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BriefingMedia

At the heart of general practice since 1960

BMA battles to win pension concessions

Rival unions take hard line on changes to contribution hikes as GP leaders return to talks

EXCLUSIVE

By Sofia Lind

The BMA is facing an uphill battle in fresh talks over the Government's pension reforms, after rival health unions said they were unlikely to back any move to apply the proposed hike in contributions more equally across the NHS.

The Department of Health reopened talks on its 'final offer' last month after the BMA suspended industrial action and agreed to inter-union talks on contribution increases next month. It will also begin a review into the safety of NHS workers retiring at 68 next month.

But BMA leaders hoping to win concessions on contributions have been met with intransigence from other unions, while rank-and-file members expressed anger at the return to talks.

The DH has offered to reconsider some parts of the deal it tabled in March, which spared NHS workers earning less than £26,000 at the expense of higher earners. But it said it would only consider an alternative distribution of contribution rises within the same overall cost envelope, and with the agreement of all unions.

Unite's national officer for health Fiona Farmer told Pulse the unions were unlikely to agree an alternative: 'We have just been put in an impossible position here. If the Government wants to make this change, then the Government should decide who makes what contribution. If we try tinkering around with it then it shifts the blame onto the unions.'

Jon Restell, chief executive of the managers' union Managers in Practice, said he would support 'flatter tiering of contributions' among higher-paid NHS workers, but warned: 'Managers in Practice is committed to protecting low-paid NHS workers from the brunt of the increased pension contributions.'

The BMA will join separate talks next month as part of the Government's Working Longer Review, which will look at whether NHS workers should be working until 68, if they can move into back-office roles and how the DH can make it easier to purchase earlier retirement.

Dr David Bailey, deputy chair of the BMA pensions committee, said: 'We know age is a significant risk factor with GMC fitness-to-practise hearings. While there will be GPs who are capable of working longer, others will not. There aren't really any back-office tasks suitable for GPs, so I suspect they will be forced to work longer, with any safety risks to be locally managed by the NHS Commissioning Board.'

Some grassroots members reacted furiously to the BMA's decision to suspend industrial action, with a number saying they had quit the association in protest.

The BMA refused to disclose how many had resigned, but new chair Dr Mark Porter, writing in Pulse this week and understood to be personally heading up the pension talks, said his 'postbag has been full of emails and letters from GPs', both for and against the decision.

Dr Andrew Thomson, a GP in Dundee, described the BMA's decision as 'very disappointing'.

Although he had not personally resigned, he said: 'I do not doubt there will be some members who will feel the need to walk away. It is important doctors send a message back to the BMA that it is not a good move and makes us look weak at a time when we were looking strong'.

But Dr Mark Sanford-Wood, chair of Devon LMC, said most of his members were 'happy enough' with the decision: 'I think the BMA recognises it isn't going to get all that it wants on pensions'.

@sofialind_Pulse

Dr David Bailey: 'While there will be GPs capable of working longer, others will not'

What remains on the table

Contribution rises

Possible redistribution of the contribution hikes that would see GPs pay 14.5% by 2014

Back-office roles

Review of whether GPs and other NHS workers nearing 68 could be moved into 'back-office' roles

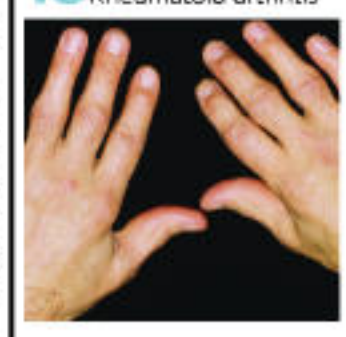
Retirement age

Discussions over how NHS workers could buy early retirement through additional contributions

▶ Dr Mark Porter: 'Now is the time to talk', page 16

▶ Letters: BMA blew it on pensions, page 17

▶ Editor's blog: This is what defeat looks like pulsetoday.co.uk/pensions



The week in general practice

INSIDE

Professor Greg Rubin

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GPs have reported inaccurate outcomes data on a performance dashboard set up to scrutinise thousands of practices
▶ pulsetoday.co.uk/practicenews

Download of the week
Read the latest recommendations from NICE for changes to the QOF in 2013/14
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The Big Interview
Watch RCGP cancer lead Professor Greg Rubin in the second in our new weekly series
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PULSENEWS

GPs struggle on QP prescribing indicators

Quarter of practices drop points on indicators worth £2,000 as GPC warns of growing 'target fatigue'

EXCLUSIVE
By Madlen Davies

GPs have missed out on practice funding worth up to £2,000 under the new 'quality and productivity' domain of the QOF, with more than a quarter of practices failing to gain the maximum points available under prescribing indicators introduced last year.

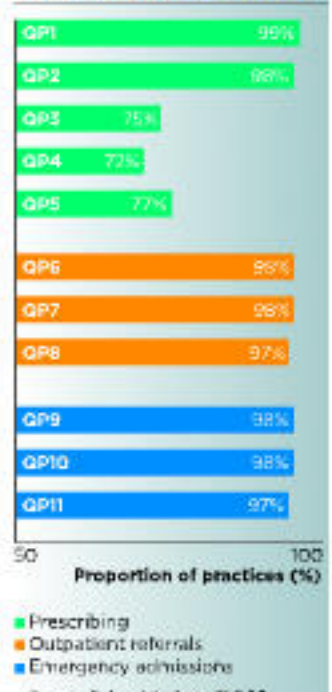
Figures obtained by Pulse from 31 primary care organisations reveal just 72% of practices achieved maximum points against one of the prescribing indicators.

The data, released under the Freedom of Information Act, shows GPs performed well on reviewing and implementing plans for reducing outpatient referrals and emergency admissions, with 97% of practices achieving maximum points for the full set of indicators.

The initial performance of GPs on reviewing their prescribing and agreeing a plan of action with NHS managers was also impressive, with 98% of practices achieving maximum points.

But performance fell when it came to implementing the plans, with only 75%, 72% and 77% achieving maximum points for the three areas agreed.

Who earned maximum points?



GPC shelves plans

The GPC has dropped plans to review the Carr-Hill formula for GP practice funding as part of next year's contract talks, and warned a 'period of stability' is essential as practices struggle to balance budgets.

The Carr-Hill formula, named after the professor who devised it and introduced as part of the 2004 contract, is applied to practice populations to calculate the global sum and reflects a range of factors such as patient demographics, mortality and rurality.

As part of the coalition agreement, the Government pledged to look at increasing funding for practices in the most deprived areas via a so-called 'patient premium'.

The last thing we need is changes to the formula now
Dr Peter Holden

Statin prescribing was one of the areas GPs struggled with

Combined, the three indicators are worth £1,958 for the average practice.

