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BriefingMedia
At the heart of general practice since 1960

GP training falls back as specialists surge

Latest deanery figures add to concern over secondary care bias at education bodies

EXCLUSIVE
By Madlen Davies

Deaneries are failing to respond to the growing workforce crisis in general practice, creating only eight more GP training places across the UK this year.

A Pulse investigation reveals a drop in the proportion of GP trainees compared with hospital trainees across the UK, amid falling numbers of GP training places in England.

The drop in GP places comes after the Government announced in May it was targeting a 20% increase in GP training places by 2015, and as the RCGP called for 10,000 more GPs 'just to stand still'.

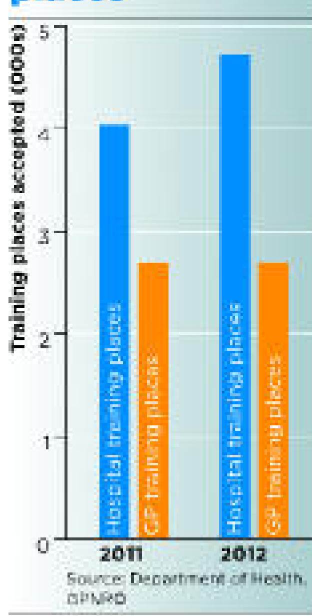
EDITORIAL ▶
GPs need voice on local training boards 14

The figures add to growing concern over secondary care bias in educational bodies. Information obtained by Pulse shows that the new Local Education and Training Boards (LETBs) are overwhelmingly dominated by hospitals' representatives.

Figures from the GP National Recruitment Office (GPNRO) show 3,152 offers were accepted for GP trainee positions this year across the UK, compared with 3,144 offers last year, and despite a 6% rise in applications in 2012. There was a decrease of three GP places in England compared with the previous year, with 2,693 GP training places accepted in 2012. This compared with a rise of almost 700 in hospital training places in England, with 4,725 places accepted, compared with 4,034 in 2011. This meant the proportion of GP trainees fell from 40% in 2011 to 36% in 2012.

Professor Bill Irish: People on boards will not support reductions in hospital specialties that would cut their own income streams

Medical training places



Source: Department of Health, GPNRO

This year's intake is the last by deaneries, with LETBs due to be authorised from October.

Of the 11 LETBs Pulse surveyed, most have stuck rigidly to the minimum requirement for authorisation that there are at least 10% of GPs on their boards. Although some have not achieved this, Kent, Surrey and Sussex LETB has only one GP representative on a shadow board of 19 members.

RCGP chair Dr Clare Gerada said the college would soon be publishing a 10-year strategy recommending an increase in GP numbers: 'We've estimated that we need 10,000 GPs over the next 10 years just to stand still, which equates to about one more GP per practice.'

Professor Bill Irish, chair of the GPNRO and director of GP education at Severn Deanery, said the new figures were a concern as hospital specialists were already being overproduced by 60%. He said: 'People on boards are not going to support a cut to hospital specialties, which would be a cut to their own income streams. LETBs are configured in such a way that there are vested interests, and we need a strong voice for primary care.'

Dr Barry Lewis, chair of the Committee of General Practice Education Directors, pointed to a lack of high quality applicants, but he added: 'There are potential blockers [such as] funding restrictions and potentially the current lack of adequate GP representation on LETBs in many parts of England.'

Dr Nigel Watson, chief executive of Wessex LMC and the GP representative for Wessex LETB, said training boards needed a radical change of mindset. He said: 'I went to a board meeting and a hospital chief said "You're a GP – why are you here?"'

A DH spokesperson denied there was a current crisis in the GP workforce, but said they would be asking LETBs to plan to increase the number of GP training posts steadily towards 2015.

He said: 'We're carrying out detailed research and planning to understand what training programmes are needed to fill the required posts.' A spokesperson for Health Education England said GPs would be 'well represented' on LETBs.

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Read GP trainee Dr Krishna Kasaraneni's analysis of the latest GP training figures
pulsetoday.co.uk/analysis

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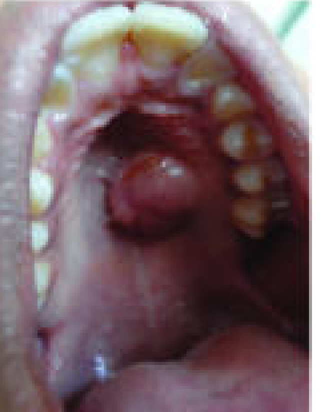

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CCGs remodel GP out-of-hours contracts

CCGs have begun remodelling GP out-of-hours contracts to enable direct referrals from new NHS 111 services and tie providers into targets for reductions in A&E attendances, Pulse can reveal.

More than half a dozen commissioning organisations across England have already placed GP out-of-hours services in their areas out to tender under revised specifications, with more set to follow as a host of contracts expire when CCGs become statutory bodies in April 2013.

The move signals CCGs' intent to reshape out-of-hours services to help them meet QIPP targets.

In Staffordshire, where six CCGs are leading on the procurement of two new out-of-hours services set to commence on 1 April 2013, GPs are looking to reshape the service to try and reduce the burden on A&E by integrating it closely with the new 111 urgent care line.

Dr Chandra Kanneganti, a GP in Stoke-on-Trent and GP adviser for urgent care for Stoke-on-Trent CCG, explained that they wanted to reduce the 20% of out-of-hours calls sent to A&E that were inappropriate.

He said: 'There is no point in having two triages, it makes the patient pathway very cumbersome.'

GPs discuss Scots-flavoured contract

Scottish Government begins discussions over localised GMS contract

EXCLUSIVE
By Sofia Lind

GPs in Scotland are being consulted on a Scottish version of the GMS contract and could be working to a series of Scottish-only QOF indicators by April 2014, Pulse can reveal.

Pulse has learnt the Scottish government is holding a series of talks with GPs, LMCs and NHS chief executives on how to implement changes towards a 'Scottish-focused' contract.

Pulse understands the meetings will gather ideas for a localised contract, and are the precursor to a special 'programme board' that will take forward their recommendations, and will include members from NHS Boards and the Scottish GPC (SGPC).

The Scottish government is also planning to introduce a raft of Scottish QOF indicators from April 2014, to start implementing a promise made in December last year to make three-quarters of the income from the GP contract locally determined.

It has tasked Health Improvement Scotland, which was set up last year, to prepare new QOF indicators that will form the basis of negotiations with the Scottish GPC for the first time. The new indicators are likely to be in areas such as alcohol, smoking, and improving patient safety and care in deprived areas.

A Scottish government spokesperson refused to give definite timescales for the changes, but said: 'We are committed to developing the GP contract in Scotland.

'We are currently in the process of establishing a Programme Board to provide strategic leadership and governance that will include membership from Scottish Government, SGPC and NHS Boards.'

The idea of a Scottish GP contract has been criticised as 'ideological' by the GPC, but welcomed by some members of the Scottish GPC.

Dr Bob Mack, a GP in Dumfries and Galloway, a member of SGPC and deputy chairman of Scottish LMC conference, said flexibility was needed.

He said: 'The Scottish government health department has held a round of meetings with GPs for information gathering. As far as I am aware, the main area of suggested change will be in QOF.'

He added: 'We shouldn't have an entirely separate contract from the UK-wide contract because we still benefit from it, but we should have Scottish variation bringing us flexibility.'

Dr Georgina Brown, a GP in Glasgow and a member of SGPC, said: 'I think suggesting that one contract for the whole of the UK would be sensitive to the needs of a diverse population is naive.

'There is definite strength in unanimity in terms of nego-

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Date of preparation: June 2012 UK/BUTR-11065a

ANALYSIS

Scottish GP contract talks

One of the advantages of devolution is that the four countries get to learn from each other. Scotland has certainly done that with England's much maligned health reforms, and has decided to go completely another way.

As soon as health secretary Andrew Lansley published his market-focused white paper in 2010 it was perhaps inevitable that Scotland would try something different.

The Scottish NHS model was already increasingly divergent from England's, with health secretary Nicola Sturgeon saying she wanted less private sector involvement, not more, and seeking to integrate

DH alters NICE

EXCLUSIVE
By Jaime Kaffash

The Department of Health has bowed to industry pressure to make the NICE appraisal process more 'politically accountable' and is set to remove the institute's power to appoint its own appeal committee and hand it to ministers.

Pulse has learnt that the Department of Health is set to table regulations that will see the health secretary approving all appointments to the panel that considers drug company appeals against NICE appraisals.

The chair of the appraisal appeal panel will also have to be 'someone from outside NICE'.

The move comes after the Association of the British Pharmaceutical Industry urged the health secretary to revamp the appraisal procedure so independent academics had less say.

Seen by Pulse, the ABPI letter reads: 'Policy is made a long way from political accountability and the NICE Executive appears to have no remit or desire to challenge the decisions of independent academics.

'The burden of proof is currently absolutely on industry, and academic purity can over-ride pragmatism.'

A DH spokesperson confirmed there will be changes to the appeals panel 'to give stakeholders more confidence in its independence'.

BIG Question Is it time to break up the UK-wide GP contract? ▶ pulsetoday.co.uk

Dr Georgina Brown: 'naive' to suggest one contract can be used across the UK

tiation, but there has to be local adaptation and local response to differing need.'

GPC negotiator Dr Chaand Nagpaul said the UK contract was of 'immense value' and the GPC would fight to protect it.

He said: 'While we recognise this statement by the Scottish government, we think this is the wrong way to approach it. There is no point in simply having an arbitrary approach to separating from the UK contract for ideological reasons.'

A spokesperson for the SGPC said they remained committed to a UK-wide contract, and that they had not yet been told of any firm proposals.

The move comes as Northern Ireland health minister Edwin Poots is also looking at negotiating a larger proportion of the contract locally.

A health department spokesperson said: 'Minister Poots has been giving this position added consideration now given the more recent variation across the four countries within the GMS contract.'

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Next steps for a Scottish GP contract

- **Health Improvement Scotland to develop Scotland-specific QOF indicators**
- **Scottish government to negotiate with the SGPC on new QOF indicators for 2014/15 GP contract**
- **The Scottish Government to form 'programme board' with SGPC to take forward new Scottish-focused GMS contract**

strain UK-wide deal

commissioning and providing services in health boards, rather than divide them.

Since then the gap has become ever wider – and so it was little surprise when Ms Sturgeon announced last December that she aimed to make up to three-quarters of the GP contract in Scotland locally determined, with a particular focus on public health. As we report this week, that process is now well under way but there are dangers.

Can the GMS contract survive as a UK-negotiated deal if there is little in common between countries, and will that mean diminished negotiating power for the BMA?

Nigel Praities is deputy editor of Pulse

appraisals

But they said there were no plans to broaden the grounds for NICE appraisal appeals.

The move comes after health secretary Andrew Lansley revealed NICE would no longer have the power to make 'yes' or 'no' decisions on access to drugs from 2014, with the DH setting the maximum price the NHS will pay for new medicines.

Sir Andrew Dillon, the chief executive of NICE, said: 'These changes, which we are aware of, underline the independence of the existing appeal process and will enable NICE to draw on a larger pool of qualified and experienced panel members.'

But Dr David Jenner, GMS and PMS contract lead at the NHS Alliance and a GP in Cullompton, Devon, said: 'If they are political appointees, that risks NICE being seen as an agent of Government.'

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'The change risks NICE being seen as an agent of Government' Dr David Jenner

ONLINE SURVEY Tell us how increasing rationing of treatments in the NHS is affecting patient care pulsetoday.co.uk/rationing-survey

The week in general practice

INSIDE

NHS has made 'impressive' progress on revalidation, say DH advisers **page 4**

HPA survey shows GPs register only a third of migrants **page 6**

Surge in vitamin D prescribing sparks concerns over costs **page 9**

Review finds 'no difference' in depression options **page 10**

Dr Deborah Colvin

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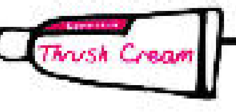

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Date of preparation: March 2012

Diabetes and CVD Update 2012
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NHS 'ready to go' on revalidation

Report shows 'impressive' progress on preparations for revalidation, but one in 10 PCTs still not ready

By Sofia Lind

The NHS has made 'impressive' progress, but there are still likely to be areas not completely ready to begin revalidation, says the Department of Health body responsible for rolling out the scheme later this year.

In a crucial report on the readiness of the NHS for revalidation of doctors, the NHS Revalidation Support Team says over 90% of GPs had participated in an annual appraisal in 2011/12 and almost all were now linked with a responsible officer who has received appropriate training.

But the report also showed one in 10 PCTs was 'red' or 'amber' rated on revalidation, with less than half of GPs linked with a body that has a policy for remediation of struggling doctors and less than two-thirds with a system for GPs to obtain structured feedback from patients and colleagues.

The report will form the basis of the health secretary's final decision on whether to go ahead with revalidating all doctors from the end of this year.

It comes after BMA chair Dr Mark Porter admitted revalidation is 'not going to be perfect from the start' and that the profession may have to proceed without all issues the union is fighting for being resolved.

The first round of revalidation is due to begin from December this year and will involve revalidating responsible officers and 'medical leaders'.

Dr Mark Porter: revalidation 'won't be perfect from the start'

Dr Martin Shelly, director of implementation at the NHS Revalidation Support Team, said the report showed the NHS was 'ready to get started': 'We wouldn't need every organisation in the country rated green to start. We can get started with the process then refine it in the first year or so.'

But a BMA spokesperson said the report showed there still was 'a fair amount of work to do' before revalidation can be introduced: 'It is essential that our concerns about appraisal rates, remediation issues and support for locum doctors are addressed.'

In the latest issue of the BMA newsletter, Dr Porter wrote the process for revalidation was much improved and while there was some progress on the issue of clinical governance procedures, the issue of funding for remediation remained a sticking point.

He told *BMA News*: 'I think there has to be a point at which we say we have come as far as we can in terms of making it a good process and making sure no doctor will be adversely affected by the process not being perfect from the start. Let's go.'

@sofialind_Pulse

Revalidation in numbers

100%
Proportion of GPs linked to a responsible officer

46%
Proportion of GPs who are covered by bodies with a policy for remediation

63%
Proportion of PCTs that say GPs are able to obtain structured feedback

Source: NHS Revalidation Support Team

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Prescribing study prompts change

One of the country's biggest GP software providers has implemented changes to almost 2,000 practice systems in the wake of a GMC-funded study that estimated there are errors in one in 20 GP prescriptions nationally.

The PRACTICE study, published in May, looked at prescribing in a random sample of practices using a range of different software providers, and found on average 4.9% of prescriptions contained an error.

Now TPP SystmOne has become the first software provider to implement a series of improvements based on the study's findings.

The changes include warnings for clinicians who issue a repeat medication without appropriate tests and changes to encourage clinicians to partake in more active monitoring of patients prescribed drugs such as warfarin and methotrexate.

The country's largest provider, EMIS, told Pulse it had not made any changes because its new system already incorporated many of the report's recommendations.

Dr Chris Bates, software developer at TPP, said: 'We continually analyse SystmOne and, in consultation with clinicians, make developments to it.'

Professor Tony Avery, lead researcher on the PRACTICE study and a GP in Nottingham, welcomed the move, but said the 'real issue is trying to tackle the number of low-level alerts people get'.

GPs get faster broadband

GPs are set for broadband access at double the current speeds, as the Department of Health plans to install faster digital lines in up to 7,000 GP practices by March of next year.

The GP Next Generation Access Project will update the broadband network N3, which underpins services such as Choose and Book, to double its current speed using 21 DSL technologies.

The plans will see surgeries benefit from increased speeds on primary and backup links, and remote-hosted GP systems.

The new technologies are fibre to the cabinet (FTTC), meaning they use fibre-optic cables to give faster broadband speeds, and where possible will give speeds of up to 40MBps.

Where FTTC is not available, ADSL 2+ will give speeds of up to 20MBps.

The project was funded by Connecting for Health and will be delivered by BT. The NHS Informatics Business Plan 2012/13 says the update will be rolled out to 70% of practices by March 2013.

A DH spokesperson said: 'The GP Next Generation Access Project will increase the bandwidth of the N3 broadband network and allow GP practices even faster access to information.'

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Date of Preparation: August 2012. CHGBI/CHNIQ/0072/12

References: 1. Ferguson SG and Shiffman S. The relevance and treatment of cue-induced cravings in tobacco dependence. Journal of Substance Abuse Treatment 2009; 36: 235-43. **2.** Durcan MJ *et al.* Efficacy of the nicotine lozenge in relieving cue-provoked cravings. Presented at the 5th European SRNT. Padua, Italy, 2003.

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Key questions: polycystic ovary syndrome ▶ page 18

GPs register one in three migrants

HPA analysis calls for migrant registration drive and raises questions over targeted list-cleansing campaigns

By Emma Wilkinson

A national campaign is needed to ensure that all migrants register with GP practices, according to a Health Protection Agency (HPA) analysis that shows only a third register with a GP – far lower than official estimates.

Researchers looked at records for around 250,000 new entrants who arrived in the UK and found only 33% were registered with a GP at least nine months later.

These estimates are far lower than estimates published by the Office for National Statistics, which suggest a high proportion of migrants are registered – 622,178 in 2009/10 compared with 572,000 long-term migrants entering the UK in the same year.

The HPA also found a high proportion of more vulnerable migrants who were likely to have complex health needs – the elderly and asylum seekers – were among those not registering with GPs.

The study comes after GP leaders criticised the population data used as the basis for list-cleansing exercises, which routinely target migrant populations to remove 'ghost patients'.

The HPA researchers looked at all patients screened for tuberculosis because they came from a high-risk country arriving at Gatwick and Heathrow airports between June 2009 and November 2010. They then checked in August 2011 whether these patients were registered with a GP using the Personal Demographics Service. Only 33% had registered with a GP, with the least likely to sign up from the Americas, with only 16% found in GP records, and Africa, with a 24% registration rate. Asylum seekers and their dependents, who made up just 1% of the migrants in the study, were also less likely to register, along with men and the over-65s.

