practice. The GDPR applies to individuals as well as organisations.

In the course of your work, if you have any concerns about a practice's data protection policies, you should raise these concerns with the practice manager.

Be aware that the law is changing and familiarise yourself with ICO guidance. It would be prudent to regularly check the ICO website over the next few months to review updates as they are published.

The GDPR has been well-publicised in the media. As such, patients may ask questions about it during consultations, for example, regarding subject access requests or their patient rights. Any queries should be directed to the practice manager. ●

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Susan Smith, Practice Manager, Glebe Surgery, Storrington

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sugar - the uncoated truth

COULD LIFE BE SWEETER WITH LESS SUGAR?

By Kate Little @katelittle71

The other day I was out walking with friends when I suddenly felt very light-headed and shaky - it didn't pass until I ate something. I remembered feeling like this before, years ago, when cycling after a large bowl of shreddies. This time I had eaten a bagel. I looked at the sugar content and was staggered to see that each bagel (even wholemeal) contained 6.6g sugar, four times the amount of a standard slice of wholemeal bread. Of course, a bagel weighs double a slice of bread, explaining some of this. And I guess that most of us know that bagels are "unhealthy" food options, yet they had somehow slipped into our family staples without me really thinking about it.

Given the explosion of adult and childhood obesity and Type 2 Diabetes globally, what we eat is clearly important, as well as how much or little we move.

Most of us know that if we want to lose weight, we need to reduce calories. We know that reducing sugar is part of this, as sugar equals calories. We are also aware that there are many hidden sugars, particularly in processed food, and that complex carbohydrates, such as rice, pasta and bread are all metabolised into sugar. So reducing our carb intake makes total sense.

Many high profile people, such as comedian Eddie Izzard, have given up sugar and claim to feel better for it. Gwyneth Paltrow also follows a “sugar free” diet, but given that many of her practices are not perhaps grounded on a strong evidence base, is this just another celebrity fad?

And aren't all calories equal? If, for example, I ate a chocolate bar and skipped dinner, would that be enough to offset the chocolate?

Sugar – the bitter truth

For years, the focus has been on eating low-fat foods and reducing calories, yet in the last decade there has been mounting interest and increasing evidence on the harms of sugar, in particular, fructose.

Table sugar (and most fruits that we eat) contain sucrose, a disaccharide with one glucose molecule and one fructose molecule. High fructose corn syrup, previously commonly used in the United States, has a ratio of 55% fructose.

Fructose, unlike glucose, which can be metabolised almost anywhere in the body, can only be metabolised by the liver. Whilst the rest of the body metabolises the glucose, the liver works on any excess glucose and all the fructose, resulting in a high carbohydrate load concentrated within the liver. Any surplus is converted to glycogen and once glycogen stores are full, it all gets converted to fat. Fatty liver then develops, which in turn promotes insulin resistance. A vicious cycle of hyperinsulinemia and obesity then follows, leading to type 2 diabetes and all its complications.

High sugar diets have also been linked with poor behaviour in children, worsening seizures in epilepsy, and Alzheimer’s dementia with some going as far as to call Alzheimer’s type 3 diabetes. Public Health England suggest that around one third of Alzheimer’s dementia might be attributable to lifestyle factors, including diet, exercise and smoking.

Given this, perhaps not all calories are equal, and we should take sugar more seriously.

So how do we start reducing sugar in our diet?

The first step is not to add extra sugar to any food or drink, like tea or coffee, and to cut out sugary drinks and obvious sweet foods.

The next step, which is harder, is to limit processed foods, many of which have high concentrations of hidden sugars, often listed under different names such as glucose, dextrose, molasses, which some may not recognise as sugar. Many ready-made savoury sauces are very high in sugar, for example. The Public Health collaboration has some excellent infographics on carbohydrate contents and sugar equivalents to help us to identify which foods are the worst offenders.

According to that reliable dietary source, the Daily Mail, nearly half of all ready meals eaten in Europe last year were consumed in the UK. “On average, people in the UK consume at least one ready meal a week – twice as often as the French and six times the number consumed by the Spanish.” So if the Daily Mail is anything to go by, our fast food consumption is also something to be mindful of.

I’m a fat man in a thin person’s clothes

This is what a friend’s husband told me once, after having successfully lost weight and maintained it.