Figures from NHS Trafford showed no practices gained maximum QOF points for looking at their prescribing of ezetimibe and statins, and only a quarter did so for PPIs.

In NHS Somerset, only 37% of practices achieved maximum QOF points for improving their

EDITORIAL ▶

***GP are weary of an ever-changing QOF* 13**

first area of prescribing, with areas such as statin and alendronate prescribing proving particularly difficult.

Dr Barry Moyse, deputy medical director of Somerset LMC, said practices had struggled to convince patients to switch to cheaper alternatives: '[Patients] try them for one or two prescriptions and then come in and change. This causes more waste, which isn't factored in. We should respect patient choice and shouldn't see them as prescribing units.'

GPC member Dr Helena McKeown said her practice in Salisbury struggled as it tried to make gains following years of prescribing efficiency savings: 'There's a real worry it's undermining patient-doctor trust.'

The 11 'quality and productivity' indicators were brought in under the 2011/12 GMS contract, by retiring indicators and reassigning nearly 100 points.

Dr Peter Holden, GPC negotiator, said GPs faced 'target fatigue': 'We were aware of these problems, but the Government wanted them in.

'We agreed to them because they were the least worst options.'

A DH spokesperson said the figures represented only a 'snapshot of local achievement', and full data would be published in October.

@madliendavies

Call for child CPD quota

By Jaimie Kaffash

GPs should be forced to gain 'appropriately validated' points for CPD that reflects the proportion of the time they spend with children and young people, say Department of Health advisers.

The recommendations in a Government-commissioned report are aimed at improving health outcomes in children and young people, but have been dismissed as inappropriate 'micromanaging' by the GPC.

The report, published last month by the Children and Young People's Health Outcomes Forum, found that 'too many health outcomes for children and young people are poor' and laid out a series of recommendations to improve them.

These included the royal colleges working together to agree skills and competencies in child health, all GP practices appointing a medical and nursing lead for children and young people and GPs gaining appropriate CPD.

The report said: 'All GPs who care for children and young people should have appropriately validated CPD reflecting the proportion of time spent with children and young people.'

Forum joint chair Christine Lenehan, director at the Council for Disabled Children, said: 'This report needs to form the basis of a wider children and young people's health outcomes strategy, which needs to be owned by all organisations in the health system and beyond who have a responsibility for improving the health and wellbeing for this group.'

But GP leaders attacked the proposals as too prescriptive.

Dr Richard Vautrey, GPC deputy chair, said it was important GPs maintained CPD across a range of clinical areas: 'It is inappropriate to be specific about one aspect of their work – you could start to be specific about all aspects and micromanage CPD.'

RCGP chair Dr Clare Gerada said the proposals went too far, and the important thing was not the amount of CPD, but the learning GPs took from it: 'We advise CPD should span a variety of areas and should reflect the needs of the patient population as well as the individual GP and the practice.'

A spokesperson for the DH said: 'Over the next few months, we will be working with organisations within the wider health and care system to agree a joint response to the forum's report and will also be publishing the children's and young people's strategy.'

feedback@pulsetoday.co.uk

GP opens the Games

A GP involved in the Olympics opening ceremony has spoken of her pride in representing the NHS to rest of the world.

Dr Elizabeth Holder, a GP and A&E specialist in Watford, London, was one of hundreds of doctors, nurses and children who performed a dance routine in tribute to the NHS.

She said preparing for the show was 'demanding', but she was proud at representing its values in the ceremony.

'After all, many countries do not have free healthcare,' she said.

to review Carr-Hill

GPC chair Dr Laurence Buckman told GPs last year that negotiators had 'agreed in principle to explore how the Carr-Hill formula might be adjusted from 2013/14 onwards to give greater weighting to deprivation factors'.

But speaking to Pulse this week, GPC negotiator Dr Peter Holden said: 'We did a review in 2007/08 and the people who complain about the formula are the ones hard done by – like me, in a deprived area of Derbyshire.

'But when you change the formula, you create different winners and losers. What practices need is a period of stability. The last thing we need is changes to the formula now.'

A Department of Health spokesperson said it would be 'inappropriate' to comment on contract talks: 'We have made clear that the allocation of NHS resources should be based on a range of factors, including deprivation, to ensure a fair allocation of funding.'

Depression screens of 'little benefit'

GPs have to screen 1,000 patients with chronic disease under QOF to identify one with depression

By David Swan

GPs have to screen nearly 1,000 patients with cardiovascular disease or diabetes to identify one case of depression, according to a large study that raises fresh questions over the utility of the current depression indicators in the QOF.

The UK study compared the impact of the QOF depression screening questions with usual care by GPs, and found only a 'small impact' on the number of patients identified with depression.

The research, published in the journal *Psychological Medicine*, came in the same week NICE recommended all three depression indicators be removed from the QOF.

Last summer, NICE recommended two depression indicators for assessing severity be removed following GP concerns that the questionnaires the indicators are based on were ineffective, but ultimately they were retained after protests from mental health groups.

Last week, the institute again recommended they be removed, along with the indicator on screening for depression in patients with heart disease and diabetes. The institute said they should be replaced by two new indicators requiring a review 10 to 35 days after diagnosis and a biopsychosocial assessment in all patients newly diagnosed with depression.

The research raises questions over the QOF's effectiveness

Scottish researchers looked at a database of 1.3 million patients registered with general practices in Scotland and found 4% of patients with cardiovascular disease or diabetes were diagnosed with depression over 12 months.

When they looked at the additional new diagnoses of depression over the 12 months from QOF screening, they found a small but statistically significant increase of 69 cases with screening – 8% of all new diagnoses in patients with CVD and diabetes. A similarly small relationship was seen with the number of newly initiated antidepressant treatments – 98 patients (3% of all patients with CVD and diabetes started an antidepressant that year).

The figures equated to a number needed to screen for one new diagnosis of depression of 976, and 687 for one new antidepressant treatment.

Study leader Dr Chris Burton, senior research fellow at the University of Edinburgh and a GP in Sanquhar, Scotland, said the study showed QOF screening for depression added very little benefit to those picked up during standard GP care.

He said: 'Around 4% of the adults with chronic heart disease or diabetes were diagnosed with depression or started an SSRI antidepressant during the year, but in over 90% of cases this could not be attributed to routine screening. Our findings should help NICE in deciding on the future of the DEP1 indicator.'

Dr Liz England, a GPSI in mental health and RCGP clinical commissioning champion in Birmingham, said the findings added to a growing body of evidence questioning whether a different approach was needed in the QOF: 'We should perhaps be focusing our efforts on what we currently have and upskilling our GPs and practice nurses in managing depression.'