The HPA researchers concluded in their report – published in *BMJ Open* this month – that specific measures to promote GP registration were needed, especially among the groups at highest risk. They suggested this could include information packs when visas are issued, from employers or at the border.

Study leader Dr Helen Stagg, from the HPA's respiratory department, said: 'It's vital everyone has proper access to healthcare to ensure the wellbeing of the entire UK population. This is particularly important for conditions where infection is easily transmitted and where a delay in care could lead to the need for more costly treatment.'

Migrant screening programmes and other awareness campaigns run by GPs may not be reaching the intended audience if patients are not registering, she added.

Dr Chaand Nagpaul, GPC negotiator and a GP in Stanmore, Middlesex, said the study findings pointed to a major cost and public health challenge for GPs and commissioners: 'There is a consequence to GP practices of having high numbers of unregistered patients because they will end up having to be seen on an emergency basis for which the GP is not resourced.'

Dr Deborah Colvin, chair of City and Hackney LMC, said: 'People come here and do not know how the system works or why it is worthwhile registering. It is an issue for them when they get ill and for preventive work. There is less money coming into the health economy in that area and it will make a mess of the commissioning budget.'

Professor Steve Field, chair of the Department of Health's national health inclusion board and a GP in Birmingham, said migrant access was a major issue he was looking at.

feedback@pulsetoday.co.uk

Dr Deborah Colvin: migrants struggle to understand how GP registration works

Are migrants registering with GPs?

32.5%
Migrants registered with a GP, according to the HPA

622,178
New migrants registered by GPs in 2009/10, according to the ONS

ANALYSIS

The system is failing the vulnerable

It's not surprising this research showed that only 33% of migrants register with a GP. The barriers are numerous, be they cultural, linguistic, administrative or simply related to a misunderstanding of what an individual is entitled to in the UK.

Much of the blame can be placed on an antiquated, paper-based system run through individual practices. There is no other Government department that operates this way – driving licences and passports, for example, are all obtainable online and through a centralised system.

Any British citizen wishing to travel to Europe can apply or renew their European Health Insurance Card online, by phone or post. If we can do this for the whole of Europe, why do we not have a centralised system for the NHS, where people can update their details as needed?

This would solve the issue of ghost patients and negate the issue of list cleansing. And any new migrant staying for more than six months should be able to apply for an NHS number at the same time as their visa, making sure everyone knows what they are entitled to.

Dr Sam Everington is chair of Tower Hamlets CCG

RCGP backs half-hour appointments

GP appointments lasting 30 minutes should be the norm rather than the exception in order to 'do justice' to patients with multiple complex conditions, a senior figure at the RCGP has said.

RCGP honorary secretary Professor Amanda Howe admitted the move to longer appointments would require 'workforce planning', but said it was an inevitable consequence of the shift towards managing a greater proportion of long-term conditions in primary care. Professor Howe made the claim in an exclusive interview with Pulse that covered extended GP training, women's place in medicine and GP workload.

Professor Howe, a GP in Norwich and professor of primary care at the University of East Anglia, said that by limiting their session to 10 minutes GPs were struggling to address the needs of some patients, such as those aged over 65 with several chronic diseases.

She said: 'Sometimes we know we need a thorough, long appointment, and we need to plan that in rather than making it an exception. The patient may have hypertension, diabetes and arthritis. If you're trying to do your job properly and not make them keep coming back, you need longer [than 10 minutes].

'It may be that we need quarter of an hour or even half-hour appointments – like an outpatient appointment would be – if you have a complex patient, to do them justice.'

Professor Howe acknowledged that increasing the length of appointments would only be possible if the Government listened to the college's call for a significant extension of the GP workforce. It has called for there to be 10,000 more GPs by 2022.

Dr Simon Gilbert, a GP in Mitcham, Surrey, said: 'I am not convinced. The time limit in GP consultations helps focus patients and GPs on the important problems, as well as allowing the appropriate use of time for diagnosis and resolution of many problems. But I agree with offering more planned reviews for patients with multiple long-term conditions.'

A Department of Health spokesperson said it encouraged practices to offer 'appropriate care to ensure they are meeting the needs of patients'.

The Big Interview

Watch the full interview with Professor Amanda Howe online

MORE ONLINE
pulsetoday.co.uk/the-big-interview

GPs face record negligence claims

GPs are finding themselves at the centre of more medical negligence claims than ever before, according to new data from medical defence experts.

The Medical Defence Union's annual report for 2011 shows disciplinary cases against GPs and hospital doctors increased by 56% since last year, with the union opening 17% more medical claims files and seeing an 18% rise in requests for assistance with GMC investigations.

The MDU said the number of medicolegal challenges faced by doctors were 'unmatched in the company's 126-year history', and it expected the numbers to grow with the introduction of revalidation and Care Quality Commission registration.

Dr Christine Tomkins, MDU chief executive, said: 'Our members are turning to us for support and advice at a time of unprecedented change in both the medicolegal climate and their working environment. There has been a sharp increase in the number of complaints to the GMC, though there is no evidence of a drop in professional standards. The number and cost of negligence claims against doctors is also rising.'

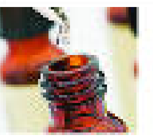
The MDU also reported that 30,000 of its members contacted its 24-hour helplines last year for expert medico- and dento-legal advice.

The GMC has confirmed it has received another complaint relating to a doctor who took industrial action over pensions in June, adding to the two existing complaints Pulse revealed last month.

The regulator has refused to confirm the nature of complaints if any of the complaints are being investigated, or whether the doctors involved have been informed.

> **There has been a sharp increase in the number of complaints**
> Dr Christine Tomkins

IN BRIEF



Homeopathy scheme

The MHRA has vowed to keep its controversial homeopathy indications scheme.

Full story ▶ pulsetoday.co.uk/clinicalnews

Health outcomes fall

Patients have reported worse outcomes after hip replacement compared with last year.

Full story ▶ pulsetoday.co.uk/clinicalnews

Delay EPS, says GPC

The GPC has warned against rushing the rollout of the electronic prescription service.

Full story ▶ pulsetoday.co.uk/practicenews

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ADULT INDICATION[1]

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Pneumococcal polysaccharide conjugate vaccine (13-valent, adsorbed)

ABBREVIATED PRESCRIBING INFORMATION
Prevenar 13® suspension for injection
Pneumococcal polysaccharide conjugate vaccine (13-valent, adsorbed)

Adverse events should be reported. Reporting forms and information can be found at www.yellowcard.gov.uk.
Adverse events should also be reported to Pfizer Medical Information on 01304 616161

Reference: 1. Prevenar 13 Summary of Product Characteristics October 2011

www.pfizervaccines.co.uk

Date of Preparation October 2011 *Trademark

1 in 4

of your adult patients could develop shingles in their lifetime if they are among the 90% that have had chickenpox[1,2]

Shingles (herpes zoster) vaccine (live)

Prevention of shingles and post-herpetic neuralgia – 1 dose* for adults aged 50+[3]

ABRIDGED PRESCRIBING INFORMATION

ZOSTAVAX® powder and solvent for suspension for injection [shingles (herpes zoster) vaccine (live)] *Refer to Summary of Product Characteristics for full product information.* **Presentation:** Vial containing a lyophilised preparation of live attenuated varicella-zoster virus (Oka/Merck strain) and a pre-filled syringe containing water for injections. After reconstitution, one dose contains no less than 19400 PFU (Plaque-forming units) varicella-zoster virus (Oka/Merck strain). **Indications:** Active immunisation for the prevention of herpes zoster ("zoster" or shingles) and herpes zoster-related postherpetic neuralgia (PHN) in individuals 50 years of age and older. **Dosage and administration:** A single dose should be administered by subcutaneous injection, preferably in the deltoid region. **Contraindications:** Hypersensitivity to the vaccine or any of its components (including neomycin). Individuals receiving immunosuppressive therapy (including high-dose corticosteroids) or who have a primary or acquired immunodeficiency. Individuals with active untreated tuberculosis. Pregnancy. **Warnings and precautions:** Appropriate facilities and medication should be available in the rare event of anaphylaxis. Deferral of vaccination should be considered in the presence of fever. In clinical trials with Zostavax, transmission of the vaccine virus has not been reported. However, post-marketing experience with varicella vaccines suggest that transmission of vaccine virus may occur rarely between vaccinees who develop a varicella-like rash and susceptible contacts (for example, VZV-susceptible infant grandchildren). Transmission of vaccine virus from varicella vaccine recipients without a varicella-zoster virus (VZV)-like rash has been reported but has not been confirmed. This is a theoretical risk for vaccination with Zostavax. The risk of transmitting the attenuated vaccine virus from a vaccinee to a susceptible contact should be weighed against the risk of developing natural zoster and potentially transmitting wild-type VZV to a susceptible contact. As with any vaccine, vaccination with Zostavax may not result in protection in all vaccine recipients. **Pregnancy and lactation:** Zostavax is not intended to be administered to pregnant women. Pregnancy should be avoided for three months following vaccination. Caution should be exercised if ZOSTAVAX is administered to a breast-feeding woman. **Undesirable effects:** Very common side effects include: pain/tenderness, erythema, swelling and pruritus at the injection site. Common side effects include warmth, haematoma and induration at the injection site, pain in extremity, and headache. Post marketing use has shown hypersensitivity reactions including anaphylactic reactions, joint and muscle pain, fever, swollen glands, rash, also hives and rash at the injection site. For a complete list of undesirable effects please refer to the Summary of Product Characteristics. **Package quantities and basic cost:** Vial and pre-filled syringe with two separate needles. The cost of this vaccine is £99.96. **Marketing authorisation holder:** Sanofi Pasteur MSD SNC, 8 Rue Jonas Salk, F-69007 Lyon, France **Marketing authorisation number:** EU/1/06/341/011 **Legal category:** POM ® Registered trademark **Date of last review:** June 2012

Adverse events should be reported.
Reporting forms and information can be found at www.mhra.gov.uk/yellowcard Adverse events should also be reported to Sanofi Pasteur MSD, telephone number 01628 785291.

References: **1.** Miller E, Marshall R, Vurdien J. Epidemiology, outcome and control of varicella-zoster infection. *Rev Med Microbiol* 1993; 4: 222-30. **2.** Bowsher D. The lifetime occurrence of Herpes zoster and prevalence of post-herpetic neuralgia: A retrospective survey in an elderly population. *Eur J Pain* 1999; 3: 335-42. **3.** ZOSTAVAX® SmPC.

* The need for a second dose is currently unknown

Scan the QR code with your smartphone to access www.shinglesaware.co.uk

UK15206a c 06/12

A quick guide to commissioning dementia care
▶ page 27

Commissioners express concern over the rising cost of vitamin D after a 16% spike in GP prescriptions

PRESCRIBING

Surge in vitamin D prescribing

By Sofia Lind

GP commissioners have raised concern over the cost implications of vitamin D prescribing, after new figures showed the number of prescriptions given to patients has risen 16% year-on-year since January.

Data extrapolated from 150 GP practices by healthcare market research agency Cegedim Strategic Data found there were 3.3 million prescriptions issued in the first six months of this year, compared with 2.8 million in the same period in 2011.

The steep rise comes after the Chief Medical Officer wrote to all GPs in January urging them to prescribe vitamin D to all at-risk groups, including pregnant and breastfeeding women, children under five years of age and people aged 65 years and over.

Funding vitamin D supplements is becoming an increasing burden on GP commissioners, with Tower Hamlets CCG predicting in June that costs could hit £20m locally over the next few years.

Barnet CCG has developed a 'shared protocol' with secondary care on vitamin D prescribing after a 160% annual increase in prescribing since March 2011.

Dr Lyndon Wagman, medicine optimisation lead at Barnet CCG, said: 'There are huge cost implications.

'The issue has been the numerous guidance documents available and the exorbitant cost of the high-dose prescriptions.'

Dr Helen Tattersfield, GP lead at NHS Lewisham CCG and a GP in Bromley, south London, said: 'We are definitely recognising this as an increasing area of prescribing as the level of need and importance of this as a health issue becomes more and more apparent.

'Cost is a real issue as most vitamin D products are unlicensed and are therefore costed as specials. Great care needs to be taken in how vitamin D is prescribed to avoid excessive "special" costs.'

Pulse revealed earlier this year that Tower Hamlets CCG in east London had launched a local campaign for people to spend more time in the sun this summer in order to offset the cost of vitamin D supplementation.

The CCG sent out leaflets to residents and held talks in local schools on the importance of spending time in the sun and eating a healthier diet.

@sofialind_Pulse

Prescriptions for vitamin D have climbed 16% year-on-year

Copperfield

Pharma's creating an epidemic around vitamin D

pulsetoday.co.uk/dr-tony-copperfield

GP vitamin D prescriptions*

Number of UK prescriptions (000s)

600
500
400
300

Jan 2011, Feb 2011, Mar 2011, Apr 2011, May 2011, Jun 2011, Jul 2011, Aug 2011, Sep 2011, Oct 2011, Nov 2011, Dec 2011, Jan 2012, Feb 2012, Mar 2012, Apr 2012, May 2012, Jun 2012

*Figures extrapolated from 150 GP practices. Source: Cegedim Strategic Data

RATIONING

'No barriers' to NICE

CCGs will have to publish a list of all the treatments they provide on the NHS by next April in a bid to end the 'postcode lottery' of access to NICE-approved treatments.

In a letter to primary care organisations, NHS chief executive Sir David Nicholson warned he would be changing NHS contracts from April 2013 to include a standard clause ensuring that new drugs approved by NICE cannot be blocked. He said PCT clusters and CCG leaders will have to publish information online in a 'clear' and 'transparent' way that sets out which NICE Technology Appraisals are included in their formularies.

Under the new regime, CCGs would be compelled to include drugs in formularies within 90 days of a NICE approval being released – although the sanctions for failing to do so remain unclear.

Sir David emphasised that formularies 'should not duplicate NICE assessments or challenge an appraisal recommendation', and added: 'Once on formularies, there should be no further barriers to the use or prescription of technologies or medicines.'

PCTs

Early handover planned

PCTs and SHAs will lose their operational responsibility for the NHS from October, a full six months earlier than planned, the Department of Health has announced.

In a letter sent last week, NHS chief executive Sir David Nicholson said the NHS Commissioning Board and the NHS Trust Development Authority would be handed management responsibility for existing organisations from 1 October to ensure 'stability and resilience' through transition and to avoid a leadership vacuum.

But PCTs and SHAs will retain formal statutory functions – including accountability for budgets and employment of staff – until their official abolition date in April 2013.

The letter said NHS senior managers would be accountable to the new organisations for 'future planning and development', and to PCTs/SHAs for delivery in the current financial year.

MORE ONLINE
Read Sir David Nicholson's letter in full
pulsetoday.co.uk/commissioning

New evidence review says GPs should let patient preference guide choice of depression treatment

DEPRESSION

'No difference' in depression options

By David Swan

GPs should give patient preference a greater weight for treatment decisions in depression as there is little difference in efficacy between the options recommended in guidelines, concludes a new analysis.

The systematic review found antidepressants and behavioural therapies showed no significant difference in the reduction of depression symptom scores compared with alternative therapies, such as acupuncture or exercise.

The US researchers concluded the type of treatment GPs offer patients with depression is 'less important than getting patients involved in an active therapeutic programme'.

NICE guidance currently recommends a stepped approach to care, with antidepressant medication and psychological interventions suggested for mild to moderate depression or worse.

The authors assessed 115 trials, involving a total of 10,310 patients with depression aged between 18 and 65 years, that looked at drug treatment, behavioural therapies – including cognitive behavioural therapy – or alternative therapies, and compared them with controls, usual care or placebo.

They found all interventions studied resulted in significant reductions in depression symptoms compared with placebo, usual treatment and controls.

A combination of antidepressant medication and behavioural therapies had the greatest impact in reducing depression symptoms – a 52% reduction compared with before the intervention.

This change was significantly better than that seen with antidepressant therapy alone, behavioural therapies alone or alternative therapies, which recorded 46%, 47% and 47% reductions respectively compared with before the intervention.

But antidepressants alone, behavioural therapies alone, alternative therapies and active intervention controls showed no significant differences when compared with each other, leading the authors to question whether the type of treatment offered was relevant.

The study authors, from Duke University School of Medicine in the US, concluded: 'This suggests the preference of the patient, accessibility of various treatment options and riskiness of the therapy should be factored into depression treatment decisions.'

But Dr Margaret McCartney, a GP in Glasgow, said: 'Mild depression and dysthymia are very different from severe depression. If we put all types of depression together, we won't see much treatment effect from anything.'

Professor Helen Lester, a GP in Birmingham and RCGP mental health commissioning lead, also said: 'They did not evaluate the role severity of depression may have played in treatment outcome, and we know that in other studies treatment efficacy has been linked with just how depressed someone is.'

PLoS One 2012, online 30 July
david.swan@pulsetoday.co.uk

NICE guidance currently recommends a stepped approach to care for depression

Reduction in depression symptom scores

52% Antidepressants plus psychotherapy

46% Antidepressants alone

47% Psychotherapy alone

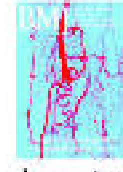
47% Alternative therapies

Source: PLoS One 2012, online 30 July

Online CPD
Effective prescribing in depression
pulse-learning.co.uk

GASTROENTERITIS

Rotavirus vaccination reduces hospitalisations



Rotavirus vaccination is as effective in clinical practice in reducing hospital admissions for gastroenteritis in children as it was in trials, according to new research.

Belgian researchers looked at cases of gastroenteritis in 215 children aged 14 weeks or older that were eligible to have received at least one dose of any rotavirus vaccine.

Effectiveness of two doses of the vaccine in preventing hospital admissions, compared to not being vaccinated, was 90%. This remained the same when looking solely at children aged 12 months or older, but increased slightly to 91% in children aged between three and 11 months.