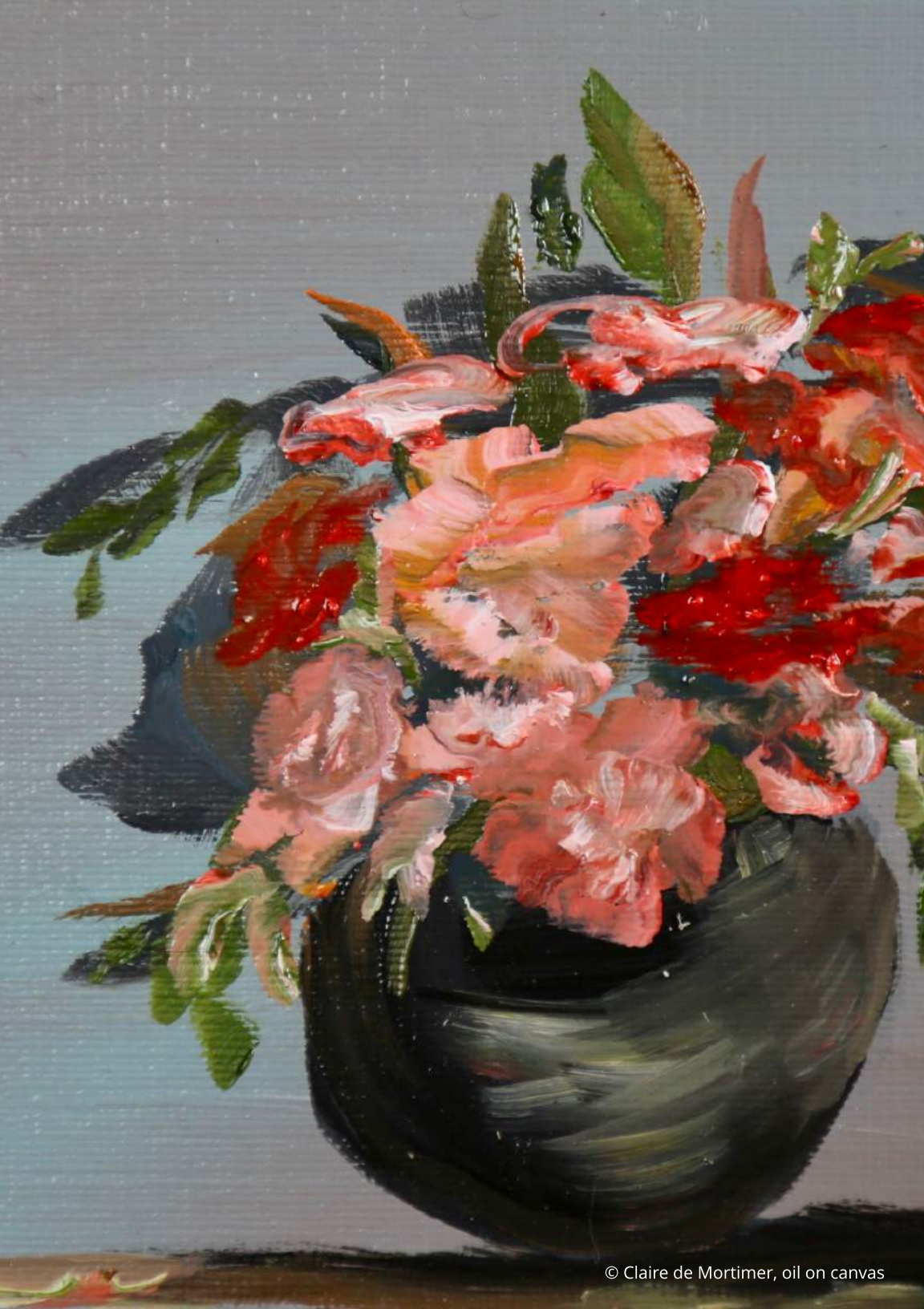
And he’s right. According to Charles Duhigg, the author of “The Power of Habit”, bad habits don’t really disappear. We can ignore, change or replace them, but the pathways are “always lurking there, waiting for the right cues and rewards”. This is clearly beneficial for tasks like driving and riding a bike, as we don’t need to re-learn them after a break, but not so good when we actually want to get rid of unhealthy habits. So there is some truth in the slippery slope…

Duhigg adds that “most people don’t set out to eat fast food on a regular basis. What happens is that a once-a-month pattern slowly becomes once-a-week, and then twice-a-week – as the cues and rewards create a habit - until the kids are consuming an unhealthy amount of hamburgers and fries.”