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Key recommendations from NICE for the 2013/14 QOF

In

- Reviews within 10 to 35 days of the date of diagnosis in patients with depression
- Biopsychosocial assessments in patients newly diagnosed with depression
- Face-to-face annual reviews in patients with rheumatoid arthritis
- Asking about erectile dysfunction in men with diabetes

Out

- Case finding for depression in patients with CHD/diabetes (DEP1)
- Depression severity assessments at the time of diagnosis and two to 12 weeks later (DEP6/7)
- ß-blocker treatment in patients with CHD (CHD10)
- Record of blood pressure in CKD patients (CKD2)
- BMI and eGFR checks in patients with diabetes (DM02 and DM22)

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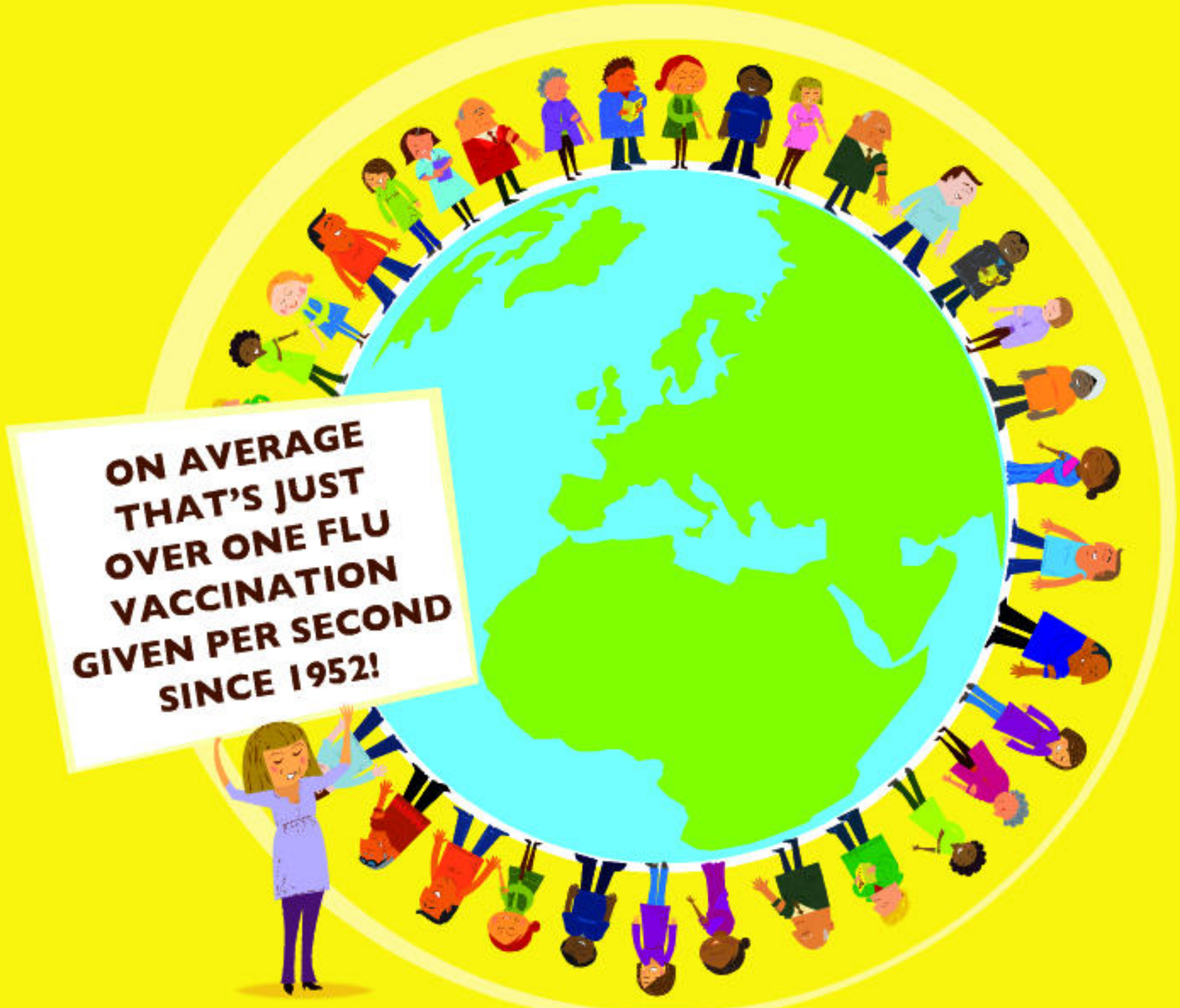

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For a complete list of undesirable effects please refer to the Summary of Product Characteristics. **Package quantities and basic NHS cost:** Single dose prefilled syringes in single packs, basic NHS cost £6.59; packs of 10 single dose prefilled syringes, 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

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UK15944 c 07/12

NHS Commissioning Board will weight indicators according to case mix

COF

NICE sets CCG quality premium targets

By Madlen Davies

NICE has revealed the final list of targets the quality premium for GP practices will be tied to, with indicators covering areas such as mortality for cancer and respiratory disease and patient experience of GP out-of-hours services.

The publication of the Commissioning Outcomes Framework (COF) comes as the NHS Commissioning Board revealed it was looking at ways of adjusting scores so CCGs with more deprived populations do not lose out.

The list of 44 indicators (see box, right) includes the number of people with dementia taking antipsychotic medication, emergency admissions for conditions that do not normally require hospital admission and the proportion of patients 'feeling supported to manage their own condition'.

The COF has been developed by the NHS Commissioning Board and NICE, and forms the basis for how the performance of CCGs will be assessed. This performance will help determine the quality premium payments eventually made to GP practices.

GPC chair Dr Laurence Buckman said the GPC was against any quality premium in principle, but would work with NICE's suggestions.

He said: 'Some of the indicators are more problematic than others. Many are population-dependent for things that GPs or commissioners can't influence.

'But we will work with the Government to make these indicators as good as they can be under the understanding that the basis for which they are col-

Dr Louise Irvine: new indicators should be piloted first

What are the indicators?

- Under-75 mortality rate from cancer, cardiovascular and respiratory disease
- Patient experience of GP out-of-hours services
- Emergency admissions for alcohol-related liver disease
- Dementia patients prescribed antipsychotics
- People with diabetes who have received nine care processes

MORE ONLINE
Read the full list of indicators
pulsetoday.co.uk/downloads

ANALYSIS

Finally, GPs will be measured on what matters

For years, clinicians have asked to be measured on things that mattered to them and their patients. The Commissioning Outcomes Framework starts us on that journey.

It is not perfect, but the direction is correct. It is better to have our system reward patient independence three months after a stroke rather than the time they spend in hospital.

However, there are so many variables that influence that outcome – such as severity of stroke, presence of comorbidities and home circumstances – that it is difficult to come up with the perfect measure.