Effectiveness against severe rotavirus was 91%, compared with not being vaccinated. In mild to moderate severity, this was reduced to 66%, a non-significant difference.

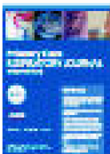
The authors from the University of Antwerp concluded: 'These figures are similar to those seen in clinical trials of the vaccine. Our findings should prove useful to encourage implementation of rotavirus vaccine.'

The Department of Health is currently looking at the cost-effectiveness of adding rotavirus to the infant immunisation schedule in the UK.

BMJ 2012, online 8 August

ASTHMA

Non asthma-related visits predict exacerbations



Patients with asthma who frequently visit their practice with non asthma-related health problems are more likely to suffer an exacerbation in the near future than those who do not visit regularly, say researchers.

The study looked at 166 patients with asthma and prescribed inhaled steroids at a semi-rural GP clinic in south-west England.

They found a statistically significant relationship between asthma exacerbations and non asthma-related visits, with a statistically significant correlation factor of 0.35.

There were also statistically significant associations with adherence by prescription records and asthma stage.

A patient presenting with two or more non-asthma visits per year provided 79% sensitivity and 58% specificity for detected three or more exacerbations over five years.

The authors said: 'Our results suggest a focus on medication adherence and severity alone misses an important factor.

'The dysfunctional patient with multiple non-specific health problems is the most at risk and more likely to benefit from education.'

Prim Care Respir J 2012, online 26 July

STATINS

Statins raise risk of diabetes

Statin treatment raises the likelihood that patients with risk factors will develop diabetes, but this is more than outweighed by the cardiovascular benefits of treatment, say researchers.

The analysis of 17,603 patients taking statins for primary prevention showed those with at least one risk factor for diabetes were 28% more likely to develop diabetes when taking the drugs, compared with patients in the control group.

But those taking statins were also 39% less likely to develop cardiovascular illness and 17% less likely to die than controls over the five-year trial period.

For those who had no existing risk factors for diabetes – including metabolic syndrome, impaired fasting glucose, BMI of 30kg/m² or higher, or HbA_1c greater than 6% – there was no discernible added risk when taking statins compared with controls.

The team from Harvard Medical School calculated that for those with diabetes risk factors, 134 vascular events or deaths were avoided for every 54 new cases of diabetes diagnosed.

Lancet 2012;380:565-71

SEMINAR
Diabetes and CVD Update 2012: ensure you're up to date
pulse-seminars.com

GUIDANCE ROUND-UP

Ivabradine recommended

NICE has recommended that a heart rate-reducing drug should be made available on the NHS in patients with chronic heart failure. The draft appraisal recommends ivabradine is used in combination with ß-blockers in patients with chronic heart disease whose heart rate is over 75 beats per minute, or if ß-blocker therapy is contraindicated or not tolerated.

NICE draft TA, August 2012

Supervised exercise for PAD

Patients with intermittent claudication should be offered a supervised exercise programme, says NICE guidance on peripheral arterial disease (PAD). The guideline also recommends examination of the femoral, popliteal and foot pulses for patients with suspected PAD, as well as the ankle brachial pressure index.

NICE CG147, August 2012

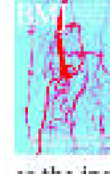
Use FRAX or QFracture tools

GPs should use the FRAX or QFracture risk assessment tools to assess fragility fracture risk in all women aged 65 or over, and all men aged 75 or over, say new guidelines. NICE also suggests not routinely assessing risk in patients under 50 years of age, unless they have major risk factors such as frequent recent use of oral or systemic glucocorticoids.

NICE CG146, August 2012

FALLS

Functional movements help reduce risk of falls



A programme that encourages older people to include functional movements into their everyday life reduces the incidence of falls by 30%, say researchers.

The Australian study looked at a programme of regular functional movements, such as squatting to pick something up from a low shelf as opposed to bending at the waist.

Over 300 men and women aged 70 years or older who had suffered two or more falls in the previous 12 months were randomised into one of three treatment groups – functional movements, a structured exercise or a control group that did gentle flexibility exercises.

The overall incidence of falls with functional movements was 1.66 per person-years, compared with 1.90 in the exercise group and 2.28 in controls.

The researchers concluded: 'Functional-based exercise should be a focus for protection from falling.'

BMJ 2012, online 7 August

CPD TIP OF THE WEEK

Give levodopa for intermittent restless leg syndrome

Patients that present complaining of intermittent symptoms of restless leg syndrome – defined as less than three episodes per week – could benefit from off-label levodopa, say the authors of a new case-based learning module. Levodopa has a faster onset and shorter duration of action than dopamine agonists, making it the preferred choice for intermittent symptoms. But for patients with frequent or daily symptoms, dopamine agonists are the treatment of choice. Non-ergot types such as pramipexole and ropinirole are licensed for restless leg syndrome, but ergot-derived medicines can cause serious side-effects and should be avoided.

CASE-BASED LEARNING
Restless leg syndrome and peripheral neuropathy: pulse-learning.co.uk

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Visit www.flu-protect.co.uk for more information about flu and flu vaccination

ABRIDGED PRESCRIBING INFORMATION

Inactivated Influenza Vaccine (Split Virion) BP

Refer to Summary of Product Characteristics for full product information. **Presentation:** Inactivated Influenza Vaccine (Split Virion) BP contains 15 micrograms of antigen (per 0.5 millilitre) from each of the three virus strains recommended by the World Health Organization for the present influenza season. It is supplied as single dose prefilled syringes each containing 0.5 millilitre of suspension for injection. The vaccine may contain traces of eggs, such as ovalbumin, neomycin, formaldehyde and octoxinol 9 which are used during the manufacturing process. **Indications:** Prophylaxis of influenza especially in those who run an increased risk of associated complications. Inactivated Influenza Vaccine (Split Virion) BP is indicated in adults and children from 6 months of age. **Dosage and administration:** Adults and children from 36 months should receive one 0.5 millilitre dose. In children aged 6 months to 35 months clinical data are limited and dosages of 0.25 or 0.5 millilitre have been used. Children who have not been previously vaccinated should receive a second dose of vaccine after an interval of at least 4 weeks. Doses should be administered intramuscularly or deep subcutaneously. **Contraindications:** Hypersensitivity to the active substances, to any of the excipients, to eggs, chicken protein, neomycin, formaldehyde, and octoxinol 9. Immunisation should be postponed in patients with febrile illness or acute infection. **Warnings and precautions:** Do not administer intravascularly. Medical treatment should be available in the event of rare anaphylactic reactions following administration of the vaccine. Immunosuppressed subjects may not produce adequate antibodies. Other vaccines may be given at the same time at different sites, however adverse reactions may be intensified. **Pregnancy and lactation:** Inactivated influenza vaccines can be used in all stages of pregnancy. May be administered during lactation. **Undesirable effects:** Common side effects include: injection site reactions (redness, swelling, pain, ecchymosis, induration) and systemic reactions (fever, malaise, shivering, fatigue, headache, sweating, myalgia, arthralgia). These usually disappear within 1 to 2 days. Other serious side effects have been reported and include, allergic reactions (in rare cases leading to shock, angioedema), convulsions, transient thrombocytopenia, vasculitis with transient renal involvement and neurological disorders such as encephalomyelitis, neuritis and Guillain-Barré syndrome.

For a complete list of undesirable effects please refer to the Summary of Product Characteristics. **Package quantities and basic NHS cost:** Single dose prefilled syringes in single packs, basic NHS cost £6.59; packs of 10 single dose prefilled syringes, basic NHS cost £65.90. **Marketing authorisation holder:** Sanofi Pasteur MSD Limited, Mallards Reach, Bridge Avenue, Maidenhead, Berkshire, SL6 1QP. **Marketing authorisation number:** PL 6745/0095

Legal category: POM. Date of last review: April 2012

Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard

Adverse events should also be reported to Sanofi Pasteur MSD, telephone number 01628 785291.

UK15944 c 07/12

'While I'm here, doctor...'

It may cut itchy bottom complaints, but the 'one problem per consultation' rule has **Copperfield** in two minds

Some readers criticise this column for being doctor-centric. They claim I'm uncaring and act as though patients exist to provide me with an income rather than a vocation. Which is unfair. It's no act.

But even my doctor-centredness draws the line at the 'one problem per consultation' rule many of you seem to favour – and strongly enough to put up a finger-wagging poster to that effect in your waiting rooms, too.

I think it's unrealistic and unfair. It's not that difficult dealing with multiple problems in one slot, and being able to spin plates without the consultation crashing is one of our USPs. Besides, illnesses often present as multiple problems. Under draconian 'one problem per consultation' legislation, a woman complaining of infertility, hirsutism, acne, amenorrhoea and obesity would have to make five different appointments before being diagnosed with PCOS – by which time she's also developed the unfortunate complication of endometrial carcinoma. ('And irregular bleeding, you say? You'll need another appointment for that.')

So that's where I stand on the one problem per consultation controversy.

Okay, stood: I'm having a change of heart. I've just finished what is laughably known as 'morning surgery' – but what is, in reality, a parallel universe in which everyone has chronic pathology, which I'm meant to a) be interested in, and b) sort out. I spent three hours on recalls of patients with IHD, hypertension, asthma and COPD

In trying to improve patients' lives, I'm ruining mine

– each appointment prompted by the QOF, prescription reviews or some other misguided notion that requires us to see patients with chronic disease every year to remind them they're ill.

This is what the typical surgery has become, and it's as much fun as punching myself in the face every 10 minutes. In trying to improve the quality and quantity of patients' lives, I'm ruining mine.

Worse, it generates work from thin air. Think about it – if you were an asthmatic with any kind of life, would you take time out of your schedule for the pleasure of blowing in a peak flow meter while your GP ticks a box? No. So you justify the hassle by making sure you deal with all those annoyances you wouldn't otherwise have bothered the doctor with: your itchy bottom, tiredness and anything else you can think of to destroy your GP's soul.

Maybe that's what has prompted the 'one problem per consultation' clampdown. But, frankly, rather than scrap the average punter's traditional right to 'while I'm here...', I'd rather scrap chronic disease management, which is the chief forum for them. With a bit of imagination – home blood pressure monitoring, an information leaflet stapled to an annual cholesterol blood form, a group lobotomy of those in charge of the QOF – the whole thing could be ditched.

For us GPs, it would generate spare appointments and the excitement that we might sometimes see people who are acutely sick rather than chronically ill. And for patients, it would free them from the manacles of their long-term disease. Not that I give a monkey's about that, of course.

Dr Tony Copperfield is a GP in Essex. You can email him at tonycopperfield@hotmail.com

More online

You can get your regular blast of the world according to Copperfield online at pulsetoday.co.uk/copperfield and on Twitter @doccopperfield

OPINION

Be brave, and hand the purse strings to patients

Headlines about patients buying homeopathy overshadow the true benefits of personal budgets, writes **Dr Simon Fradd**

There was a terrible amount of opposition to the Government's proposals for clinical commissioning.

Why? Where has it got us? Back to where we were in 1992, doing total purchasing under the fundholding regulations – that's where. The real opposition should have been to the financial cutbacks. Ministers must have been laughing their heads off.

So if you think commissioning is radical, just look at what's coming next: patient-held budgets. This means the individual is handed the fund to buy their chosen package of healthcare. They are already being piloted around the country – for instance, where I work in Southwark, we are testing them out with patients who have long-term conditions.

I can see the profession's reaction now. 'Patients don't know what is good for them.' 'They will buy rubbish such as alternative therapies and then run out of money.' 'It will destroy the NHS.' 'Hospitals and practices will go bust.' Why would anyone introduce such a mad system? Because the NHS is still run as if it is for the benefit of the service and not the consumer.

I commend Bernard Shaw's play *The Doctor's Dilemma* (currently on at the National Theatre) to all of you. It opens with a receptionist trying to get a patient seen first by a medical student and then by a series of doctors. Our colleagues all have more pressing things to do.

The play was written in 1906. From the public's perception, however, it looks much the same today. Just think of the impact the recent industrial action over our pensions has had.

Why should the purchaser/provider interface be between general practice and secondary care? How can this possibly be relevant? I have heard arguments that only doctors can set and enforce clinical standards. I agree, but they should be a matter of key performance indicators in hospital contracts in just the same way as they are in our contracts.

How would we feel if, when we went shopping, someone else held the purse strings? Would it not severely limit our choice? Don't we complain that the public wastes resources through DNAs and inappropriate use of A&E because they do not pay for them and don't recognize their value?

Though they are not without their problems, I believe patient-held budgets have multiple advantages for all players in the NHS. They will give the public leverage for the first time. If any of you have had to seek healthcare in a private system, either here or abroad, you will recognize how patient-focused those systems are – no waits, for example, but rather appointments 'when it would suit you'.

What about when the money runs out? If the budgets are not big enough, it will be the public clamouring for increased resources. For the first time, there will be benefits to the individual in taking responsibility for using the service appropriately.

This could really impact on the DNA rate and also on the self-care agenda. I don't have to tell you over 20% of GP consultations are for minor, self-limiting conditions. Do any of us really get any pleasure out of dealing with these? Yes, they may give us a breathing space between complex problems, but with the patient paying we would charge more for complexity. We would get our first real opportunity to be rewarded properly for using our skills.

One benefit we can already see in my CCG is the ability for co-payments. In long-term care, we have an obligation to deliver a total package of care to patients eligible for NHS services and also to provide that at an economic cost.

Time and again we deny patients who wish to be looked after in their own home because the cost is much greater than being cared for in an NHS facility. Under the traditional funding model patients could not supplement the budget. Under patient-held budgets, they can.

I know which system will suit me better when I need it.

Dr Simon Fradd is a GP in Southwark, south London, clinical lead at NHS Southwark CCG and non-executive director of Concordia Health

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DH must act to make training vision a reality

Steve Nowottny
Acting editor

It feels like we've been here before. This time last year, Pulse reported deaneries had been forced to cut the number of GP training places, and amid ever-increasing workload and an acute locum shortage, GP leaders warned of a looming job crisis.

Over the past 12 months, that concern has only escalated – and so Andrew Lansley's announcement in May that he planned to boost the number of GP trainees was met with a rare chorus of approval from the profession.

The health secretary not only set an ambitious new target for the number of GP training places – 3,250 in England alone by 2015 – but also indicated the increase would come as part of a radical alteration in the balance of the medical workforce. The proportion of specialty training places taken by GP registrars was to rise from 41% to 50% – a significant realignment reflecting the accelerating shift of workload from hospitals to primary care and, perhaps, a little of GPs' new commissioning importance as well.

But while no one was expecting a transformation overnight, the figures for this August's training intake show just how far that vision is from current reality. Across the UK, just eight more GP registrars have been recruited. In England, there has been a more marked increase, but one still dwarfed by hundreds of extra hospital trainees. Far from primary and secondary care beginning to reach parity, the proportion of GP trainees has actually fallen.

While ministers, GP leaders, educators and expert bodies such as the Centre for Workforce Intelligence seem in uncommon agreement on the problem, the causes – and the possible solutions – depend very much on who you ask.

The argument floated by deanery leaders last year was that a fall in the number of applicants was to blame. A shortage of quality applicants, and those for whom general practice is their first choice, undoubtedly remains a factor. But it's not the full story, not least because this year the number of first-round applications nudged upwards.

Others point to funding restrictions and a lack of capacity in GP practices. As Dr Krishna Kasaraneni, chair of the GP trainees subcommittee, writes on PulseToday, deaneries can only take on extra GP trainees if they can be placed in an approved training environment with the funds to support them. Addressing funding concerns must be a priority. But perhaps the most worrying reason offered – and the one with the most alarming implications for the future – is that in the age-old tussle between GPs and hospital colleagues, it is secondary care that is coming out on top.

The new local education and training boards may not be entirely responsible for the failure to boost GP trainee numbers. They are, after all, operating only in shadow form for now. But senior GPs believe they may already be 'potential blockers', and the fact that they are overwhelmingly dominated by hospitals does not bode well.

Health Education England's assurance that 'primary care-registered professionals will have proportionate membership on the board' seems incompatible with what's happening on the ground – and indeed the board's own targets. The requirement that 10% of LETB board members be from primary care may strictly speaking reflect GPs' share of the NHS workforce. But it takes no account of the organisational complexity of general practice, its importance to the health service as a whole or the relative numbers of primary and secondary care doctors.

The Department of Health may be inclined to let LETBs be, but taking a hands-off approach to the evolution of the new bodies could jeopardise the success of its workforce transformation. If we are to really see a historic shift in the balance of training, then a significant number of GPs must help oversee it.

Do you agree? Let us know by emailing Steve at editor@pulsetoday.co.uk

More online

Dr Krishna Kasaraneni: How can we create more GPs?

pulsetoday.co.uk/news-analysis

THE BIG INTERVIEW

Every Thursday, Pulse interviews the biggest names in general practice – and you can watch the interviews in full online. See this week's video interview, plus our full archive

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Revalidation will solve a nonexistent problem

LETTER OF THE WEEK

From Dr Graham Brown
Kirkcaldy, Fife

Professor Mike Pringle states that 'without revalidation, we will be mired in the spiral of mistrust' ('Revalidation is a reality GPs must accept', pulsetoday.co.uk/opinion).

Really? Where is the evidence for this? In fact, surveys regularly show doctors to be at the top of the public's list of trustworthy professions, with politicians and second-hand car salesman at the bottom. It appears we are undertaking a very expensive and time-consuming process to address a problem that does not exist.

Should the current appraisals process be more targeted?

Would revalidation have picked up Harold Shipman? Many doctors feel he would probably have been an appraiser.

I do not wish to be complacent. There are admittedly some under-performing doctors, but could we not consider a more focused approach to dealing with them, rather than making the entire profession jump through meaningless hoops?

There are already indicators of poor practice – prescribing, referrals and complaints which have been upheld. It is likely the PCT or health board and LMC secretaries will have a fairly good idea of who these problem doctors are.