For me as a parent, this is really important information. It has made me sit up and consciously think about what we eat and how we eat at home and outside, to make sure that we keep treats as treats, and not allow them to creep into everyday life - like the bagels!

Given #Health is one of my #3 words this year, let's hope this new habit lasts!

Dr Kate Little, a GP Clinical Champion for Physical Activity and the founder of physicianburnout.co.uk, a resource for doctors that are feeling fed-up, stressed, anxious, depressed or burnt-out. Kate has worked as a GP in the NHS for the last 16 years in a variety of roles – partner, salaried & locum. She has also worked in medical education as a GP trainer and facilitator, and as a GP appraiser.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whacking moles

Judith Harvey

SHORT-TERM FIXES AREN'T THE SOLUTION TO NEGLECT

By Judith Harvey @judithharvey12

Last year the malware WannaCry attacked IT systems worldwide. Microsoft wasn't making any more money from their hugely successful Windows XP so to encourage sales of a new operating system they had stopped maintaining XP. Some NHS trusts were among the thousands of institutions and companies that suffered.

A new hospital opens with a fanfare and a celebrity. It is smart and up-to-date. Well, up to the date that the plans were approved. What does it look like a year later? Ten years later? How stained is the concrete on the outside and how scuffed the paintwork on the inside? How many of the lifts are out of order today? Are the shrubberies now sprouting discarded coffee cups? Is the IT system just limping along?

And 100 years later? My local hospital does procedures in the cellar of its decaying Victorian building. Keeping the ceilings up, the leaks stopped and stairways safe is an expensive and ultimately unwinnable battle.

Proper maintenance is a long-term investment. It costs. It's boring. Perhaps the only sexy maintenance project ever was repainting the Forth Bridge.

In health it's an axiom that prevention is better than cure, but we are often poor at applying those principles to our environment. If molehills appear in your lawn, you whack the mole. A satisfying cosmetic fix, but sooner or later the mole pops up again. It doesn't solve the underlying problem.

The demands on the NHS have increased relentlessly, but since 2010 funding has flatlined. The government has not maintained the system so this winter the seasonal pressures are even worse than usual. Ministers conjure some magical thinking on the Today programme, dump the responsibility on hapless NHS managers and produce a sop if the problem doesn't go away. Whacking moles with a feather duster.

Ignore even modest wear and tear and any system spirals down to dilapidation. By the time people realise it's seriously affecting their ability to do their job, breaking the vicious circle isn't easy. But it can be done. Zero tolerance calculates that clamping down on window-breakers and litterbugs will discourage serious crimes. It may not fulfill that promise, but people love it and feel safer.

Facilities managers need the authority to foresee and uncover potential problems. They need adequate funding which can't be raided to fund another need. No hospital should be relying on sticking plaster to cover deficiencies before the CQC comes round. Maintenance crews aren't odd-job men; they need manifold skills. And they deserve recognition and our thanks.

It's not just hospitals, motorways and the Houses of Parliament that suffer from lack of maintenance. "Never go to a doctor whose office plants have died" observed American humourist Erma Bombeck. She's right; first appearances set the stage. Locums have little control over neglected poinsettias but they can check that their shoes aren't scuffed and they can whack a few moles to improve the look of the room before they start consulting.

There are times when short-term thinking is inevitable. Given a terminal diagnosis, who buys new shoes? If a building is scheduled to be demolished, the budget for maintenance will have been cut. But then the demolition is postponed, so the sagging structure staggers on, difficult to work in and depressing for everyone who uses it.

We are living in an increasingly throw-away society. Grandmother said “A stitch in time saves nine”. But who darns their socks now? Clothing is so cheap that it’s rarely mended, and Christmas-themed jumpers are worn once and thrown out to end up in landfill. And why hang on to last year’s phone? Last decade’s washing machine? Cars? Modern technology has done away with young men in oily overalls who enjoyed spending their time trying to keep aged Austin 7s on the road.