Some of these outcomes will be challenging. Influencing COPD mortality in under-75 year olds will take some time to achieve, but it makes sense that we work towards that outcome.

Improving satisfaction with GP out-of-hours services appears to be out of the individual clinician's immediate remit. But if patient care is not satisfactory, as the new commissioners we need to get CCGs to change things.

A lot of the outcomes can only be achieved through integrated care. Influencing admissions for alcohol-related disease will be achieved only in co-operation with local authorities, public health and the voluntary sector.

Individual GPs will see the measurements used in health management becoming more closely aligned with their day-to-day experiences. This marks a huge change, from being a reactive service into a proactive NHS.

Dr Donal Hynes is co-vice chair of the NHS Alliance and a GP in Bridgwater, Somerset

CCG BOARDS

Rethink over consultants on boards

CCGs may be allowed to recruit local consultants to their boards, after the head of the NHS Commissioning Board signalled he was 'very open' to relaxing the stipulation that they must come from outside the area.

Regulations laid before Parliament in June stated that every CCG board must have at least one consultant, but that they cannot be anyone who 'provides any relevant service to a person for whom the CCG has responsibility'.

The stipulation was designed to prevent conflicts of interest, but has created obstacles for CCGs in sourcing suitable candidates to sit on their boards, with the GPC arguing the restriction 'did not make logical sense'.

A Pulse investigation last month revealed that only 36 out of 100 CCGs surveyed had reserved a position for a secondary care doctor – with only seven of these positions currently filled. It means the vast majority of CCGs face a scramble to appoint a consultant in the next few months, with the authorisation process set to begin in September.

But Sir David Nicholson, chief executive of the NHS Commissioning Board, told Pulse he would consider relaxing the restrictions: 'What we need to do is go through this round of recruitment and then take stock. I'm very open about thinking about what the alternatives might be if we simply can't get the quality.

'I don't think CCGs should appoint people just for the sake of it – we should get the best people we can. If that means we might have to look in local communities in the future, then I'm open to that discussion.'

A spokesperson from the NHS Commissioning Board said the presence of a consultant was legally required on boards, but CCGs could be authorised with conditions: 'A CCG cannot be fully authorised until it meets this and other requirements concerning governing body composition. But if at the point of authorisation a CCG does not have a suitable candidate for this role, it could be authorised with conditions. These conditions would then be discharged once the CCG was fully compliant.'

He added that if CCGs were finding it too difficult to appoint a secondary care consultant from outside the CCG's boundaries, the board would be open to a discussion about alternatives.

Dr Chaand Nagpaul, a GPC negotiator, said: 'I'm glad common sense is prevailing belatedly. This was always an unusual and logistically difficult requirement.'

MORE ONLINE
Watch the full interview with Sir David Nicholson
pulsetoday.co.uk/videos

lected – the link to financial targets – is wrong.'

A spokesperson for the NHS Commissioning Board said: 'The COF is still under development, but it is recognised that a robust approach to case-mix adjustment will be needed to weight achievement in accordance with the scale of the challenge.

'CCGs will be held to account not only for the outcomes they achieve for patients through the COF, but also for other aspects of performance, such as financial management.'

Dr Louise Irvine, a BMA Council member and a GP in Lewisham, south-east London, said she thought the indicators should be piloted in order not to discriminate against GPs in poorer parts of the country.

She said: 'Even with case mix, there is that usual dread that there won't be a proper understanding of GPs in deprived areas. We've got people living in overcrowded housing, in poverty, people that are moving around all the time so it's hard to follow up on their care.'

'A lot of what leads up to these mortality risks are factors that start in childhood. It's really hard for any interventions in later life to change them. That doesn't mean we don't want to give great care.'

@madlendavies

NHS 111

Only 4% ask to delay 111

Just 4% of CCGs have applied for a delay in their rollout of NHS 111, despite concerns over the safety of the new urgent care service.

Eight CCGs out of the 212 across the country have formally applied to their SHA for an extension to the April 2013 deadline.

An expert clinical panel at the Department of Health will now decide if a delay is needed.

The DH agreed in June to allow CCGs to apply for an extension to the April 2013 deadline by 27 July, following pressure from the GPC.

GP leaders said they were worried about the safety and reliability of the new urgent care service.

Sarah McIlwaine, senior programme manager for urgent care at NHS North East London and the City, said CCGs in her area had applied for a delay to allow the 'safe implementation' of the new service.

MORE ONLINE
See the full list of CCGs asking for a delay in NHS 111
pulsetoday.co.uk/commissioning-news

WHOOPING COUGH

Vaccinate earlier for whooping cough

By Madlen Davies

GPs have been told to advise parents to consider immunising their baby earlier against whooping cough to help stem a sharp rise in cases.

The Joint Committee on Vaccination and Immunisation (JCVI) has asked the Department of Health to raise the issue with the RCGP and the BMA to ensure all children receive their first pertussis immunisation at eight weeks of age.

It also said GPs could advise parents not able to bring their child to an appointment at eight weeks that they can have the vaccination from six weeks of age instead.

The move comes after the Health Protection Agency (HPA) announced that cases of whooping cough have continued to rise, with 2,466 cases reported this year so far – more than double the number of cases over the same period in 2011.

The JCVI has asked the HPA to assess the cost-effectiveness of a range of new pertussis immunisation schemes, including vaccinating adolescents, pregnant women and neonates.

The JCVI also recommended GP IT systems that cap the number of children attending vaccination clinics should be replaced.

Draft minutes from the June meeting of the JCVI said: 'It was noted that delays in some infant immunisation clinics may be caused by the way GP IT systems

Vaccinating children earlier could cut rising disease rates

schedule immunisation clinics, as they may cap the number of children attending any one clinic.

'The committee advised that the importance of adherence to the routine immunisation schedule should be reinforced and agreed the DH should have discussions with the BMA and RCGP to clear waiting lists and advocate timely immunisation.'

Dr George Kassianos, RCGP lead on immunisation and a GP in Bracknell, Berkshire, said that GPs should begin giving booster vaccines to adolescents while they wait for the results of the HPA's modelling strategies.

He said: 'The situation is worsening year on year. I'm seeing whooping cough every week in my practice in people of all ages, including in the elderly. We're impotent because neither the vaccine nor the disease itself can give lifelong immunity.'

He added: 'We must wait for the results of the HPA's studies, but I have always asked for a booster vaccination at the school leaving age of 16 years. This is done in many countries already.

'We have the vaccine – Repevax – already, and it's not expensive. Why don't we start now?'

@madlendavies

INFLUENZA

Flu programme extended

The Department of Health has announced a major extension of the flu vaccination programme to include all nine million children aged two years and over, and not just those in at-risk groups.

The preferred delivery method will be a nasal spray vaccine in a programme designed to prevent 11,000 hospitalisations and around 2,000 deaths a year as a result of flu.