Could we not use these sorts of screening procedures to identify possible problem doctors and examine them in more depth, along with a small number of randomly chosen others for benchmarking purposes?

This would be a much more efficient use of everyone's time and would be more likely to identify under-performing doctors, in my view.

The current appraisal process is in danger of being too superficial to pick up problems. It will also irritate the profession and waste its time.

Time to run in a different direction

From Dr Pip Hayes
Exeter

Dr Margaret McCartney made such perfect sense when she questioned all the QOF- and pharma-driven activity that dominates the working life of GPs ('The lost art of standing still', pulsetoday.co.uk/margaret-mccartney).

It's time for us to run in a different direction. I swim at lunch time when I can, and today my local pool was full of obese kids on their summer holidays, wallowing by the inflatables.

They come out of the pool and head for the machines full of junk food, making the entire pool visit a net calorie gain. The manager refuses to change the machines as they make the leisure company so much money.

This is a chance for GPs to take action. Dr McCartney is right – patients don't want drugs – so how about pointing them to man's best medicine?

If they have a computer, tell them about the *23 and a half hours* video on YouTube.

If there is no computer at home, show this in your consultation.

Michael Mosley's *Horizon* programme on alternate day fasting is another good one, but too long to show in consultation.

Tell them about their local Transition Town Movement. Discuss sustainable lifestyles and allotments.

Please help steer primary care towards changes that will really make a difference.

Wake up and smell the roses, BMA

From Dr Peter Swinyard
Chair, Family Doctor Association
Swindon
Via pulsetoday.co.uk

The Olympics have been an object lesson in the benefits of hard work and dedication, and they have shown the British attitude of fair play at its best.

So your story, 'BMA battles to win concessions' (pulsetoday.co.uk/news), highlighted how unsporting current pensions proposals seem to be.

What is fair about changing a recent agreement on pensions (the 2008 scheme) unilaterally, to tax senior doctors – for that is what it is, a tax – who are too near retirement to make other arrangements?

For younger doctors, they are seeing all their hard work is unappreciated.

I fear that the best will either leave the NHS scheme, making it potentially insolvent, leave the NHS or leave the country, all of which would be tragic.

The Government must play fair.

If you are in the soup financially, impose the same contribution levels on all civil and public servants. Don't just target doctors.

The BMA, meanwhile, must wake up and smell the grassroots roses. We doctors are furious about this.

For the record

Our recent article 'NICE sets CCG quality premium targets' suggested the institute had published a 'final list' of targets for the NHS Commissioning Outcomes Framework. The final list of targets will, in fact, be determined by the NHS Commissioning Board on the basis of NICE's recommendations.

Pulse's priority is accuracy. However, in the busy process of preparing a weekly publication, mistakes can occur. To draw our attention to an error, email letters@pulsetoday.co.uk.

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> **Good – highlights what we need to do to help us focus on the job at hand.**
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> **Interesting and relevant to my daily practice.**
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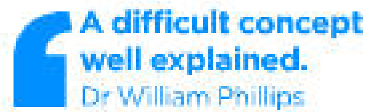

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Pulse Clinical

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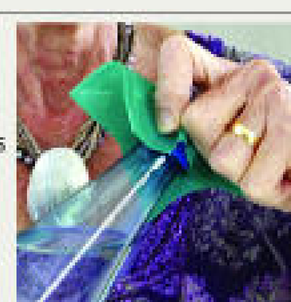

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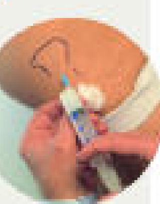
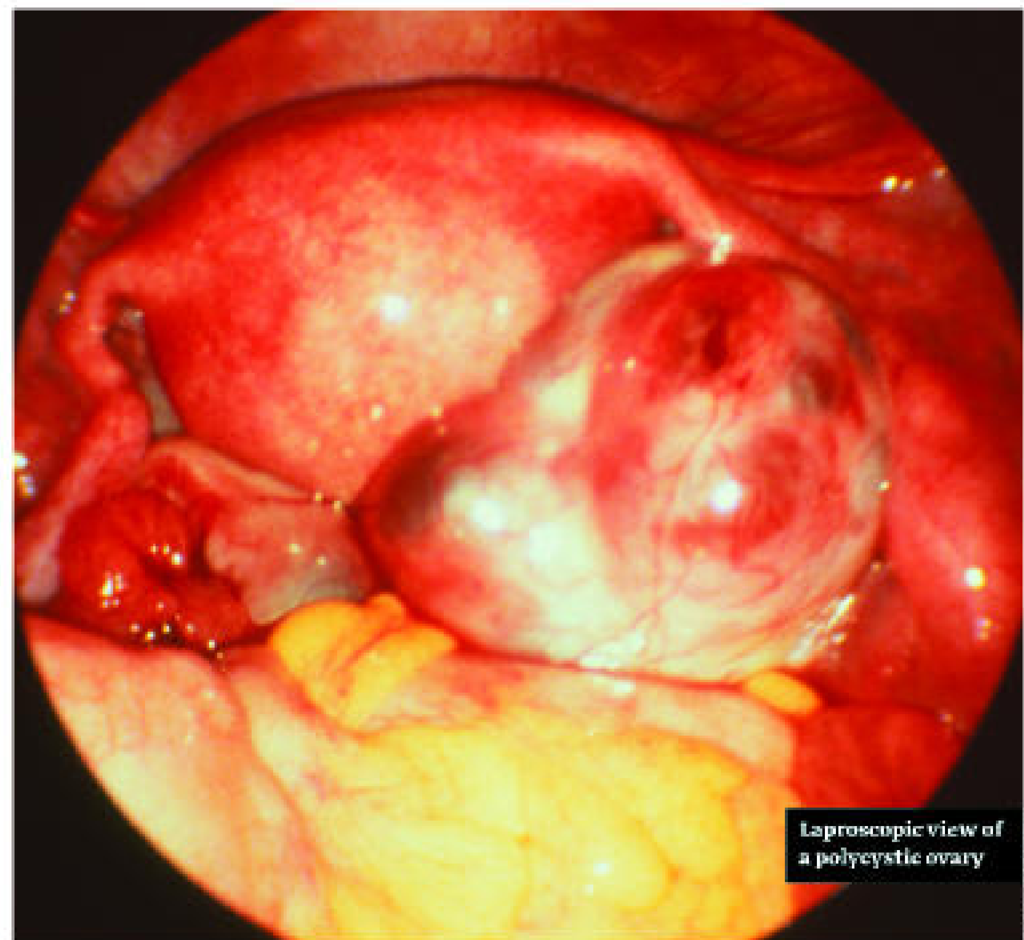

Our new online-only series on joint injection techniques

KEY QUESTIONS

Polycystic ovary syndrome

Dr Louise Melvin, consultant in sexual and reproductive health, tackles GP Dr Pam Brown's questions on diagnostic criteria, investigations, contraception and weight loss



Laproscopic view of a polycystic ovary

1 What signs and symptoms should prompt us to suspect polycystic ovary syndrome (PCOS)?

The classic symptoms of PCOS are oligomenorrhoea and hirsutism or acne. Most – but not all – women with PCOS are overweight. Symptoms may develop in adolescence or later in the reproductive years, following weight gain.

Women with PCOS may also present with infertility, male pattern alopecia, difficulty controlling weight or dysfunctional uterine bleeding. An incidental finding of polycystic ovaries on an ultrasound scan may indicate PCOS, but not necessarily. You should also consider PCOS – and type 2 diabetes – in women with acanthosis nigricans.

2 The Rotterdam diagnostic criteria are not universally accepted. What other diagnostic criteria should we consider?

The Rotterdam criteria define PCOS as the presence of two out of the following three criteria:

- oligo-ovulation and/or anovulation
- clinical and/or biochemical hyperandrogenism
- polycystic ovaries.

Other causes of menstrual disturbance or androgen excess must be excluded.[1]

The main criticism of the Rotterdam criteria is that they are too wide. A tighter definition that includes hyperandrogenism as an essential feature has been proposed.[2]

This new definition has advantages for those researching the causes of PCOS, but the Rotterdam criteria are more pragmatic for use in clinical practice.

A possible advantage of wide diagnostic criteria is that the patient may benefit psychologically from being able to give a name to their problem, although in some cases the label may cause anxiety.

I think that rather than changing the diagnostic criteria, patients would benefit more from a change in terminology to alleviate concern about cysts and divert the focus away from their ovaries.

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3 What is the differential diagnosis of PCOS, and what other conditions should we exclude before making a diagnosis?

It is initially important to exclude other causes of amenorrhoea – particularly pregnancy – but also menopause (premature ovarian failure), hypogonadotrophic hypogonadism and prolactinoma.

Next, consider rarer causes of hyperandrogenism as a differential diagnosis. Virilising features such as deepening of the voice and clitoromegaly are red-flag symptoms that should trigger radiological investigations to exclude androgen-secreting tumours of adrenal or ovarian origin. In patients with hirsutism, also consider the possibility of Cushing's syndrome, iatrogenic (drug-induced) or idiopathic hirsutism and congenital adrenal hyperplasia. Exclude iron-deficiency anaemia in women with alopecia.

4 Which investigations are appropriate in women with suspected PCOS? Should blood tests be done on a specific day of the cycle?

For menstruating women, a hormone profile is best done in the early follicular phase – the first few days of her period – but if a patient is amenorrhoeic, blood tests can be performed at any time. Combined hormonal contraception will interfere with results and should ideally be stopped at least three months before testing.

There is less reliance on LH and FSH as diagnostic indicators of PCOS now than there used to be, but gonadotrophin levels should still be measured to exclude other causes of anovulation. The LH:FSH ratio may be elevated in some women with PCOS, particularly in lean women.

It is necessary to measure estradiol to interpret abnormal gonadotrophin levels.

High FSH and LH, and low estradiol, indicates premature ovarian failure.

Low FSH and LH, and low estradiol, indicates hypogonadotrophic hypogonadism.

High estradiol is often seen in women with anovulatory cycles, but high estradiol coinciding with high LH indicates the LH surge preceding ovulation.

Measure thyroid function and prolactin levels to exclude pituitary pathology. Measure testosterone and SHBG to determine the free androgen index. In women with PCOS, the total testosterone level will usually be normal. While this is reassuring for the patient, it can be confusing and unhelpful if not measured along with SHBG.

A high free androgen index indicates elevated levels of free, active testosterone. But because of the wide range in individual sensitivity to androgens, this may not be associated with clinical hyperandrogenism.

Guidelines from the Royal College of Obstetricians and Gynaecologists (RCOG) advise that if total testosterone is greater than 5nmol/l, then 17-hydroxyprogesterone levels should be checked to exclude congenital adrenal hyperplasia.[3]

5 How actively should long-term risks be managed?

This is difficult because the long-term risks in PCOS have not been fully quantified – information on disease progression is scarce, and most screening tests and risk assessment tools have not been validated in women with PCOS. Diabetes and hypertension should be treated, but RCOG guidelines suggest that lipid-lowering treatment should only be prescribed by a specialist.

NICE advises that a fasting plasma glucose of 5.5-6.9mmol/l or an HbA_1c level of 42-47mmol/mol (6.0-6.4%) indicates a high risk of progression to type 2 diabetes, which should be managed with an intensive lifestyle-change programme.[4] NICE highlights that all adults from Asian backgrounds with a BMI greater than 23kg/m² are at increased risk of type 2 diabetes and should be encouraged to lose weight.

There are no hard and fast rules on how frequently women with PCOS should be screened for diabetes and cardiovascular disease. Some specialists advise annual fasting glucose. I would suggest an individual approach, taking into account age, BMI, lifestyle, ethnic origin and family history.

6 When is it appropriate to prescribe metformin in women with PCOS, and does this facilitate weight loss in these patients?

Metformin was hailed as a panacea for PCOS a few years ago, but it has failed to live up to expectations. Patients have often read about metformin and are understandably desperate to try anything that might help with weight loss or fertility.

A number of studies have demonstrated a significant reduction in weight with metformin – but the average weight loss is very modest, in the order of no more than one BMI unit.[5,6]

Metformin is relatively ineffective as a single agent for treating infertility, but it may improve fertility rates in combination with clomiphene, especially in very obese women.

The impact of metformin on androgenic symptoms and menstrual irregularity is modest. Although it does appear to delay the onset of diabetes in women at high risk, the effects of metformin on preventing cardiovascular disease are unclear.

I would discourage GPs from suggesting metformin to women with PCOS, unless the patient has type 2 diabetes or is progressing towards diabetes despite an intensive lifestyle programme.[4]

If you do prescribe metformin, it is important to explain that PCOS is not a licensed indication and that benefits are modest.

There is also a small risk of lactic acidosis, which may be triggered by exposure to iodinated intravenous contrast agents.

7 Should a diagnosis of PCOS alter contraception advice?

Because fertility is variable, women with PCOS should be advised that it is still important to use contraception. No contraceptive method is contraindicated because of PCOS itself, but prescribers should adhere to the usual restrictions.

Where there is a relative contraindication, the benefits of the method – for example, COC use for acne or hirsutism – may outweigh risks in patients with PCOS with risk factors such as obesity or a family history of cardiovascular disease.

Any hormonal methods, particularly Mirena, are likely to reduce the risk of endometrial hyperplasia and carcinoma in women with PCOS.

8 How should we handle amenorrhoea or oligomenorrhoea in women with PCOS?

Severe oligo- and amenorrhoea in the presence of premenopausal levels of oestrogen can lead to endometrial hyperplasia and carcinoma. In women with PCOS, intervals between menstruation of more than three months may be associated with endometrial hyperplasia.

Regular induction of a withdrawal bleed with cyclical progestogen for at least 12 days, oral contraceptive pills or the IUS would be advisable in oligomenorrhoeic women with PCOS. Other hormonal methods are probably protective, but there is no direct evidence. Women who are oligomenorrhoeic or who have abnormal bleeding should be investigated and managed according to local protocols.

Dr Louise Melvin is a consultant in sexual and reproductive health at Sandyford Sexual Health Service, Glasgow, and director of the clinical effectiveness unit of the Faculty of Sexual and Reproductive Healthcare

Along with a consultant colleague, Dr Anja Guttinger, Dr Melvin runs a gynaecology clinic specialising in PCOS and other reproductive endocrine problems.

Competing interests None declared

Dr Pam Brown is a GP in Swansea

References

1 Fauser B, Tarlatzis B, Chang J et al. The Rotterdam ESHRE/ASRM-sponsored PCOS consensus Workshop group. Revised 2003 consensus on diagnostic criteria and long-term health risks related to PCOS. *Hum Reprod* 2004;19:41-7

2 Azziz R, Carmin E, Dewailly D et al. The Androgen Excess and PCOS Society criteria for PCOS: the complete task force report. *Fertil Steril* 2009;91:456-88

3 Royal College of Obstetricians and Gynaecologists. Green-top guideline 33. *Long-term consequences of PCOS*. 2007. tinyurl.com/cexsppy (accessed 19 July 2012)

4 NICE. Preventing type 2 diabetes: risk identification and interventions for individuals at high risk. July 2012;PH38

5 Nieuwenhuis-Ruifrok A, Kuchenbecker W, Hoek A et al. Insulin sensitising drugs for weight loss in women of reproductive age who are overweight or obese: systematic review and meta-analysis. *Hum Reprod Update* 2009;15:57-68

6 Legro R, Barnhart H, Schlaff W et al. Co-operative Multicenter Reproductive Medicine Network. Clomiphene, metformin or both for infertility in PCOS. *N Engl J Med* 2007;356:551-66

Online extra: more Q&As

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Go online to read an extended version of this article, with the author answering questions on premature menopause in PCOS, facial hirsutism and weight loss

ENT CLINIC

Pleomorphic adenoma

ENT GPSI Dr Raj Singh on the most common salivary gland tumour

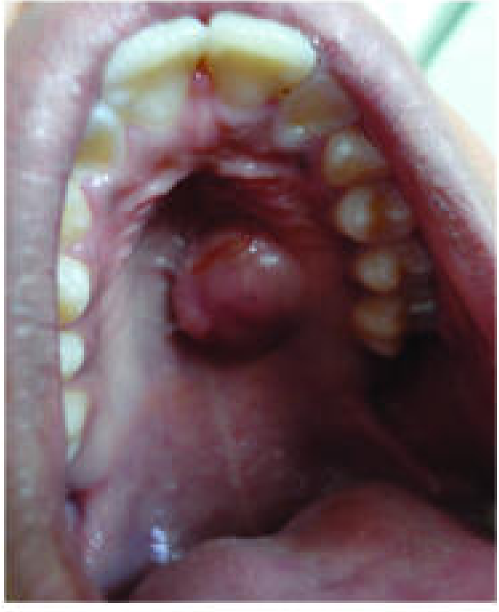
CASE

This 44-year-old man presented to his GP with a nodule on the left side of his hard palate. His dentist had noticed it around two years previously and had referred him to a dental hospital – but he had not kept the appointment or seen his dentist since. The nodule had grown slowly since and his wife had finally seen it and urged him to seek medical attention. So he now presented in a state of great agitation.

Examination showed a firm, painless swelling just over 1.5cm in diameter. It was well demarcated, pinkish and the overlying mucosa was intact. There was no evidence of regional lymphadenopathy and no history of oral trauma. His past medical history was unremarkable.

He was referred for investigation of the lesion, and a CT scan showed a smooth, well-marginated tumour. A biopsy revealed a benign tumour characteristic of a pleomorphic adenoma.

The entire tumour was excised with a wide margin and there has been no recurrence at 12 months' follow-up.