Few new buildings now meet future needs, because the predictions that underlie their design are almost invariably wrong. And buildings designed to be maintenance-free are hard to repurpose – think of the Pyramids. If buildings are going to stand the test of time, they need to be flexible. There must be better ways than tacking on Portacabins. Simple buildings are usually more adaptable. They’ll need maintenance, but they can ‘learn’.

Homeostasis is a beautifully intricate maintenance system, an arrangement of chemical pathways which preserves our internal environment. It’s so reliable that we take it for granted. But when something goes wrong the outside maintenance team is called in. That’s us.

So there will still be work for Vishnu, the god of maintenance, and he’ll need to be ever more vigilant. E.M. Forster’s novella The Machine Stops was written as science fiction but it could easily become science fact. Undersea cables carry 97% of global communications and so underpin almost every aspect of our lives. How well maintained are they? They are vulnerable to sharks, those in the sea and those occupying seats of government, and if the network goes down, so will we.

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faltering growth in children

OFTEN AN INSIDIOUS ONSET WITH LONG TERM CONSEQUENCES IF NOT TREATED.

By Louise Hudman

This is a recent guideline from NICE, which gives advice on managing faltering growth in children. A lot of this is common sense, but as it is a new guideline, I will summarise the bits relevant to us. I will not deal with weight loss in the first few days, as this is generally managed by the midwives, but there is advice there if needed.

When should you worry about an infant's growth?

If they have faltering growth:

- >1 centile fall if birth weight was < 9th centile
- >2 centile falls if birth weight was 9th to 91st centile
- >3 centile falls if birth weight was > 91st centile
- If weight is < 2nd centile, whatever the birth weight.
- If height is > 2 centiles below mid-parental height (ie take both parents heights and plot the mid point on a chart).

NB - if weight is < 2nd centile, this can be undernutrition or small stature, but < 0.4th centile is likely to be undernutrition.

What should you be measuring?

Weight and height (or length if they are under 2 yrs). Plot on WHO chart.

If > 2 yrs, work out BMI and plot BMI on WHO chart, or BMI centile chart.

How to assess a child with faltering growth.

- Do a clinical, social and developmental assessment.
- Feeding and eating history (consider asking parents to do a diary of food intake with amounts and types and any mealtime issues).
- Consider associated features, e.g. preterm birth, neurodevelopmental disorder, maternal anxiety or depression. Also consider a multifactorial cause (e.g. an underlying issue and difficult carer/child interactions).
- Investigations. Consider checking for UTI, coeliac disease and any other investigations suggested by the assessment.
- Observation of mealtimes. This should be considered and should be done by a trained person (I'm not sure who is trained, but I guess the health visitors are a good starting point).

Causes to consider in milk fed infants

- Ineffective bottle or breast feeding.
- Feeding patterns used.
- Feeding environment.
- Feeding aversion (eg signs of distress with feeding, spitting out, avoidance behaviour etc).
- Parent / carer interactions with infant and how they respond to feeding cues.
- Physical disorders.

Causes to consider in children eating food

- Mealtime practices
- Foods offered
- Food avoidance or aversion.
- Carer interactions with infant and response to child's cues.
- Little appetite.
- Physical disorders.

Interventions

Offer a management plan.

Offer feeding support (whether breast fed or bottle).

Give advice. A useful leaflet can be found on patient.co.uk.

- Relaxed and enjoyable mealtimes.
- Eat together.
- Encourage child to feed themselves.
- Let them be messy with food.
- Mealtimes not too long and not too short.
- Reasonable boundaries, but not punitive.
- Avoid coercive feeding.
- Regular routines (eg 3 meals / 2 snacks).
- Avoid too much milk or energy rich drinks (as they decrease the appetite for food).

Ensure that foods offered are appropriate for the age of the child and that they optimise nutritional and energy density.

If they need more nutrients than can be achieved through food, consider supplements, or referral and monitor regularly.

How often to review children

- Daily if < 1m
- Weekly if 1 - 6m
- 2 weekly if 6 - 12m
- Monthly if > 1 yr.
- Height / length - every 3 m
- NB - doing it more frequently may lead to parental concern increasing.

When to refer children.

- Suspicion of underlying disorder.
- Not responding to above interventions.
- Slow / linear growth or unexplained short stature.
- Rapid loss of weight or malnutrition.
- Safeguarding concerns.

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