The DH said it was still finalising how the £100m programme would be delivered, including whether it would be led by GPs or school nurses.

The rollout could begin as early as 2014.

The Joint Committee on Vaccination and Immunisation said in May though it would pose significant implementation challenges, a schools-based programme in the over-fives would be 'highly cost-effective'.

But the DH has decided a broader programme in all children aged between two and 17 years is warranted, making the UK the first country in the world to immunise all children against flu.

Even with moderate vaccination uptake, the DH estimates there could be a 40% drop in the number of people affected by flu.

HPV

Gay men could receive HPV vaccine from GPs

GPs could be tasked with administering HPV vaccines to gay men under a possible expansion of the current female-only vaccination strategy.

Minutes published last month reveal the Joint Committee on Immunisation and Vaccination has recommended a review of the current immunisation programme to see if gay men should also be vaccinated.

The draft minutes of the June meeting said: 'Given that there may be a higher burden of HPV-related disease in men who have sex with men and that they are likely to get less direct protection from the vaccination of girls, vaccination strategies to protect [these individuals] should be evaluated.'

The committee has asked the Health Protection Agency to model the impact and cost-effectiveness of the vaccine being administered to gay men by GPs or at genitourinary medicine clinics.

Dr Richard Ma, a GP in Islington, north London, and member of the RCGP's Sex, Drugs and HIV task group, said extending the programme would be 'good news'.

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

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Referral rules 'block Ca diagnosis'

RCGP cancer lead warns inflexible NICE guidelines don't allow GPs to use their 'sixth sense' when referring

By Sofia Lind

GPs are being forced to 'manipulate' the two-week cancer pathway by inflexible NICE referral criteria that make no allowances for their 'sixth sense', the RCGP's lead on cancer has warned.

Professor Greg Rubin, the clinical lead on cancer for both the RCGP and Cancer Research UK, claimed two-week wait GP referrals were being wrongly categorised as inappropriate by NICE guidance that focuses on red flags, even though only half of patients with cancer present with such symptoms.

In an exclusive interview with Pulse – the second in our Big Interview series with key figures in general practice – he said it was often a GP's intuition that dictated whether a cancer was detected early, citing a study from 2011 that found 8% of patients referred 'inappropriately' by GPs were found to have cancer.

Professor Rubin revealed that new figures to be published next month in the *British Journal of General Practice* will show just 11% of referrals under the two-week wait pathway go on to have a diagnosis confirmed.

Professor Greg Rubin: referrals should allow for GPs' intuition

He said the data showed that NICE's referral criteria needed to be revised and GPs needed much better access to diagnostic services before making a referral.

His comments come after cancer charities said a threefold variation in cancer referral rates through the two-week wait pathway revealed last week was 'very worrying'.

But Professor Rubin said absolute numbers were not as important as diagnosis rates and that some practices referred fewer patients but had a higher detection rate.

He admitted UK rates of early diagnosis were 'less good' than other comparable countries, but said he believed this was partly because current NICE guidance was a barrier to referrals.

Professor Rubin said: '[NICE guidance] probably is a bit of a barrier. GPs also have a sixth sense when something could be wrong. Sometimes they squeeze patients into the two-week wait pathway and sometimes specialists complain about that.

'The fact of the matter is that while 11% of all two-week wait referral patients have cancer, about 18% of those that are appropriately referred have cancer – but interestingly, 7.7% of those inappropriately referred also have cancer. So GPs sometimes have to manipulate the two-week wait system to get patients seen who they have got a pretty good idea might have cancer.'

He added: 'The guidance is okay as it stands, but it really only addresses alarm symptoms, and 50% of patients don't have alarm symptoms. Something better is needed.'

He also said that changing models of care and giving GPs access to diagnostic tests should be a priority: 'NICE is in the process of reviewing guidance, but we also need to think about models of care and the access for GPs to diagnostic tests.'

He said future options could include diagnostic centres where patients can be tested more easily than going through a two-week wait referral pathway.

He also backed the introduction of new risk assessment tools for cancer – such as QCancer and RATS – into GP practices.

Professor Rubin said: 'Risk assessment tools are almost certainly one of the ways forward. Which one is going to be best is currently uncertain – it is probably going to be a combination of all of them.'

A spokesperson for NICE said its guideline for suspected cancer was in the process of being updated so patients could receive a timely referral, and was likely to be published in 2014.

@sofialind_Pulse

The Big Interview

Watch interviews with Professors Greg Rubin and Helen Lester as part of our weekly series with the biggest names in general practice

pulsetoday.co.uk/the-big-interview

Rescue inhaler goes OTC

By Madlen Davies

Salbutamol inhalers will be sold over the counter in pharmacies, after a large supermarket chain said it would supply them to patients without a prescription for the first time.

Pharmacists at 218 Asda stores have started dispensing the inhalers to customers aged 16 and over, with two inhalers available every eight weeks at a cost of £7.

Patients do not need a GP prescription but will have to fill out a questionnaire to receive the medicine, with the scheme being monitored by Asda pharmacists and online doctor service DrThorn. Salbutamol is still classified as a prescription-only medicine, but Asda will be selling the inhalers under a patient group direction.

Faisal Tuddy, deputy superintendent pharmacist at Asda, said the scheme would make accessing an inhaler more convenient: 'It can often prove to be stressful trying to book a GP appointment when your inhaler is running low.'


'Prevention is an essential part of long-term management of asthma'
Dr Bill Beeby

But Dr Bill Beeby, chair of the GPC's clinical and prescribing subcommittee, said that making inhaled ß-agonists more readily available would undermine efforts to ensure asthma patients did not use rescue inhalers long term and neglect the use of inhaled steroids.

He said: 'It allows [the patient] to just treat the symptoms without going through the process of talking through long-term management with GPs.

'There are already a large number of people who overuse relief medication. Prevention is an essential part of long-term management of asthma. I'd be very concerned if over-the-counter inhalers made this worse.

Dr Beeby added: 'The sort of use we're talking about here – two inhalers every eight weeks – would normally trigger a review with a doctor to discuss preventive treatments. It's concerning that patients will be able to bypass this.'

A Department of Health spokesperson said: 'Medicines should be dispensed by appropriately qualified staff and in line with all legal requirements.'

@madlendavies

Opportunistic screening 'finds more diabetes'

Practices could pick up many new cases of asymptomatic diabetes at minimal cost by opportunistically asking patients if they want a blood glucose test, GP researchers have concluded.

The research – conducted by GPs at the St Leonard's Research Practice in Exeter – found two-thirds of patients picked up by opportunistic screening were asymptomatic, with a cost per case of under £400.

The study – published in *Diabetes Medicine* last month – raises questions about the large-scale diabetes prevention exercise recently recommended by NICE.