The problem

- Pleomorphic adenoma is a benign tumour of the salivary gland and is the most common salivary gland tumour in all ages.[1]
- It makes up 45-75% of all salivary gland neoplasms and the annual incidence is approximately two to 3.5 cases per 100,000 population.[2,3]
- The average age at presentation is between 43 and 46 years.
- Tumours affecting salivary glands may be benign or malignant and are diverse in their pathology.
- The major salivary glands are the parotid glands, submandibular glands and sublingual glands, but there are also up to 1,000 minor salivary glands.
- Some 80% of salivary gland neoplasms arise in the parotid glands, 10-15% in the submandibular glands and the remainder in the sublingual and minor salivary glands
- About 80% of parotid neoplasms are benign, but the relative proportion of malignancy increases in smaller glands. About half of submandibular gland neoplasms and most sublingual and minor salivary gland tumours are malignant.
- A pleomorphic adenoma developing in a minor salivary gland such as this is rare.

Features

- Pleomorphic adenoma is usually solitary and presents as a slow-growing, painless, firm, single nodular mass.
- Most develop in the parotid gland (see above), where they are usually mobile and can cause atrophy of the mandibular ramus. The example here developed in the hard palate and was immobile.
- Patients with minor salivary gland tumours may present with a variety of symptoms depending on the site – including dysphagia, hoarseness, difficulty chewing and epistaxis.
- Pleomorphic adenomas – though classified as benign – can become huge and may undergo malignant transformation, causing signs of facial nerve weakness.
- Features of a salivary gland mass suggesting malignancy include:
  - hardness
  - fixation
  - tenderness
  - infiltration of surrounding structures
  - ulceration.

Diagnosis

- Differential diagnosis includes:
  - Warthin's tumour – a benign parotid tumour typically seen in 60- to 70-year-olds
  - salivary gland malignancies – see below.
- Salivary gland tumours are usually diagnosed using both biopsy and imaging.
- Core-needle biopsy is more accurate than fine needle aspiration biopsy and allows histological typing.
- Both MRI and CT scanning can be used, but CT allows direct, bilateral visualisation of the tumour and can better assess surrounding tissue invasion in malignancies.

Management

- Surgical resection is the mainstay of treatment for any salivary gland tumour.
- Benign tumours of the parotid gland are treated with superficial or total parotidectomy.
- The latter is more common for pleomorphic adenomas because of the high incidence of recurrence.
- Benign tumours of the submandibular and minor salivary glands are treated with simple excision.

Dr Raj Singh is a ENT GPSI in Manchester

References

1 Eveson J, Kusafuka K, Stenman G and Nagao T. Tumours of the salivary glands. In: Barnes L, Eveson JW, Reichart P, Sidransky D, eds. *Pathology and Genetics of Head and Neck Tumors*. IARC Press, France. 2007:254-8

2 Pinkston JA and Cole P. Incidence rates of salivary gland tumours: results from a population-based study. *Otolaryngol Head Neck Surg* 1999;120:834-40

3 Spiro RH. Salivary neoplasms: overview of a 35-year experience with 2,807 patients. *Head Neck Surg* 1986;8:177-84

THE INFORMATION

Thumb-base osteoarthritis

Musculoskeletal GPSI Dr Tom Margham continues our series with a look at osteoarthritis of the thumb

THE PATIENT'S UNMET NEEDS (PUNs)

A 68-year-old woman attends with pain at the base of her thumb. She was seen by a colleague a few months ago when the symptoms began. No specific diagnosis was made and she was given NSAIDs with a PPI, which has helped a little. She's concerned that she's developing arthritis, which apparently her mother suffered from. She is keen for you to confirm the diagnosis and wants to know what other management options are available.

THE DOCTOR'S EDUCATIONAL NEEDS (DENs)

Wrist or thumb pain is common in general practice. What pointers in the history suggest arthritis rather than a more transient problem such as tendonitis?

Thumb-base osteoarthritis (OA) describes OA in the main articulations of the thumb carpal and metacarpal joints. The most commonly affected articulation is the trapezio-metacarpal joint, where patients complain of thumb and hand symptoms. Less commonly a patient may report pain radiating up the wrist, in which case the trapezio-scaphoid joint may be affected.

Hand OA typically presents with a degenerative history. Pain is often intermittent with insidious onset, felt on initiating movement and possibly associated with crepitus. There may be mild morning and inactivity stiffness and pain may worsen towards the end of the day.

Patients sometimes describe instability in the thumb and difficulty performing activities such as precision pinch or a strong grip – for example, lifting the kettle and removing lids from jars.

Family history of OA is a risk factor. In this case, it is important to elicit whether her mother had OA or rheumatoid arthritis and what concerns she has, given her mother's experience.

Tenosynovitis usually affects younger people with a history of recent increased activity. Also rule out recent trauma, particularly a fall onto the outstretched hand, as a scaphoid fracture can present with pain at the base of the thumb.

What physical signs confirm the diagnosis? Is there any value in arranging an X-ray?

Inspection of the hand may demonstrate other joints affected by OA, and Heberden's and Bouchard's nodes.[1] In more advanced cases, swelling may be present with the characteristic 'squared-off' appearance of the base of the thumb.

Check for pain on palpation of the carpometacarpal joint and do the axial grind test – gently push the thumb along its long axis towards the base – which reproduces the pain in OA. If the base of the thumb is fixed and the distal end moved in a circular motion, crepitus may be felt and patients may report that the joint feels unstable.

Patients' symptoms correlate poorly with X-ray appearance – and normal X-rays do not rule out OA. Plain radiographs can be used if the diagnosis is in doubt or for morphological assessment. Classical features are joint space narrowing, osteophyte, subchondral bone sclerosis and subchondral cysts.

A confident clinical diagnosis of OA can be made without further tests in patients over 40 presenting with thumb-base pain and a corroborative history and examination.

What is the prognosis in thumb-base OA? Patients often try over-the-counter remedies such as chondroitin and glucosamine – is there any evidence of benefit?

Thumb-base OA generally has a worse prognosis than hand OA, which mostly becomes asymptomatic after a few years. Thumb-base OA can cause continuing pain, weakness and instability, and disability can be as severe as in rheumatoid arthritis.

The debate around chondroitin and glucosamine for OA continues – overall, there has been less research into their efficacy in thumb-base OA than in hip and knee OA. The most recent guidelines do not recommend either.[2,3]

Advise patients on pain management strategies such as topical NSAIDs and capsaicin, which are both effective and safe treatments for thumb-base OA and are preferred over systemic treatments – especially for mild to moderate pain.[2,3,4]

Are splints helpful? If so, which are most suitable? What other conservative measures can relieve symptoms?

Splints are recommended for thumb-base OA.

In primary care, most patients will present with trapezio-metacarpal OA – in these patients, a short, hand-based, soft thumb spica can be tried. These can be purchased from many pharmacies or online.

For patients with trapezio-scaphoid OA, who have more wrist pain, a combination thumb and wrist splint is better. I would suggest referring to a hand therapist to advise on appropriate splinting in these cases. Go online to pulsetoday.co.uk/tools-and-resources to download a patient booklet on splints from Arthritis Research UK.

Advise patients to aim for thumb stability, not mobility. Osteoarthritic thumbs collapse on active and resistive movement, so encourage patients to carry out daily activities with thumbs in mid-range as far as possible. Avoid hand exercise that aims for full range of thumb movement, as this will make an unstable thumb even worse.

Other practical advice includes using two hands to carry, lifting close to the body and avoiding repetitive grasping, pinching and twisting motions.

Patients can use devices such as enlarged grips for writing, small non-slip cloths for opening objects, and electric can openers to help in daily life.

Early referral to a hand therapist is advised for patients not responding to first-line treatments.

Are cortisone injections effective? When should surgery be considered? What procedures are used?

Steroid or local anaesthetic injections are recommended for painful flares of thumb-base OA. This may be performed by a suitably trained GP, but don't inject more than every three months.

Only refer for surgery after other conservative treatments, including input from a hand therapist, have failed.[4] But do refer before there is prolonged and established functional limitation and severe pain.

The most common form of surgery for hand OA is a trapeziectomy – also known as an excision arthroplasty – which has excellent outcomes in terms of pain relief. This involves removing the trapezium and replacing it with an augmented tendon or ligament reconstruction. The thumb joint can also be replaced, which offers a stronger pinch grip but carries the risk of dislocation. Or the joint can be fused, sacrificing joint mobility for stability – this may be the best option in young patients or manual workers.

Key points

Risk factors for thumb-base OA
- Female
- Age over 40
- Family history
- Obesity
- Joint laxity
- Prior hand injury
- Occupational or recreational use

Epidemiology
- Some 20% of people over 55 have symptomatic thumb-base OA

Clinical features
- Joint pain lasting three months or more that is worse with use and may be associated with joint instability and loss of strength
- Morning stiffness for less than 30 minutes
- Functional problems, including difficulty with pinch grip
- Association with OA of other joints

Main differential diagnoses
- De Quervain's tenosynovitis
- Carpal tunnel syndrome
- Gout
- Inflammatory arthritis

Treatment
- Joint sparing advice
- Aerobic and strengthening exercises
- Topical NSAIDs or capsaicin
- Splinting
- Early referral to a hand therapist

Advise patients to use a small non-slip cloth to help with opening things

Dr Tom Margham is a musculoskeletal GPSI in Hackney, east London, and primary care lead for Arthritis Research UK

Competing interests None declared

Arthritis Research UK produces a wide range of information for patients on arthritis and musculoskeletal conditions. *Hands On and Synovium*, sent out three times a year in association with the *British Journal of General Practice*, contains up-to-date information on managing common musculoskeletal disorders seen in primary care. If you would like to receive the publication, access information for your patients or find out about GP training bursaries and awards, go to arthritisresearchuk.org.

References

1 Zhang W, Doherty M, Leeb B et al. EULAR evidence-based recommendations for the diagnosis of hand osteoarthritis: report of a task force of ESCISIT. *Ann Rheum Dis* 2009;68:8-17
2 Zhang W, Doherty M, Leeb B et al. EULAR evidence-based recommendations for the management of hand osteoarthritis: report of a task force of ESCISIT. *Ann Rheum Dis* 2007;66:377-88
3 Hochberg M, Altman R, April K et al. American College of Rheumatology 2012. Recommendations for the use of non-pharmacologic and pharmacologic therapies in osteoarthritis of the hand, hip, and knee. *Arthritis Care Res* April 2012; 64(4); 465-74
4 NICE. Osteoarthritis: the care and management of osteoarthritis in adults. 2008;CG59

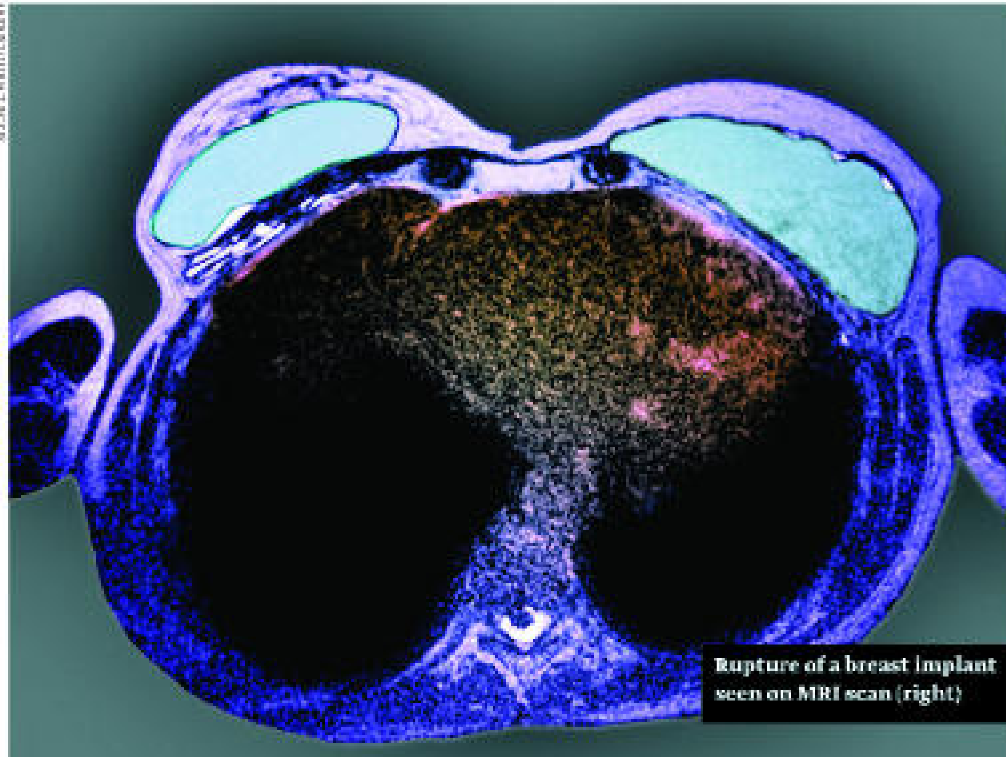
Resources

- Arthritis Research. *Joint protection: looking after your joints.* arthritisresearchuk.org/arthritis-information/arthritis-and-daily-life/looking-after-your-joints.aspx (accessed 3 August 2012)
- Arthritis Research UK. Self-help and daily living: splints for arthritis of the wrist and hand booklet. arthritisresearchuk.org/~/media/Files/Arthritis-information/Living-with-arthritis/2275-Splints-for-the-wrist-and-hand.ashx (accessed 3 August 2012)

POST-OP PROBLEMS

Cosmetic surgery

Mr Mark Ho-Asjoe, consultant plastic, reconstructive and aesthetic surgeon, discusses potential complications of cosmetic surgery



Rupture of a breast implant seen on MRI scan (right)

The most common aesthetic operation for women in 2011 was breast augmentation, followed by eyelid and facial surgery. Rhinoplasty is the most common procedure in men. But there are still far fewer surgical procedures carried out than non-surgical procedures, such as botulinum toxin injection and fillers.

All surgical procedures carry a risk of complications and aesthetic surgery is no different. This should have been discussed with the patient in the initial consultation.

Most patients should expect to notice bruising and swelling, which is usually worst on the day after surgery. But most aesthetic procedures have minimal complications in the first couple of weeks – besides the risk of infection, seroma collection within the cavity and wound dehiscence.

Bleeding and haematoma formation usually happen within the first 48 hours, but can present weeks later. Since most aesthetic procedures are cutaneous in nature, sudden-onset swelling of the area is normal.

Aside from these general complications, there are some complications that are specific to – or more significant in – particular procedures.

If a patient presents with any of these complications, they should usually be referred back to their surgeon.

Classification

These complications can be classified as immediate (within six hours), early (six to 72 hours) or late (after 72 hours)

Breast augmentation

Early

- *Bleeding and haematoma formation* usually occurs within 24 hours of surgery, but can happen over the following six weeks if there is injury or overexertion. The patient will present with sudden-onset swelling and pain. These patients need urgent review by their surgeon and may require evacuation of the haematoma.
- *Infection* occurs in less than 5% of cases. The patient will present with a red, hot, swollen breast and will require intravenous antibiotics and most likely removal of the implant.
- *Implant exposure* is also rare, but is a serious complication. It may be related to infection or poor wound closure, but with the implant being exposed. The patient needs to go back to theatre for removal or exchange of implants.

Late

- *Implant malposition* presents with a history of the breast changing shape. It is not uncommon for implants to rotate, or for ptosis to take place, once the soft tissue relaxes. These patients require review by a specialist.
- *Rupture* is rare with most types of implants – despite recent concerns over the French PIP implants – but the risk does increase with time. Patients usually present with an alteration in the size and shape of the breast, with or without pain. Clinical examination may be non-specific, but patients may have palpable enlarged lymph nodes.
- *Capsular contracture* is by far the most common complication with implant surgery, as the capsule surrounding the implant can thicken and alter in shape as it contracts. Patients present with localised pain, shape change and distortion. The risk of capsular contracture increases with time. On clinical examination, the implant will be hardened.

Rhinoplasty

Immediate

- *Bruising and swelling periorbitally* and intranasal swelling with reduction of nasal airway can be expected after rhinoplasty. Patients usually have an external nasal splint for protection and reduction of oedema, which is normally removed after one week.

Early

- *Septal haematoma* is a potentially serious complication and the patient may present with nasal obstruction, pain or rhinorrhoea. Examination will show an ecchymotic nasal septal mass. The patient requires prompt evacuation of the haematoma and antibiotics.
- *Injury to the cribiform plate* is rare, but can lead to cerebrospinal fluid leak and anosmia.

Late

- *Airway changes* may present after rhinoplasty. The patient may have symptoms such as persistent blockage, which may have been present before surgery or may be related to problems such as synechiae, valving and sinus obstruction. These patients need to be reviewed by their surgeons.

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Blepharoplasty

Immediate and early

- *Bleeding* is the most urgent complication immediately after surgery, as there is a risk of compression of the optic nerve. While this is extremely uncommon, it requires immediate decompression.
- *Chemosis* is oedema of the conjuctiva and it presents with a fluid-filled blister, usually on the lateral aspect of the conjuctiva. The patient needs reassurance and regular lubricating eye drops with antibiotics. It will normally resolve in a couple of weeks.

Late

- *Sclera show, ectropion, dry eye, epiphora* and *prolonged tissue oedema* all need to be reviewed by the specialist.

Botulinum toxin

Botulinum toxin injection inhibits the release of neurotransmitter and paralyses the muscle.

Immediate and early

- *Allergic reactions, bruising* and *bleeding* occasionally occur. The botulinum toxin usually starts working a few days after the injection.
- *Paralysis of adjacent muscles* may occur because of migration of the botulinum toxin. This can lead to eyelid ptosis, loss of zygomaticus major function and diplopia.

Dermal filler

Fillers can be permanent or non permanent. The most commonly used non-permanent filler is hyaluronic acid, which lasts between six and nine months. Other substances such as polymerised lactic acid and calcium hydroxyapatite may be used.

Early

- *Skin symptoms* such as redness, bruising, swelling, lumpiness and asymmetry are all normal. Occasionally, there may be acne-like skin eruptions, but this generally resolves within a few days.
- *Infection* is unusual but bacterial, fungal and viral infections – including herpes simplex – are all possible. Other complications include skin necrosis, allergic reaction and damage to deeper structures.

