LETTERS

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NHS RESOURCE ALLOCATION

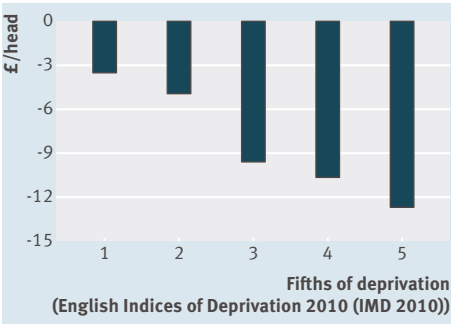
Poor areas lose out most in new NHS budget allocation

As reported in the *BMJ*, NHS England has included a "deprivation indicator" in the new resource allocation formula for Clinical Commissioning Groups (CCGs).[1] This follows concerns about an earlier proposed version of the formula, which would have shifted resources from poor areas with the worst health to more affluent areas with better health.[2] We used data provided by NHS England to consider the likely equity impact of the new formula.[3]

With regard to the level of overall allocation, although the total CCG programme budget will increase slightly above inflation over this period,[1] taking into account the predicted increase in population,[3] there will be an average cut of £8 (€9.7; $13.2) per head (authors' calculations, available on request) in real terms.

But will these cuts hit poorest areas hardest? The figure shows that CCGs serving the most deprived populations will lose out the most. This is because the new formula gives less weight to deprived areas than the current pattern of funding.

The new resource allocation is likely to increase health inequalities, despite being an improvement on the original contested proposal. The King's Fund recommends that resource allocation should be used to deliver policy objectives.[4] It is hard to see how cutting NHS resources most from areas with the worst



Change in real terms in clinical commissioning group (CCG) programme budget allocation per head between 2013 and 2015 by degree of deprivation (based on data from NHS England).[3] Real terms in 2013 prices adjusted for inflation using gross domestic product deflator; fifths are five equally sized groups of CCGs based on deprivation level; NHS England estimates of registered populations

health will help NHS England achieve its stated objective of reducing inequalities in health.[5]

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Competing interests: None declared.

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MOST EXCLUSIVE CLUB IN THE NHS

Tips for dealing with the members of the Shelford Group

GPs and clinical commissioning groups (CCGs) have no need to be afraid of the members of the Shelford Group.[1] Here are my tips for taking on these members of the "most exclusive club in the NHS."

- General practices can work in federations to share resources and expertise. CCGs can come together in joint commissioning activities. Working in larger groupings—whether general practices or CCGs—will give you more bargaining power and greater consolidation of expertise
- Become skilled in using the language of evidence based medicine, healthcare evaluation, and data driven healthcare in your dealings with hospital managers. You will soon discover that many NHS managers are poorly trained in these essential components of modern healthcare delivery
- Shelford Group trusts may be large, but like many NHS trusts they often operate on narrow financial margins. Even a small shift in GP referrals (and hence in their income) can destabilise one of their clinical services, and sometimes even an entire NHS trust. Move referrals to NHS trusts that are more flexible and more responsive to your patients' needs. Write to the finance director, medical director, and chief executive to let them know what you are planning
- Take back power from NHS England and commissioning support units. Hold them to account for any top slicing of your budgets to fund their activities and make a case with the Department of Health that consortiums of CCGs can take over many of their functions
- NHS managers often hope that, as busy clinicians, you won't have time to keep on dealing with them on a single matter. So, if you have a strong case, be tenacious and don't give up.

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Competing interests: I am currently an honorary consultant with the Imperial College Healthcare NHS Trust and was formerly an honorary consultant with University College Hospitals NHS Trust. Both these NHS trusts are members of the Shelford Group.
Full response at: www.bmj.com/content/347/bmj.f7318/rr/678202.

1 Hawkes N. Welcome to the most exclusive club in the NHS. *BMJ* 2013;347:f7318. (11 December.)

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BLOOD PRESSURE LOWERING

Benefit from all BP agents in black patients with kidney disease?