GPs at the St Leonard's practice asked all patients at high risk of diabetes attending a routine appointment if they would like a blood glucose test. Over three years, the practice recorded 86 patients with a new diagnosis of diabetes.

Study leader Professor Denis Pereira Gray, a professor at the University of Exeter and a GP at St Leonard's Research Practice, said they had shown an opportunistic method was 'practical' and a cheaper alternative to NICE's approach.

Bundled diabetes QOF 'demotivating'

Plans to bundle most of the diabetes indicators in the QOF will demotivate GPs, increase referrals and infringe on a patient's right to refuse treatment, the GPC has warned.

The GPC has written to the Department of Health in protest against plans to force GPs to carry out nine separate checks in each patient with diabetes.

But the DH insisted a composite indicator would improve care for patients with diabetes and is achievable for GPs, given nearly a fifth of GP practices already complete all nine care processes for diabetes in more than 70% of patients.

Last month, Pulse revealed the DH had asked NICE to look into creating a single QOF indicator for diabetes worth more than £5,000, with practices having to conduct all nine checks – such as HbA1c, cholesterol, blood pressure and BMI – in every patient to get their points.

But in a letter sent to Sir Bruce Keogh, medical director of the NHS, GPC chair Dr Laurence Buckman said: 'The suggestion that GPs should only be paid for diabetes care if they ensure all nine processes are delivered would have consequences where patients did not wish to engage in some checks or continue to attend.

A regimented, tick-box check would be extremely counterproductive
Dr Laurence Buckman

'A composite indicator risks demotivating practices completely and would almost certainly have the unintended consequence of increasing diabetic referrals.'

Dr Buckman added that a composite indicator did not allow for a patient's right to decline parts or all of their treatment: 'A regimented, tick-box check that was mandatory to secure any funding for the service would, we believe, be extremely counterproductive.'

But in a written reply, Sir Bruce defended the plans for a composite indicator: 'The QOF is currently not incentivising practices to increase the number of their patients who receive all nine care processes that are the hallmark of good diabetic care.'

GPC draws line in sand over GP care in hospitals

New GPC guidance has warned that GPs should not feel 'morally blackmailed' to provide services outside their level of competence, after an increase in cases where GPs have been called into hospitals and other secondary care settings to treat patients.

The new guidance is designed to help practices draw a line in the sand over the services they should be providing, and comes after Pulse revealed in April that some hospitals were using ambiguities in practice registration rules to pressure GPs to treat inpatients.

The GPC has raised concerns with the Department of Health over a rising number of incidents, and has argued the practice is not only unfair but could put patient safety at risk.

The latest guidance says: 'GPs should not allow themselves to feel morally blackmailed or contractually threatened to provide services beyond their level of competence.'

Dr Richard Vautrey, GPC deputy chair, said: 'It's just being clear for patient safety reasons that GPs don't get caught up in providing care in situations that would be inappropriate.'

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References: 1. Miller E, Marshall R, Vudien 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.

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UK researchers find intensifying diabetes management has little effect on cardiovascular outcomes

DIABETES

Stricter diabetes targets fail to cut risk

By David Swan

Intensively managing risk factors in patients newly diagnosed with diabetes in primary care does not have any significant effect on their cardiovascular outcomes compared with usual care, concludes a UK study.

The study found patients treated to tough HbA_1c, cholesterol and blood pressure targets did not have significantly different risks of cardiovascular events after five years compared with those receiving standard diabetes care from GP practices.

The study is the latest to cast doubt on moves to intensify diabetes treatment early and provides evidence that current GP care may be sufficient to prevent an increase in cardiovascular risk.

An analysis published in June found aggressively lowering blood glucose in patients with type 2 diabetes only slightly reduced the risk of developing neuropathy, but greatly increased the risk of hypoglycaemia.

This study found that aggressive management to keep HbA_1c levels below 53mmol/mol (7%), blood pressure below 135/85mmHg, cholesterol below 5mmol/l and prescribing aspirin to those treated with antihypertensive medication did not significantly reduce their likelihood of having a cardiovascular event.

The research involved randomising 379 general practices in the UK, Denmark and the Netherlands to provide routine care or intensive multifactorial treatment in newly diagnosed patients with diabetes. Over 3,000 patients without a history of ischaemic heart disease were included in the final analysis, all aged between 40 and 69 years.

Routine care consisted of a standard pattern of diabetes care according to current recommendations. All patients with a cholesterol level over 3.5mmol/l were prescribed a statin.

Over five years, researchers found non-significant reductions of 17% for a risk of first cardiovascular event since diagnosis when comparing intensive treatment to routine care, and 30% for a second event. When restricting cardiovascular events to include mortality, non-fatal myocardial infarction and non-fatal stroke, the risk reduction was only 14% when comparing the two groups, but the authors said this could be attributed to chance.

The study authors said: 'Early intensive multifactorial treatment was not associated with a significant reduction in total cardiovascular burden at five years.'

Professor Mike Kirby, a GP in Radlett who participated in the study, said: 'The standard of care was already good in most of the control practices. This makes it difficult to show a difference.'

But Dr Roger Gadsby, a GP in Nuneaton and member of the NICE type 2 diabetes guideline development group, said the study follow-up period was too short to show positive outcomes.

***Diabetic Medicine* 2012, online 23 July**

david.swan@pulsetoday.co.uk

Toughening up diabetes targets may not have an impact on cardiovascular outcomes

What is 'intensive' treatment of diabetes?

<53 mmol/mol
HbA_1c

<135/85 mmHg
Blood pressure

<5 mmol/l
Cholesterol

Source: *Diabetic Medicine* 2012, online 23 July

Online CPD
Type 2 diabetes: risk factors and complications
pulse-learning.co.uk

SEMINAR
Diabetes and CVD Update 2012
pulse-seminars.com

CVD

Heart attack risk raised by hip replacement

Hip and knee replacements should be contraindicated in any patient who has had a myocardial infarction (MI) in the previous year, according to authors of a Danish study.

The researchers looked at 95,227 patients who underwent total hip or total knee replacements and compared them with controls.

Two weeks after hip replacement surgery, patients were 25 times more likely than matched controls to suffer an acute MI, and patients who had had a knee surgery were 30 times more likely.

When extending the analysis to six weeks after surgery, patients who had a knee replacement saw their MI risk return to baseline after two weeks, but patients who had a hip replacement were still at a fivefold increased risk, compared with matched controls.

The researchers say this is the first study to look at hip and knee arthroplasty and MI risk.

They concluded: 'Our data suggests elective total hip replacement surgery should be contraindicated in patients with a previous acute MI in the preceding 12 months before surgery.'