Late

- *Hardness* and *granuloma formation* do not usually require intervention, but occasionally injection of hyalase or a steroid may be required if the patient dislikes the final appearance.

Otoplasty

Otoplasty is the correction of prominent ears – the anti-helix is created and on occasion, the concha is reduced.

Early

- *Haematoma and infection* are the two most important complications. Both usually present with pain that is not relieved by simple analgesia. Haematoma usually presents with swelling either anterior or posterior to the cartilage, while infection presents with redness and overall swelling. Emergency drainage is the treatment of choice for haematoma.
- *Skin necrosis on the anterior aspect* is usually treated conservatively with dressing.

Late

- *Scarring* and a poor cosmetic result are the significant late complications. These patients need to be reviewed by the specialist.

Face lift

Immediate and early

- *Bleeding and haematoma formation* are the most important initial complications as they may compromise the airway or cause skin necrosis. This most commonly happens in the first few hours after surgery. Persistent small haematomas provide a site for infection and cause skin necrosis and, at the least, can affect the final cosmetic outcome.
- *Injury to the facial nerve*, in particular the mandibular branch, will lead to loss of function. Early stage weakness may be associated with analgesia and bruising, and it will recover with time. But actual direct injury is fatal to the nerve and will need urgent exploration and repair.

Late

- *Wound dehiscence* is usually minor and treated conservatively.

Mr Mark Ho-Asjoe is a consultant plastic, reconstructive and aesthetic surgeon at Guy's and St Thomas's Hospital, London, and The London Clinic

For more information on The London Clinic, go to thelondonclinic.co.uk

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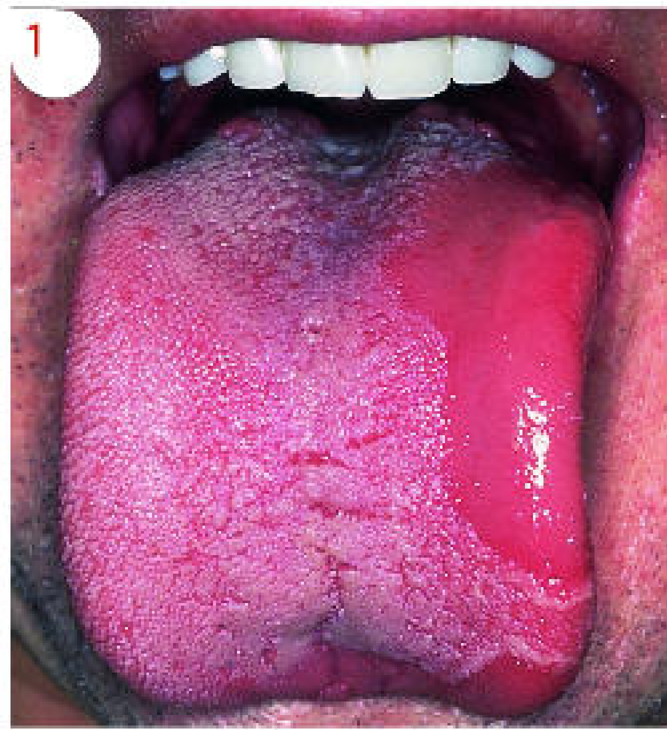
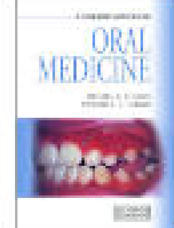
PICTURE QUIZ

Oral erythematous patches

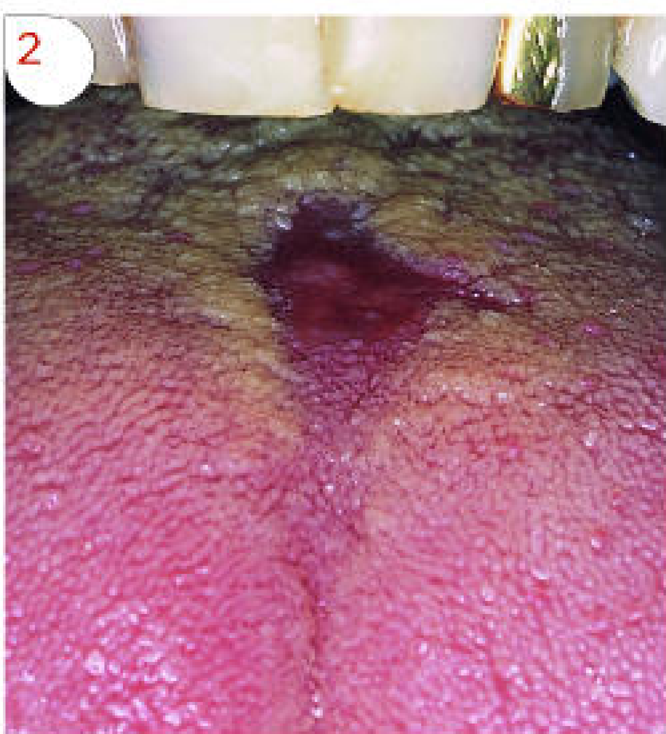


This young man had noticed painless patches like these appearing on his tongue intermittently for years. But this was the most marked example he could recall, which is why he presented.

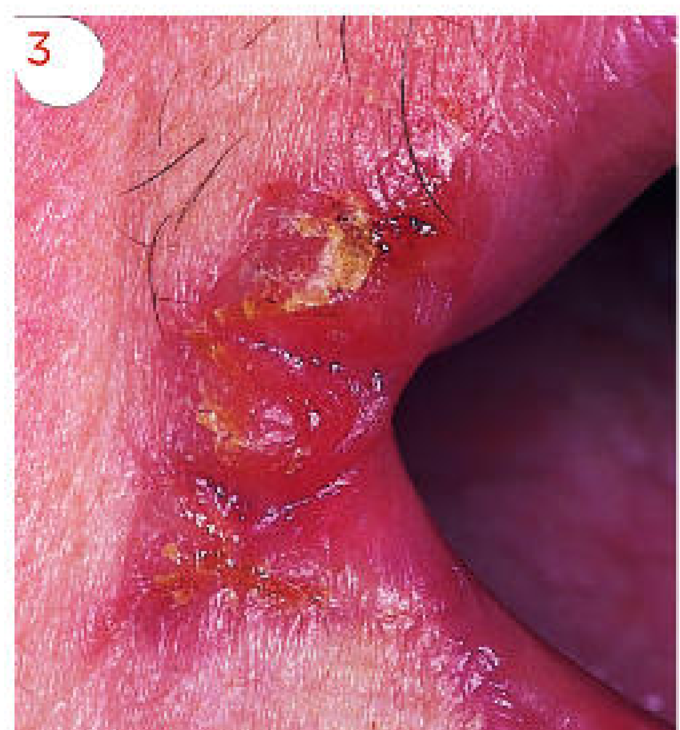
These five patients presented with lesions on their tongue and mouth. Can you work out the diagnosis in each case? Answers are at the bottom of the page



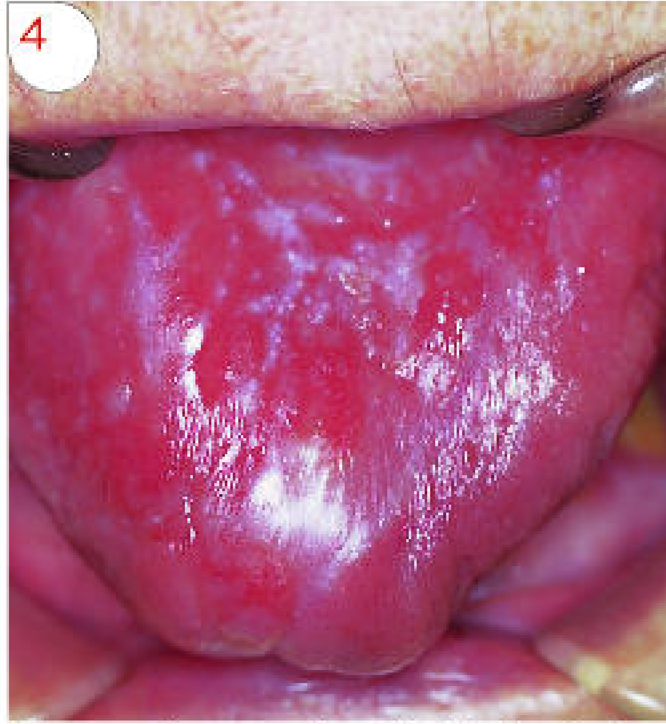
These cases are taken from *Oral Medicine – a colour handbook* by Michael Lewis and Richard Jordan. ISBN 9781840760330 (Manson Publishing); available from mansonpublishing.com/colour_handbooks and all good booksellers priced £29.95



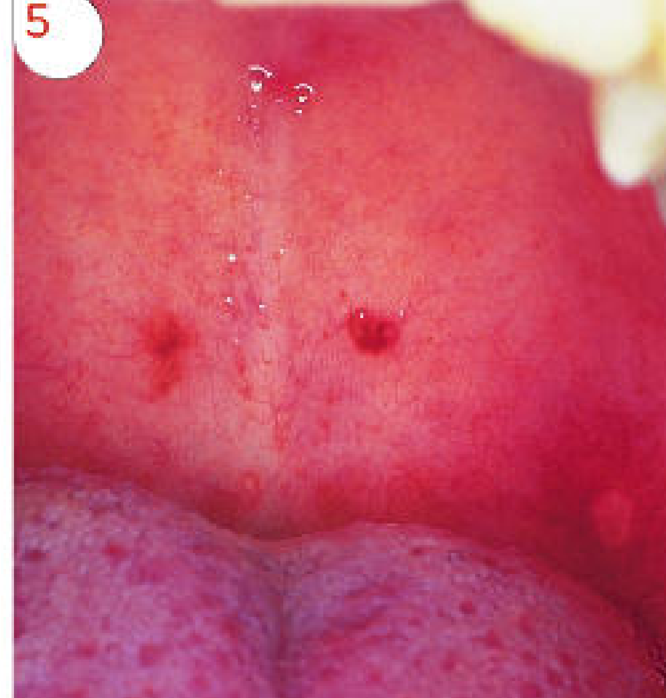
During a routine dental check-up, this patient's dentist noted an abnormal looking patch on her tongue. It had not changed in the intervening weeks and was causing no symptoms.



This elderly man thought he had cold sores in the corners of his mouth. The lesions had been present for weeks, were slightly sore and hadn't healed with antiseptic cream.



This 85-year-old woman tends not to look after herself and eats a very poor diet. She also complained of tiredness and shortness of breath.



It was the three-day history of sore throat and fever that brought this teenager to the GP. Examination revealed cervical lymphadenopathy – and when the expected pharyngitis was confirmed, these red spots were noted on the patient's palate.

ANSWERS

1 Geographic tongue

This condition is characterised by the appearance of irregular depapillated erythematous areas surrounded by pale well-demarcated margins on the dorsal surface and lateral margins of the tongue, which appear and regress relatively quickly over a period of a few days. The condition is relatively common and can affect any age. Geographic tongue can be diagnosed from the clinical appearance and history. Biopsy is rarely indicated, but should be undertaken whenever a more sinister lesion is suspected. The patient should be reassured about the benign nature of the condition. Nutritional deficiency should be excluded in all symptomatic patients – FBC, vitamin B12 levels, corrected whole blood folic acid, and ferritin should be undertaken.

2 Median rhomboid glossitis

Median rhomboid glossitis characteristically presents as a smooth, well-demarcated area of erythema at the junction of the anterior two-thirds and posterior one-third of the tongue. It has traditionally been viewed as a developmental abnormality. But recent evidence has shown that many of these lesions contain candida and respond to antifungal treatment. In the past, treatment has consisted of topical antifungal therapy – lozenges or pastilles – dissolved on the midline of the tongue every eight hours for up to three months. Lack of patient compliance with this may in part explain the poor therapeutic results. More recently, systemic antifungal agents such as fluconazole and itraconazole have produced encouraging results.

3 Angular cheilitis

Angular cheilitis is often associated with the presence of intra-oral candidiasis, either alone or in combination with staphylococci. This condition presents as erythema, possibly with yellow crusting at one or usually both corners of the mouth. Patients should apply a topical antimicrobial, such as miconazole, that has activity against candida and staphylococci every six hours. If appropriate, denture hygiene should be established. In persistent cases, investigate for diabetes or a haematological cause.

4 Glossitis (from iron-deficiency anaemia)

Iron-deficiency anaemia primarily affects women and presents clinically as lethargy, fatigue, pallor and shortness of breath. Patients may have brittle, shovel-shaped nails and brittle hair. Within the mouth, the oral mucosa may appear red, smooth and painful. Laboratory analysis of the blood shows hypochromic, microcytic anaemia with reduced haemoglobin and a reduced haematocrit. Serum analysis will also show low iron levels and decreased serum ferritin, but increased total iron binding capacity. Management is primarily directed at determining and correcting the underlying cause of the iron deficiency. Dietary iron supplements can be used to replenish the iron stores.

5 Glandular fever

Infectious mononucleosis is caused by the Epstein–Barr virus, a herpes group member. The condition is characterised by lymph node enlargement, fever, and pharyngeal inflammation. Approximately 30% of patients will also suffer from purpura or petechiae in the palate and oral ulceration. Occasionally, gingival bleeding and ulceration resembling acute necrotising ulcerative gingivitis may develop. The condition occurs mainly in childhood or early adolescence. No specific treatment is required, although hospitalisation may be necessary in severe cases of infectious mononucleosis with hepatic or splenic involvement. Ampicillin and its derivatives should be avoided as they are likely to produce an erythematous skin rash.

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Vision Awards 2012

The finalists

The finalists of the Vision Awards 2012 have been announced and winners will be revealed at the NAPC Annual Conference gala dinner on Tuesday, 30 October at the Hilton Birmingham Metropole.

Most advanced CCG
- **NHS Bassetlaw CCG**
- **NHS Nene CCG**
- **Warrington CCG**

Best efficiency innovation
- **St Levan surgery patient access scheme** New Devon CCG Western locality group
- **Co-creating best practice** NHS Erewash CCG
- **Care home advice pharmacist** NHS Nene CCG
- **Reviewing referrals and clinical behaviour** Nottingham West CCG

Best care closer to home initiative
- **Cockermouth integrated care team** Cumbria CCG
- **Transforming asthma care** NHS East Surrey CCG
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Best long-term conditions initiative
- **Reducing harm from stroke initiative** NHS Gateshead CCG
- **Pulmonary advancement network for Newark and Sherwood (PANNASH)** Newark and Sherwood CCG
- **Self-care for COPD** Wirral Health Commissioning Consortium

Best integrated care model
- **Facilitating integrated discharge** Nottingham North and East CCG
- **Integrated primary care mental health** Sandwell and West Birmingham CCG
- **Virtual ward** South Devon and Torbay CCG

Best patient engagement initiative
- **A three-level approach to engagement** Herts Valley CCG
- **Patient congress** NHS Nene CCG
- **Patient council** Wirral GP Commissioning Consortium

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Urgent care redesign
- **St Levan surgery patient access scheme** New Devon CCG Western locality group
- **Out-of-hours emergency repeat medicines service** Oxfordshire CCG
- **Urgent community support service** Principia Rushcliffe CCG

CCG manager of the year
- **Lynda Helsby** NHS Bolton
- **David Thorne** NHS Newcastle West CCG
- **Marcus Warnes** North Staffordshire CCG

Clinical leader of the year
- **Dr Theresa Eynon** Sessional GP, Leicestershire
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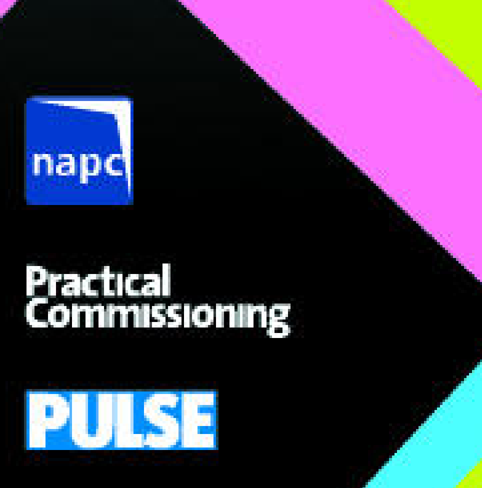

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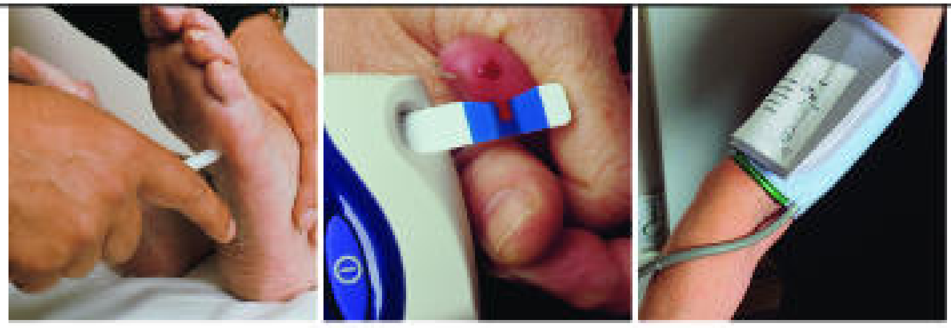

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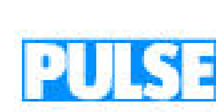

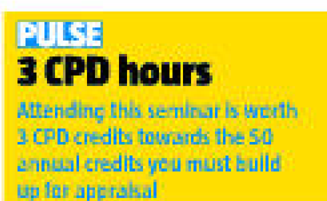

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Five tips for surviving a list-cleansing drive

Dr Tony Grewal outlines the key lessons learned by London GPs when dealing with list validation

Whether you know it as list validation, list cleansing or the FP69 process, at the end of the day most GP practices have experienced some kind of list-cleansing scheme first hand.