The Blood Pressure Lowering Treatment Trialists' Collaboration performed a rigorous and insightful analysis of the impact of antihypertensive agents on cardiovascular outcomes in patients with and without chronic kidney disease.[1] However, we believe the study's conclusion that "there is little evidence to support the preferential choice of particular drug classes for the prevention of cardiovascular events in people with chronic kidney disease" should be treated with caution. Although results from the African American Study of Kidney Disease and Hypertension do not conflict with this conclusion,[2] ALLHAT and other trials indicate that the choice of antihypertensive agent does matter in black patients.[3 4]

For example, in ALLHAT, black patients treated with lisinopril rather than chlortalidone were more likely to experience stroke ($P<0.001$) and combined cardiovascular events (coronary heart disease death, non-fatal myocardial infarction, stroke, angina, coronary revascularisation, heart failure, and peripheral

vascular disease; P<0.001). These findings persisted after time dependent adjustment for blood pressure but were absent in non-black patients. Moreover, the risk of incremental harms from angiotensin converting enzyme inhibitors in black patients is also supported by a systematic review of randomised trials.[4]

Because hypertension related morbidity and mortality are higher in black patients than in other racial and ethnic groups,[5] it would have been useful if the collaboration's study had included a subgroup analysis of black versus non-black patients. Perhaps such analyses should be the rule rather than the exception in studies of hypertension when feasible. Use of the collaboration's data to assess whether the study's conclusion about choice of drug class is applicable to black people would be of great value to clinicians and the millions of black patients with hypertension and chronic kidney disease.

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Full response at: www.bmj.com/content/347/bmj.f5680/rr/676536.

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Authors' reply

We would like to thanks Ladapo and Ogedegbe for their comments on our paper. They rightly point out data suggesting that people from different ethnic groups respond differently to blood pressure lowering drugs, as shown for African-Americans compared with Americans of other backgrounds. A substantial number of data on this important question are available from individual trials, but to our knowledge no study suggests that ethnic differences might be further modified by kidney function.

The Blood Pressure Lowering Treatment Trialists' Collaboration is a prospectively planned series of meta-analyses, with prespecified hypotheses, outcomes, and analysis plans. The protocol has prespecified subgroup analyses with tests of interaction performed to assess the association of any treatment differences with several patient characteristics—age, sex, diabetes status, baseline blood pressure, and baseline kidney function. Although ethnicity was not included in the original prespecified secondary analyses, we will explore opportunities to undertake these analyses with members of the collaboration across all levels of kidney function.

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DENTAL PAIN

The need for clinical dental treatment out of hours

Healthcare professionals need to be aware of all problems that may arise in clinic such as dental pain.[1] Patients attend general practice as a result of poor oral health education and costly emergency dental services, through no fault of their own. Oral health education is far from ideal and patients do not realise that prevention is vital.

The Department of Health's dental reform in 2006 stabilised access and simplified patients' costs. There are three banded prices: £18 (€21.7; $29.6) for examinations and emergency treatment; £49 for restorations, extractions, and root canal treatment; and £214 for advanced prosthetic work such as dentures and crowns. With regard to dental infection, patients would rather visit the GP for free than pay £18 for an examination and prescription.

I have worked as a general dental practitioner and found that once patients have the prescription they may not return for many months. It would help if GPs emphasised the importance of visiting the dentist within a month.

Oral and maxillofacial departments rarely offer 24/7 simple emergency dental cover. As a senior house officer I have been frustrated that I could physically perform the necessary treatments, such as temporary dressings on fractured teeth, but cannot do so owing to lack of resources.

This article highlights obvious red flags that aid maxillofacial referrals and points out that those who are registered with a dentist have the right to be seen at their practice within working hours.[1] Patients who are not registered with a dentist should be advised to contact the NHS hotline 111.

Ideally, patients should have access to clinical dental treatment out of hours. Unfortunately this is not the case, and this problem needs to be dealt with by the local health authorities.

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1 MacAuley Y, O'Donnell P, Duncan HF. Dental pain. *BMJ* 2013;347:f6539. (5 November.)

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COLORECTAL CANCER

Beware red dye in toilet paper

Bleeding from colorectal cancer would be obscured by red colouring of toilet paper

Blood found in the toilet is one of the most common signs of colorectal cancer.[1] As a colorectal surgeon, I found the appearance of bright blood seen in the toilet worrying until I studied the toilet paper design. Rectal cancer often bleeds episodically, but red colouring on toilet paper may delay presentation. Manufacturers and the public should be aware of this health risk.

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1 Hamilton W, Coleman MG, Rubin G. Colorectal cancer. *BMJ* 2013;346:f3172.

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