***Arch Intern Med* 2012, online 23 July**

FATIGUE

Iron reduces fatigue in non-anaemic women

Iron supplements can halve fatigue levels in women with unexplained tiredness and ferritin levels which are low but not low enough to diagnose anaemia, concludes a new study.

Swiss researchers recruited 198 adult women who were menstruating and had low or borderline ferritin levels, defined as less than 50µg/l. In the UK, a ferritin level of less than 15µg/l confirms iron deficiency. Women were randomised to receive either oral iron or a placebo to be taken before or after meals for a period of 12 weeks. Fatigue was assessed at baseline and after 12 weeks using the validated Current and Past Psychological Scale.

At 12 weeks, patients receiving the iron supplements had a 3.5 point improvement in their fatigue scores, compared with controls. This corresponded to a statistically significant 48% decrease in fatigue for the group taking iron supplements, compared with a 29% decrease for the patients taking the placebo.

The researchers from the University of Lausanne said: 'If fatigue is not due to secondary causes, identifying iron deficiency as a potential cause may prevent inappropriate attribution of symptoms to putative emotional causes or life stressors.'

***CMAJ* 2012, online 9 July**

INSOMNIA

Exercise aids sleep quality in older women

Exercise in postmenopausal women can significantly improve their sleep quality, say US researchers.

Their study looked at 437 postmenopausal, sedentary women who were overweight or obese and had normal to mildly elevated resting blood pressure.

The women were randomised to three exercise groups or a control group that did not exercise. The exercise consisted of three to four sessions per week for six months, alternating between a cycle ergometer or treadmill, and their sleep quality was assessed using the Medical Outcomes Study Sleep Scale.

When compared with controls, exercise significantly reduced the risk of sleep disturbance, with a difference in sleep quality scores of 2.09 in the control group and 3.93 to 6.22 in the exercise groups, depending on the intensity of the exercise.

The researchers from the University of Pittsburgh said the results were 'noteworthy'.

***BMJ Open* 2012, online 12 July**

CPD TIP OF THE WEEK

Consider more potent statin to prevent myopathy

Generic atorvastatin is less likely to cause myopathy than increasing the dose of simvastatin above 40mg, according to a new case-based learning module. Atorvastatin came off patent earlier this year, making it a more feasible candidate for intense lipid lowering. Women, patients aged over 65, patients with renal impairment or hypothyroidism and those who consume large amounts of alcohol are all at increased risk for myopathy. The module also covers the role of co-enzyme Q10 in statin-induced myopathy, as well as lipid targets, raised triglycerides and familial hypercholesterolaemia.

ONLINE CPD
See the Hot topics in hyperlipidaemia at pulse-learning.co.uk

CVD

Polypill can match other drugs

The polypill is as effective as the medications already being taken by patients at increased risk of cardiovascular disease, according to UK researchers.

Their crossover trial looked at 84 patients aged 50 or over with no history of cardiovascular disease, who were taking simvastatin and antihypertensives such as bendrofluazide, losartan and lisonpril.

Patients were assigned to 12 weeks of the polypill – containing amlodipine 2.5mg, losartan 25mg, hydrochlorothiazide 12.5mg and simvastatin 40mg – or placebo, then crossed over for a further 12 weeks.

Blood pressure and lipid measurements were taken at the end of each 12-week period.

Compared with placebo, mean systolic blood pressure was reduced by 17.9mmHg and diastolic blood pressure by 9.8mmHg with the polypill. There was also a 39% reduction in LDL-cholesterol. This would correlate with a 72% reduction in heart disease and a 64% reduction in stroke.

The researchers from Barts and the London School of Medicine, London, concluded: 'These are substantial reductions, remarkably similar to those predicted from published estimates of the effects of the individual drugs.'

***PLoS One* 2012, online 18 July**

CONFERENCE ROUND-UP

Resistance training helps memory

Researchers in Canada recruited 86 women aged between 70 and 80 years with probable mild cognitive impairment and found if they did resistance training they had higher cognitive scores on the Stroop test compared with balance and tone exercises, with improvements of 2.4% and 17% respectively.

Alzheimer's Association International Conference 2012, abstract FI-03-01

Drinking linked to mental decline

Older adults who binge drink are more likely to suffer a decline in cognitive function, suggests a study of 5,075 US adults aged 65 years or older. Researchers found those who reported binge drinking twice per month or more had a 2.5-times greater risk of suffering a 10% decline in cognitive function, compared with more moderate drinkers.

Alzheimer's Association International Conference 2012, abstract O4-08-06

Co-ordinated care better in dementia

A US study found patients cared for by a team including a geriatric psychiatrist, a psychiatric nurse and three individuals trained in dementia care remained in their home significantly longer than those who had usual care – 496 days compared with 445.

Alzheimer's Association International Conference 2012, abstract 34009

Key questions on CCG constitutions
▶ page 31

GPC pushes for premises cash

Negotiators in talks over additional investment in premises as part of next year's GP contract deal

By Sofia Lind

The GPC is to push for a major boost to GP premises funding as a key plank of this year's contract negotiations, after banks cut off one of the last remaining sources of investment in practice premises.

The talks with NHS Employers come as GP negotiators warned practices were struggling to gain any investment in their premises since banks ceased providing interest-free loans from the beginning of this year.

Pulse revealed in March that the GPC had held initial talks with ministers about the most comprehensive review of GP premises funding since the introduction of the nGMS contract.

Pulse has learned the GPC is set to use the example of a major premises agreement in Northern Ireland to highlight the benefits of agreeing a major long-term premises upgrade.

The 10-year arrangement commits the Northern Ireland Assembly to invest £30m per year in GP practice premises, although negotiators admitted it may not be possible to scale up to this level for investment across England, Scotland and Wales.

The decision to focus on premises investment was reached at the GPC meeting in Edinburgh last month, and the GPC is due to hold fresh talks with NHS Employers within weeks.

Premises funding has been squeezed in recent years

The negotiations are being held against a backdrop of a slump in investment in GP surgeries, with a Pulse investigation finding LIFT funding in 2010 had dropped by a quarter compared with the previous year and that the LIFT Council was preparing to cut support for new builds.

GPC chair Dr Laurence Buckman said there was a 'willingness' to negotiate on the issue on both sides: 'Primary care premises have not been updated for a very long time. We want to talk to the Government about how we will take them into the 21st century.'

Dr Peter Holden, the GPC negotiator who is leading on the matter, said the situation had become urgent because the cost-rent scheme had been made virtually impossible because banks no longer provide interest-only loans.

He said: 'One big change occurred at the beginning of this year, which is absolutely fundamental to how GP practices fund premises upgrades, and that is that banks no longer provide evergreen interest-only loans.'

NHS Employers declined to comment on negotiations, except to say that discussions were ongoing with the GPC.