Most of us would agree that checking our patient list is essential to provide honest, good-quality care to the public. It is also important to have clean lists to ensure accurate funding. Where payments are based on achieving a percentage target of patients - with the QOF, immunisations and cervical screening, for example - a clean list means that your denominator is smaller. Any activity that affects practice budgets may also be skewed by 'ghost' patients obtaining services elsewhere.

If you take the regulations on list cleansing at their word, it is hard to see a problem. But the issue really lies in the way in which the process is implemented.

Many GPs find list cleansing can be time-consuming, frustrating and confusing. It can also divert scarce resources to explaining and apologising to patients who have been wrongly removed.

As medical director for Londonwide LMCs, I am often heavily involved in negotiating how the process is undertaken. We have worked hard to put in place agreed boundaries to ensure list cleansing is implemented in a clear and fair manner, such as rolling programmes over two years.

Think ahead and always get reception staff to check patients' addresses

At the moment, we know that GPs in several parts of the capital - including Lewisham, Southwark, Lambeth, Bexley, Bromley, Greenwich, Barnet and Haringey - are sifting through FP69 requests.

Here are five checks I'd recommend to any practices who are faced with a list-cleansing exercise or who suspect there may be one in the pipeline:

1 Ensure patient details are correct and up to date

There is no requirement for GPs themselves to manage lists, other than to inform their primary care organisation (PCO) if a patient has died or is leaving the country for three months or more.

It is important to banish the myth that GPs knowingly leave 'ghosts' on their lists - there is no significant profit in it and it would leave a practice at risk of a fraud allegation. Making sure you have good contact details for patients in the first place will help ensure they don't get knocked off your list during the FP69 process.

Think ahead and always get reception staff to check patients' home address every time they make contact with the surgery - if possible, try to keep their contact number up to date as well.

In my years as a GP and as an LMC medical director, I have seen a broad range of foul-ups that have made what should be a simple process a complete mess, for practices and patients alike. Many of the issues arise with the communication to the patient. We have experienced:

- undelivered mail
- patient letters only sent out once
- letters sent without the individual's name on the envelope.

The non-delivery rate can be up to 25% in London. Having an up-to-date address for patients will help reduce the undelivered mail problem.

2 Be ready when the request comes

The NHS regulations describe the FP69 process like this: 'Where the address of a patient who is on the contractor's

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25 list is no longer known to the primary care trust/local health board', it will 'give to the contractor notice in writing that it intends, at the end of the period of six months commencing from the date of the notice, to remove the patient from the contractor's list of patients; and, at the end of that period, remove the patient from the contractor's list of patients unless within that period the contractor satisfies the primary care organisation it is still responsible for providing essential services to that patient'.

If you receive an FP69 Prior Notification Transaction from your PCO or NHS Shared Business Services, don't put it to the bottom of the growing pile of tasks, act quickly – time can fly by. Reception staff and practice staff can also proactively anticipate list cleansing by watching out for warnings and advice from LMCs in email alerts and newsletters.

3 Check your list for FP69 flags

Once you have been informed that a list-cleansing drive is under way, actively access your clinical systems to check for flagged patients. Your PCO should be able to show the practice manager how to do this, but if not then contact your system provider or ask colleagues at your local practice managers group. GPs and practice managers are not expected to flag patients themselves, but should know how to find them on patient files.

4 Keep patients informed

Tell patients when a FP69 process is taking place and remind them to keep the practice up to date with changes to their address and phone numbers.

There are many ways to effectively raise awareness of a list-cleansing drive among staff and patients. Some examples include posters and leaflets; notices in local papers, welfare offices, Citizen's Advice Bureaux and libraries; and messages on repeat prescription slips.

In some boroughs, Londonwide LMCs has negotiated a system where the PCO sends a list of patients not recently in contact with the practice to GPs, to allow them to remove any patients identified as vulnerable before the main list-cleansing mail-out is dispatched. Your area might benefit from a similar system.

Another issue has arisen whereby PCOs only write to patients in English, even though a growing proportion of patients – especially in London – do not speak English as their first language, if at all. There is little or no support from PCOs when it comes to patient queries and rarely much advice for practices either.

5 Help patients re-register

The main concern for GPs in this process is our patients. We know that those most in need of our care are, in fact, those most likely to find themselves deregistered and the most likely to be distressed and confused by this – the elderly, the mentally ill, those who have limited grasp of English and other vulnerable patients. If patients are removed from your list and are upset, provide them with the name and address of the relevant PCO contact to complain to and re-register them. It may help to give them a slip, explaining what has happened and that it is not the practice's fault. They might also not have the right ID with them to re-register at the time, so remind them they will need to bring documentation next time they visit the surgery.

In the capital, Londonwide LMCs has given practices information about who has responsibility for this and, where we have agreed list-maintenance processes, we have asked the PCTs to provide patients with a contact for enquiries and concerns.

Dr Tony Grewal is the medical director of Londonwide LMCs and a GP in Hillingdon, north-west London

'Normal work was curtailed while we chased patients'

Practice manager in north London I work in a large practice in a leafy north London suburb. We serve more than 17,000 patients on one site, and our registered list has grown from 15,000 in the last three years. The north-central London boroughs – Barnet, Camden, Enfield, Haringey and Islington – have seen their populations rise by 14.66%, according to the census figures released by the Office for National Statistics in July. Yet in spite of having just completed a validation exercise in 2011, we are poised to begin yet another round at the behest of our PCT.

Background

The first list-validation exercise we undertook back in 2008 was a huge and costly process for both the PCT and us. It started with individual letters to all patients from the trust, regardless of whether they had been in touch with the practice over the previous three years, asking them to confirm that they still lived at that address.

People didn't respond to the letters and the result was that we started to receive FP69 flags from the PCT in floods. Normal work for the registration officer was curtailed while we phoned, wrote and chased to keep patients on our list.

Having completed a second list-cleansing exercise in 2011, it was frustrating to be instructed by the PCT to complete a further exercise for the 2012/13 financial year. This time, the contact period has been dramatically shortened to 15 months, with those on disease registers excluded – although these are the most likely to have been seen in the practice, so it is an illusory concession.

Challenges

The three significant concerns for us about our PCT's increasingly draconian list-validation exercises are the increasing workload, cutting the no-contact period to 15 months and ignorance of local population trends.

Caring for our patients should be the primary aim of every member of staff's working day. It is galling to spend so much time and energy justifying what we know is the reality – our list is growing.

MORE ONLINE Go to pulsetoday.co.uk/practice-business to read the rest of the case study and share your experience of list cleansing

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A quick guide to commissioning dementia care

Professor Steve Iliffe provides an overview of dementia commissioning and outlines three approaches CCGs can take to improve care in their area

DEMENTIA IS A COMPLEX PROBLEM of growing proportions that presents clinical commissioners with many dilemmas. Early recognition is promoted forcefully in current policy, but is often difficult in practice.

This article covers the strengths and weaknesses of the Department of Health's commissioning pack on dementia, and looks at three different approaches commissioners can take to improve dementia care locally.

Existing support

Because of the complexity and high costs of dementia to health and social care – more than cancer, heart disease and stroke combined – there is a powerful policy imperative to improve suboptimal services.

The DH's commissioning pack, published last year, was designed for GPs and old-age psychiatrists, the two medical disciplines that manage most patients with dementia.[1]

It leaves clinical commissioners to decide who diagnoses, treats and supports people at a local level. The pack assumes clinical responsibility will rest with GPs, except during the formal diagnostic process and during acute admissions to hospital. Long-term follow-up of patients by specialists is actively discouraged, in order to create a rapid-response dementia service with a high throughput of patients.

The pack approaches dementia as a stand-alone problem that can be managed using a modular system of service specifications for different settings and different points on the disease trajectory. For example, the processes of diagnosis and counselling fit into the module for memory assessment services and the acute inpatient episode fits into a module for commissioning liaison old-age psychiatry services.

The pack contains a costing tool that can predict downstream gains from investments early in the process, mostly by delaying relocation to a care home. It also identifies some of the quality indicators that would help commissioners judge how well or badly a service is performing.

Tackling comorbidities

The problem that remains is that dementia is not a stand-alone condition, but one that overlaps with comorbidities, disabilities and frailty while progressing invariably to death.

Most people with dementia have major comorbidities – 57% have two or more expressions of vascular disease and/or diabetes, which predict higher mortality independent of age.[2,3,4] The incidence of recurrent stroke is doubled in patients with dementia, and these patients also show greater functional and nutritional deficits as well as higher illness burden and costs.[5,6] These comorbidities may be 'overshadowed' by dementia, with consequent suboptimal management of acute myocardial infarction and atrial fibrillation, and diminished efforts to prevent secondary or recurrent stroke.

Part of the increase in service use comes from dementia's overlap with frailty, an unstable state in which minor events – such as a urinary tract infection – can have major consequences such as delirium, falls or loss of mobility, which themselves increase mortality.[7]

Although the course of dementia always ends in death, there are substantial concerns about the quality of end-of-life care for people with dementia – one result of this being that people with dementia at the end of life are often admitted inappropriately as emergencies to acute hospital wards.[8]

Organisational challenges

Clinical commissioners will need to factor their thinking about comorbidities, frailty and end-of-life care into the decision support offered by the DH's commissioning pack. They will need to consider what skills they can mobilise from the existing workforce and potential new entrants to enhance services for people with dementia. This is where organisational problems could begin.

Old-age psychiatrists may not feel comfortable with the assessment and management of physical pathologies as well as cognitive impairment and the behavioural and psychological symptoms of dementia. They can claim, reasonably, that they are not GPs. The obvious source of clinical expertise to manage complex needs is general practice, but GPs repeatedly report that they lack confidence in managing patients with dementia, and they struggle with frailty too.

Incentivising dementia care through local enhanced services may encourage GPs to acquire the skills needed and to develop a comprehensive approach to this complex population of older people.

> **GPs repeatedly report that they lack confidence in managing dementia**

Unfortunately, the evidence does not support this optimism. The QOF has incentivised diagnosis and annual management reviews since 2006, but there has only been a slight increase in the documented incidence or prevalence of recorded dementia.

Three ways forward

I can see three options for commissioners aiming to improve the care of people with dementia syndrome. Psychiatrists and geriatricians tend to favour the first or the third, but it may be that GPs feel better disposed than their colleagues towards the second – a GP-run, federated model.

1 Improve current practice

Most CCGs currently favour an improved version of current practice, in which systematic GP follow-up is supported by specialist advice.

GPs are beginning to get more specialised training in dementia care – for instance, through masterclasses and regional pharma-funded events – and QIPP data is being used to rank patients' risk and improve case management. As the DH recommends, specialists should deal with complex problems like difficult diagnoses, care in acute hospitals, reducing antipsychotic prescribing and end-of-life care, but should not undertake routine follow-up.

2 Set up a federated model

Services can be integrated into a single organisational entity, such as a social enterprise, led by GPs who hire specialists directly. This is the federated model, promoted by old-age psychiatrist Professor David Jolley and Dr Ian Greaves, a GP in Gnosall, Staffordshire.[9]

Patients are managed in general practice, with specialists acting as consultants. The practice organises systematic follow-up of patients with dementia. However, in my experience, the success of the social enterprise or incentive-based model of care usually comes down to enthusiastic leadership rather than the model itself.

3 Be innovative

The third option is to take advantage of the new commissioning environment to innovate. For instance, I learned about an alternative model for dementia care at the Alzheimer's International event in London in March. It was based around the Dutch system, where a care-home physician takes on much of the work a GP or consultant might do – training for this role is shorter than for general practice.

In Holland, old-age psychiatrists and community geriatricians jointly run a service for older patients with complex needs, frailty or dementia. The care-home physician replaces the GP as the lead clinician for this patient group – equivalent to a specialist clinical assistant role in the UK.

This model doesn't exist here yet, but it's just one example of the way GP commissioners are already looking to other healthcare systems when they tackle dementia as a commissioning challenge.

Professor Steve Iliffe is professor of primary care for older people at University College London, a former GP and member of NHS Brent CCG in Kilburn, north London

References

1 Department of Health. *Dementia commissioning pack*. 2011. tinyurl.com/8tzrwt2
2 Connelly A, Iliffe S, Gracl E et al. Quality of care provided to people with dementia: utilisation and quality of the annual dementia review in general practice. *Br J Gen Pract* 2012;62:e91-8
3 Gambassi G, Landi F, Lapane K et al. Predictors of mortality in patients with Alzheimer's disease living in nursing homes. *J Neurol Neurosurg Psychiatry* 1999;67:59-65
4 Larson E, Shadlen M, Wang L et al. Survival after initial diagnosis of Alzheimer's disease. *Ann Intern Med* 2004;140:501-9
5 Moroney J, Bagiella M, Tatemichi T et al. Dementia after stroke increases the risk of long-term stroke recurrence. *Neurology* 1997;48:1317-25
6 Zekry D, Herrmann F, Grandjean R et al. Demented versus non-demented very old inpatients: the same comorbidities but poorer functional and nutritional status. *Age Ageing* 2008;37:83-9
7 Rait G, Walters K, Bottomley C et al. Survival of people with a clinical diagnosis of dementia in primary care. *BMJ* 2010;341:c3584
8 Sampson EL, Gould V, Lee D et al. Differences in care received by patients with and without dementia who died during acute hospital admission: a retrospective case note study. *Age Ageing* 2006;35:187-9
9 McNulty S. A federated approach to dementia. *Practical Commissioning* 2012, online 14 May. tinyurl.com/c6kawkz

5 Minute Digest

No time to get through that stack of commissioning policy documents on your desk? Go to pulsetoday.co.uk/commissioning for the first in a new Pulse series, the Five-Minute Digest. This month, Primary Care Commissioning chief executive Helen Northall summarises what's important about the draft NHS Commissioning Board mandate.

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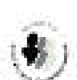

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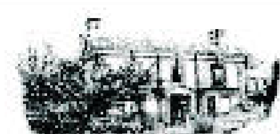

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We offer outstanding facilities and services including Psychiatry and counselling on site, consultant led Memory clinic, consultant led Gynaecology clinic, Physiotherapy Monday - Friday, Minor surgery suite, full Health Promotion, Chiropody and a wide range of nurse led clinics run by our excellent nursing team.

Gnosall Surgery is a respected and well established Training Practice for GP registrars, FY2s with close links to Keele Medical School educating year 3, 4, and 5 medical students

- 8,000 patients
- 4 GP partners
- High QOF achiever
- EMIS web
- Pharmacy and dental surgery onsite
- Active member of Stafford and Surrounds Commissioning group
- Excellent Patient satisfaction

If you are interested in this unique opportunity to be part of our visionary practice please send a full typed CV with a handwritten letter to Mrs Nicola Greaves, Business Partner, Gnosall Health Centre, Gnosall, Stafford, ST20 0GP. Tel: 01785 822220

We would welcome informal visits from interested colleagues.
Closing date 10 September 2012

The Kakoty Practice

Sheffield Road Surgery, 170 Sheffield Road, Barnsley S70 4NW

We have a vacancy for a full-time salaried GP.

We are seeking an enthusiastic doctor, willing to help us delivery high quality health services to a challenging population including Asylum Seekers and Substance Misusers.

The full-time working consists of nine clinical sessions:
Monday - Friday am
MRCGP preferred.
List size 6000
Modern, well equipped, purpose built accommodation on two sites.
10 minute appointments
Nursing team including nurse practitioners, nurse-led services including chronic disease management.
Paperless, SystemOne.
Professional Development Supported
High QoF achievement

Practice website: www.thekakotypractice.nhs.uk
Informal enquiries and visits welcome.
Written application including CV to: Dr P C Kakoty, GP Partner, Sheffield Road Surgery, 170 Sheffield Road, Barnsley S70 4NW
tel: Business Manager - Marie Hoyle on 01226 209969 or email marie.hoyle@nhs.net

Closing date: 14th September 2012.

SALARIED GP

(WITH A POTENTIAL PARTNERSHIP OPPORTUNITY)
Up to 6 Sessions per week

Dr. Bevan and Partners, Spinney Brook Medical Centre
Northamptonshire

We are looking for an enthusiastic GP to join our busy, friendly, semi rural Practice from November 2012.

- *6 GP Partners (5 wte)*
- *List size 10,800*
- *Modern purpose built premises (Main and Branch Surgery)*
- *Dispensing Branch Surgery*
- *High QOF points achieved*
- *PMS Practice*
- *Secure OOH arrangement*
- *Training Practice (Registrar and Undergraduate)*
- *EMIS LV / Paper light (moving to EMIS web)*
- *GP Triage/Nurse Practitioners*
- *Excellent road and rail links*

Informal visits and enquiries welcome. Letters of application and CV to:

Mrs. Alison Fenn Coles (Practice Manager)
Dr J. M. Bevan & Partners
Spinney Brook Medical Centre
59 High Street, Irthlingborough, Northants. NN9 5GA

Tel: 01933 650593 – Email: alison.fenncoles@gp-k83028.nhs.uk

SALARIED GP

(WITH A VIEW TO PARTNERSHIP)

ASTLEY TYLDESLEY MANCHESTER

A pleasant semi-rural area

- **Well established friendly practice with an excellent reputation**
- **8 Sessions per week**
- **To start: as soon as possible**
- **List size 3200**
- **Paperlight EMIS LV -moving to EMIS web**
- **Docman used**
- **Single-handed PMS practice with one salaried GP**
- **Actively involved in PBC**
- **Medical student placements**
- **2 Practice Nurses**
- **High QOF achievement**
- **Beautiful area-excellent schools Conveniently placed to motorway network**
- **Excellent staff**
- **We aim for a good work/life balance in a friendly atmosphere**

Closing date for applications: 31st August 2012

Interested colleagues should send a covering letter and CV. to:
Practice Manager: Ann Atherton aatherton1@nhs.net
For any further information please ring Ann on 01942 883794

The GLEBE PRACTICE

85 SYKES LANE
SAXILBY
LINCOLN
LN1 2NU

Dr's Ash, Azar, Gopee and Satyam are seeking Salaried GP for up to 6 sessions over a 3 - 5 day week on a negotiable salary.

Practice is a 2 site semi rural PMS dispensing practice utilising Emis web to manage 8,000 patients. Benefits from purpose built buildings, F2 doctors and an 8 strong nursing team alongside admin and dispensing staff.

Informal visits welcome, contact one of the management team on 01522 706900/706901 to arrange.

Further details can be obtained from Dr Ash on 0844 477 3462

Applications by CV for the attention of Dr Ash.

The London Road Surgery
Wickford, Essex.
SALARIED GP

Friendly, busy and patient focussed GP Practice in Wickford are looking for dynamic salaried GP(s).

Up to 10 sessions a week available.
Full Time or Job Share considered.

Competitive Salary including Professional Fees paid pro-rata.

Please send your CV with a covering letter to Ms Kim Hookings, Practice Manager, The London Road Surgery, 64 London Road, Wickford, Essex. SS12 0AH
Or via email: practice.managerF81041@nhs.net

Closing date for applications:
5pm 31st August 2012

Winch Lane Surgery
Haverfordwest, Pembrokeshire, West Wales

FULL-TIME SALARIED GP (8 SESSIONS)

- *14000 patients with "Personal List" system*
- *Teaching Practice - GP Trainees, Medical Students, Further Training*
- *Paperless, EMIS LV and High QOF Scores*
- *Modern, purpose-built premises*
- *Nine GPs and two Nurse Practitioners*
- *Excellent Nursing, Admin and Reception Teams*
- *Flexible start-date and prepared to wait for right candidate*

Please apply in writing with a CV to:

Michael McManus, Practice Manager
Winch Lane Surgery, Haverfordwest, Pembrokeshire SA61 1RN

For an informal chat or to arrange a visit please contact Dr David Davies
or
Michael McManus on 01437 762333

Closing Date: Wednesday 5th September 2012

MATERNITY LOCUM

Dr. Fairlamb and Partners,

Post Description

- 6 month maternity locum starting September 2012
- Potential to join partnership when senior partner retires in 2013.
- 8 sessions a week.
- Paper-light Emis based practice.
- High QOF achieving.
- Staffing: 2 full time, 2 part time Partners . We have an excellent nursing team including a nurse practitioner, and administrative support team.
- Currently providing patient centred care for 5800 patients in both Wingate and Peterlee.

For further information and an informal visit please contact Dawn Nelson Practice Manager on; Carodoc Surgery,Front St West, Wingate, TS28 5PZ Tel:01429 838217 Dawn.Nelson1@nhs.net

Closing date for application 10.08.2012

PRIVATE GP

Mayfair Practice, London requires a full time Private GP to start as soon as possible. Please contact Dr J J Masani

Tel: 020 7408 1164
Email: jmasani@me.com
www.mayfairpractice.com

We are looking for a Full Time Partner

(8 sessions per week)

- *GMS PRACTICE*
- *SYSTEM ONE CLINICAL (SMARTCARD)*
- *'PAPERLIGHT'*
- *FULL PRACTICE NURSE TEAM*
- *ABOVE AVERAGE REMUNERATION*
- *EXCELLENT LOCATION FOR LONDON & ESSEX COUNTRYSIDE*

PLEASE SEND CV BY E-MAIL OR POST TO:
DAVID WALKER, PRCATICE MANAGER
THE SURGERY, MOUNT AVENUE
SHENFIELD, BRENTWOOD CM13 2NL
Practicemanagerf81055@nhs.net

CLOSING DATE 24th AUGUST

Full time salaried GP

(would consider two part time / job share)

Are you a highly motivated, caring GP?
Would you like to join our friendly, committed, dynamic, established South Tyneside Training Practice?

Please submit CV and covering letter to
Sharon Thompson, Business Manager
Mayfield Medical Centre
Park Road, Jarrow, Tyne and Wear, NE32 5SE
or email sharon.thompson@stpct.nhs.uk

For further information contact
Sharon Thompson on 0191 4897183

Salary negotiable depending on experience.

Closing date: 28th September 2012

DOCTORS/GPS REQUIRED

Coastal North Essex

We are seeking to work flexibly with an enthusiastic doctor who will share our team commitment to providing high quality innovative care, either as a salaried doctor or as a partner.

We are semi rural Training Practice within easy reach of London and the continent, with excellent local schools and leisure opportunities, good transport links and reasonably priced housing.

List size 10,500	GPwSI Gynaecology/FP trainer
7 week annual/personal development leave(FTE)	Improving working Lives Practice
EMIS web, paperlight accredited	High Achieving PMS QOF
Nurse Practitioner surgeries	Award Winning Nurse Practitioner led community visiting
GPSpR	Opportunities to develop your own interests.

Informal enquiries/visits welcome. Apply with CV and covering letter of application to Martin Durrant, Practice Manager, The Surgery, Vicarage Lane, Walton on Naze, Essex. CO14 8PA. (01255-674373), or email m.durrant@nhs.net

Closing Date 31st August 2012

Willow Bank Surgery

Are you looking for a GP practice with INSTANT Equitable decision opportunities, equitable work load and are remunerated fairly?

Are you looking for a friendly, forward-thinking practice with experienced and approachable GPs?
We are currently 4 full-time and 1 half time Salaried GPs team looking for 1 full time or 2 part time salaried GPs for our progressive practice.

- Almost 7,500 patients and continuing to grow
- Teaching Keele Medical Students (with the view to teaching GP registrar in the future)
- Local CCG involvement
- Good QOF and QIF achievement
- Weekly clinical meetings and team meetings
- 2 Sites – Longton & Meir
  (Meir's site opening times are 8.00am to 8.00pm plus Saturday mornings)
- EMIS PCS but will be upgrading to EMIS WEB in the near future.
  - *In house minor surgery clinic*
  - *Shared Care Substance Misuse service at both sites*
  - *In surgery Alcohol Intervention clinic*
  - *Leaders in community hepatitis C screening project in Stoke-on-Trent*
- Excellent nursing team with Nurse Practitioners and Practice Nurses currently training on Warwick University diabetes course.
- We also have a Nurse Practitioner who works primarily in the Community providing care and visits for the housebound and those in nursing and residential homes.

Salary is £75,000 for a full-time GP with experience but with the opportunity to earn more for taking on additional responsibilities or doing additional clinical work. GMC and MDU fees paid for.

Full time (7 sessions face-to-face consultations with administration and CPD / PDP sessions)

Hours of work open for negotiation. Teaching or course fees open for negotiation

Your enthusiasm and ideas matter to us. If you are curious about this then why not speak to Dr Paul Roberts (03001231467) or Dr Richard Aw (03001235002)

If you're interested enough to want to apply then please email us for further details at recruit@willowbankcic.org

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Salaried GPs in Luton

6 sessions at Moakes Medical Centre

Join our friendly, high achieving and growing teaching practice with over 2000 patients. Specialist interests are welcome. Joint clinical meetings. Contact Practice Manager, Lorraine Swain on 01582 569030 or email lorraine.swain@nhs.net for more details.

5-7 Sessions at Whipperley Medical Centre & St Mary's Rehabilitation

We require a skilled GP to carry out daily ward rounds on our small rehabilitation ward at St Mary's Nursing Home. This is an exciting post designed to ensure patients recover quickly from their hospital admission and are discharged home with optimised medical care. Contact Practice Manager, Rubee Ahmed on 01582 744874 or rubee.ahmed@nhs.net for more details.

Competitive Salary + MDU & GMC & NHS pension + extra for GP Trainers

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Burntwood, SOUTH STAFFORDSHIRE

3 sessions at Burntwood Health &Well-Being Centre

We have a traditional registered list of nearly 3000 but also see some unregistered patients from 8am-8pm daily. Sessions can be split to complement another post or a portfolio GP. Enhanced pay for evening and weekend sessions. Contact Practice Manager Vicky Arbenz on 01543 687460 or email victoria.arbenz@nhs.net

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Stoke-on-Trent: GP or GP Trainer

Packmoor Medical Centre
6 sessions

We require an enthusiastic and motivated GP with an interest in teaching or a GP Trainer to join our dynamic team at Packmoor

- Modern LIFT building
- 3400 list
- Previous Training practice
- HCA, Nurse and Nurse Practitioner
- Specialist interests encouraged
- Support for Trainers Course provided
- Local joint clinical meetings

Please call our Practice Manager, Bev Heath on 01782 794606 or email bev.heath@stoke.nhs.uk

Middleport Medical Centre
6 sessions

Our new practice has grown to nearly 2000 patients since we opened in 2010 in a beautiful new LIFT building.
We also provide weekly ward rounds at two nursing homes. You would visit Scotia Heights with support from the Consultant in Rehabilitation Medicine.

- New LIFT building with PCT services
- Specialist interests encouraged
- Support for Trainers Course provided
- Local joint clinical meetings

Please call our Practice Manager, Gill Johnson on 0300 123 1131 or email gill.johnson@northstaffs.nhs.uk

Enhanced salary + MDU +GMC+NHS Pension included + Trainers Grant

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Newcastle-under-Lyme, North Staffs

6 or 7 sessions at Lyme Valley Practice: GP or GP Trainer

Our traditional training practice with a list size of over 6000 requires a dynamic GP to join our friendly team. Specialist, CCG and training interests are welcome. We have a strong nursing and HCA team and an in-house travel clinic. Very high QOF achievers. Please call Pat Bailes, Practice Manager on 01782 713370 or email pat.bailes@northstaffs.nhs.uk for more details.

6 sessions at Midway Medical & Walk In Centre

We have successfully grown from zero to nearly 3000 list size and requires GP(s) for certain sessions in the week which may all be taken or could be split to complement another job. We offer some appointments for unregistered patients who usually telephone to book these. We are open 8am-8pm every day and manage to combine a traditional practice ethos with a modern extended opening service. Contact Practice Manager Sue Manifold on 01782 663758 or email susan.manifold@northstaffs.nhs.uk

All salaried GP posts offer MDU, GMC and NHS Pension included. GP Trainers will receive an additional supplement based on the Trainers Grant.

HMP The Mount, West Herts

We are looking for a GP for two sessions on a Monday to join the large multi-professional team at the prison in Bovingdon. RCGP Part 1 Substance Misuse welcome or training offered.
Contact Diane Taylor on 0208 421 7512 or email diane.taylor7@nhs.net

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Ladbroke Grove, London

6 weekday sessions +/- Saturday morning option
Salaried GP or GP Trainer

Exmoor Surgery needs an enthusiastic and motivated GP to help us deliver the highest quality of care to our list size of 3200 patients. Specialist interests are encouraged or opportunities for CCG roles. This would suit a GP trainer or a GP interested in teaching. Based in St Charles Hospital where there is an urgent care centre. Please contact Fiona Magee by email on fiona@nhsolutions.co.uk for a chat or visit.

Competitive Salary + MDU & GMC & NHS pension + extra for GP Trainers

DOCTORS/GPS REQUIRED

WALTON-ON-THAMES
Fort House Surgery are seeking two GPs

Salaried GP

Required for 5 sessions a week, plus extended hours starting October 2012

Friendly well established GMS practice with 9950 patients, three Partners and three salaried GP's.

- 5/6 sessions
- EMIS LV clinical system but migrating to EMIS Web shortly
- Training Practice for FY2
- High QOF achievers
- Wide range of Enhanced Services
- Excellent nursing and admin support teams
- Salary and hours on application

Maternity Cover Locum

- required from November 2012
- 5 sessions plus extended hours

Applications with CV by e-mail to
Mrs Debbie Woods, Practice Manager debbiewoods@nhs.net
For further information please contact Debbie on 01932 214985

Closing date 24th August 2012

The Consulting Rooms, Watford
www.theconsultingroomssouthoxhey.co.uk

FULL TIME PARTNER (nine sessions)

We are seeking a committed and enthusiastic full time GP to join our progressive practice.

- Nine sessions a week over five days
- 7350 patients
- Recently refurbished partner owned surgery
- Friendly management and support team
- High QOF achievers
- Beautiful area and excellent schools
- We aim for a good work/life balance
- London 20 minutes away

For an informal visit or to apply please contact Paul Drinkwater
Practice manager on 02084212140 or email paul.drinkwater@nhs.net

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SALARIED GP
With possible partnership opportunity
Norheads Lane Surgery,
14 a Norheads Lane, Biggin Hill, Kent, TN16 3XS

- **4-5 sessions /flexible from October 2012**
- **Friendly, efficient Practice**
- **Excellent nursing and admin support**
- **High QOF achievement**
- **Just moved to EMIS web [ample opportunity available for training]**

Please send CV by e-mail to Lisa.dilling@nhs.net
For further information please contact:
Lisa Dilling, Practice Manager, 01959 574488

REPLACEMENT PARTNER

A full time Partner required for busy GP surgery from October 2012. A unique opportunity for a new Doctor to own premises after parity and rapidly become senior in the practice and share in the future of Oakmeadow Surgery.

Apply in writing with CV to Dr R A Leach & Partners, 87 Tatlow Road, Glenfield, Leicester LE3 8NF.

Doctors required UK-Wide for insurance medicals.

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...is growing. Join our panel of doctors who provide Insurance Medicals.

- **Adhoc or sessional work** ● **Training provided**
- **Excellent remuneration** ● **Full administrative support**

This is a unique opportunity to be part of our team. If you are interested please send a copy of your CV to:

info@dclife.co.uk   Tel: 0845 140 3000

We are looking for a salaried GP
to work 4-5 sessions per week in a
busy surgery in Southall.

Wages will be negotiable according to experience.

Please email CV to salujaballyb@hotmail.com

Bradford, West Yorkshire
WANTED: 2 salaried – 6 sessions GP's

Based in a leafy BD12 suburb close to the M62 & M606, we are a friendly practice looking to recruit 2 enthusiastic doctors to join our team.
We are looking for:

One permanent member of staff
Working Monday, Wednesday, Thursday

One maternity cover from November 2012
Working Tuesday, Thursday, Friday.

Please apply in writing with CV to:
Maureen Rowland, Operations Manager, Low Moor Medical Practice,
29 The Plantations, Bradford, BD12 0TH

Closing date: 24th August 2012
Interviews: Thursday 6th September 2012

For an information pack please call Maureen Rowland on
01274 697602
Or check out the web site for more information on www.lowmoormp.co.uk

No agency calls, thank you

GP's required
for part time medico-legal work.

Leading medico-legal reporting business require GP's in Wales and West / South West England for part time sessional work.

We pay a fixed fee per session and take care of all the administration.

All our GP partners have to do is to carry out medical examinations / interviews in accordance with our procedures at one of our designated locations local to you.

Interested GP's should send their cv stating the area(s) you are interested in covering to Derek Stephens at info@promedicalreports.co.uk

---

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Please email your CV to: peter@harleystreetgroup.co.uk
or call on 020 7224 0030

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Chelmsford, Manchester, Peterborough and Middlesex

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EDITOR'S CHOICE

My fight to get sickness benefits

When Dr Anne Dyson was diagnosed with cancer, she experienced the Byzantine bureaucracy of the benefits system first hand…

I have worked as a GP principal in the NHS since 1986. I have also recently been diagnosed with breast cancer, and have undergone a mastectomy and sentinel node biopsy.

I now need post-operative chemotherapy, herceptin and radiotherapy to give myself the best possible chance of a long-term cure. This means I have been unable to work since 9 July, and will probably be off for at least the next six months through illness.

Everyone, myself included, has encountered patients who have talked about the difficulties they have when trying to claim sickness benefit, but this was my first time experiencing the system.

I have always paid my National Insurance (NI) contributions. I wanted to claim employment and support allowance, a non means-tested benefit based on the amount of NI contributions that have been paid to date.

Dr Anne Dyson: shocked by benefits bureaucracy

So I went to the Department for Work and Pensions website, thinking that I would be able to complete an online claim. This is not possible. Instead, I was expected to ring a 0845 number, be on hold for 30 minutes and then complete a 40-minute interview. And that was just the beginning…

Dr Anne Dyson is a GP in South Woodham Ferrers, Essex

MORE ONLINE
To read more, visit pulsetoday.co.uk/opinion

VIDEO

Professor Amanda Howe, RCGP honorary secretary, explains why she believes GP appointments lasting 30 minutes should be normal for patients with multiple complex conditions, in the latest of our interview series.

▶ pulsetoday.co.uk/videos

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WHAT YOU'VE BEEN SAYING

▶ pulsetoday.co.uk/forum

The end of the beginning or the beginning of the end?

… on PCTs losing operational responsibility in just seven weeks

Why is the taxpayer still funding placebos?

… on the MHRA keeping its scheme to approve indicators for the marketing of homeopathic remedies

Half an hour of attention might be worth more than any tablet

… on Dr Margaret McCartney's recent column in praise of the lost art of standing still

BLOGS

Introducing *Weekly Practice*

Pulse's surreal blogger Through the K Hole introduces a brand-new magazine for general practice. In the sensational first issue, look out for incredible true stories such as 'I kept my practice manager in a kennel' plus a free slogan T-shirt that says 'You've got 10 minutes, moron'.

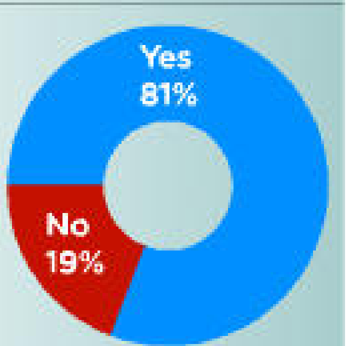
THROUGH THE K HOLE
pulsetoday.co.uk/khole

THIS WEEK'S POLL

Is it time to break up the UK-wide GP contract?

Vote at ▶ pulsetoday.co.uk/polls

Last week's poll
Is the QOF changed too frequently?



Turn inside for this week's shot of the world according to Copperfield
▶ page 12