@sofialind_Pulse

Next steps for premises

August 2012
NHS Employers and the GPC to hold first meeting on 2013/14 contract negotiations

Autumn 2012 to spring 2013
Contract terms to be negotiated, with GPC expected to push for additional funding for premises upgrades

April 2013
New contract terms to be implemented

More surgeries for Sainsbury's

Sainsbury's has opened two more GP surgeries in its supermarkets this year and has urged more practices to come forward to run services in its stores.

New surgeries have opened in shops in Newton Abbot in Devon and in Sunderland, joining four existing surgeries in Sainsbury's stores in Bath, Newcastle-under-Lyme, Manchester and Colne in Lancashire. Under the terms of the deals, the supermarket giant gives GPs the opportunity to set up branch surgeries in its stores free of charge and charges no rent.

The Newton Abbot surgery, which will be operated by GPs at the Buckland Surgery, has a fully equipped consultation room and will offer GP consultations every Monday, Wednesday, Thursday and Friday.

Dr Jill Millar, a GP at Buckland Surgery, said she hoped the store would make it easier for patients to do their shopping after they attended an appointment and said appointments would be 'useful' for people who work during the day.

David Gilder, professional services manager at Sainsbury's, said: 'Customers really value the convenient locations, good transport links and longer opening hours that the surgeries offer. I would invite any GPs out there who think a Sainsbury's store would be a good location for a surgery to get in touch.'

But Dr Michael Sparrow, a GP in Lifton, Devon, said: 'The minute we start leaving our independence to companies like Sainsbury's is a disaster. I'm very sceptical.'

IN BRIEF

Budgets warning

The RCGP has warned variation in how personal budgets are applied could create inequalities.
Full story ▶ pulsetoday.co.uk/politicalnews

Prescribing physios

Physiotherapists and podiatrists have been granted the right to prescribe painkillers and anti-inflammatories independently.
Full story ▶ pulsetoday.co.uk/clinicalnews

Call for EPS incentives

The rollout of electronic prescribing in the NHS will stall unless GPs are offered financial incentives, researchers have warned.
Full story ▶ pulsetoday.co.uk/practicenews

GPs are weary of an ever-changing QOF

Steve Nowottny
Acting editor

'No new work without new money'. That was the founding principle underlying the 2004 GP contract, the phrase rehearsed at every LMCs conference since, the *sine qua non* of the profession's support for a new system of GP funding. Eight years later, as the profession confronts an ever-lengthening to-do list on the back of successive pay freezes, it seems an increasingly sour joke – and nowhere more so than with the QOF.

The NICE QOF advisory committee has been in operation since 2009 and with the piloting and review process now fully up and running, each year a dizzying array of indicators is put forward for inclusion and removal.

Recommendations for 2013/14, published last week, could see up to 16 indicators heading in, and 14 indicators heading out, through the QOF's revolving door.

Tasks that GPs could no longer be paid for to perform include prescribing ß-blockers in heart failure and measuring blood pressure in patients with chronic kidney disease, while new targets could include checks in patients with rheumatoid arthritis, looking for erectile dysfunction in diabetes and controversial 'biopsychosocial' assessments for patients with depression – a 16-point analysis which will include looking at everything from patients' living conditions and financial worries to the quality of their interpersonal relationships.

Then, of course, there are the wild card indicators, outside NICE's remit, added at the behest of the Government. The quality and productivity indicators brought in last year marked a real departure for the QOF, incentivising GPs for the first time on the basis of efficiency savings.

Our investigation this week reveals many practices struggled on the prescribing efficiency indicators, with around a quarter dropping points.

Explanations offered include patient reluctance, lack of time and the fact that for many this was only the latest in a series of prescribing crackdowns. But when long-serving GPC negotiator Dr Peter Holden blames 'target fatigue' and claims GPs are in 'sod-it mode', it suggests GPs are simply being asked to tick too many boxes for too little reward.

It is all very well negotiators bemoaning the QOF's unrealistic expectations, but they have struggled to make their views heard where it counts, in the negotiating room. The prescribing efficiency indicators have already been scrapped, but they were replaced with a new indicator that linked GP pay to reducing A&E attendances – a target which may or may not be within GPs' control. Unpopular depression screening indicators, recommended for removal by NICE last year, were somehow spared the chop. There are even plans to bundle diabetes indicators into one daunting composite target.

The QOF remains, at its best, a valuable way of rewarding focused interventions for specific disease areas, and is admired internationally. But its perpetual evolution is distracting and demotivating to many, and the shoe-horning in of political targets and furious lobbying by various pressure groups at the negotiation stage make a mockery of a supposedly evidence-based review process.

Our columnist Dr Margaret McCartney this week praises the lost art of standing still, and what applies to clinical diagnosis could apply equally to the QOF. The framework would benefit from a pause to take stock, let practices catch up and allow real debate over how GP pay incentives should work.

As it happens, LMC leaders at their conference in May thought the same, unanimously backing a motion demanding 'no changes are made for the next two years in order to accommodate the changes to commissioning'. That makes it official GPC policy. As the next round of contract talks gets underway, negotiators might take that as their starting point.

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

EDITOR'S BLOG

This is what defeat looks like

Rarely has a retreat felt so momentous – and rarely has it prompted such white-hot anger. When the BMA announced last month that it had suspended plans for any further industrial action over the Government's pensions reforms, the response from readers was immediate...

pulsetoday.co.uk/editors-blog

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In the grip of Olympic fever

Sporting glory has done little to dampen patient demand, says **Phil** – and something's got to give

'Well, what it is doctor, it's me leg. I think I've got a bone in it...' he begins.

Well, he doesn't, not exactly. But suffice it to say, I'm in the middle of a routine consultation in a routine surgery on a routine Wednesday afternoon, when normal life comes to a sudden halt.

At 48 minutes past three on 1 August 2012, I turn to my patient and, in the middle of a monologue detailing his complaint, I raise a cautionary finger: 'I'm going to ask you to shut up for a few seconds just now. I'll get back to you in a minute.'

I twist the volume dial on the radio, and we hear this: 'And it's BRADLEY WIGGINS racing up the final straight, the greatest British Olympian of all time, winning gold for Team GB yet again!'

The Radio 5 commentary goes on for some time, and I savour a minute or two of rare national success.

We don't get to hear it all that often, and more to the point, when was the last time we had the privilege of having a national icon with the heroic bushy sideburns of a Noddy Holder? To the best of my knowledge, it was when Lord Nodward of Holderford himself was our national icon, and that was a good four decades ago now.

I'm still grinning like an idiot when I eventually turn back to face my patient. There's a pause, we stare at each other, and then we pick up the thread of his consultation. The routine resumes.

Olympic fever has gripped us like a vice, in our practice. We've never known anything like it. We can't get enough of it.

As Hartlepool United's highly valued club doctor, I am forced to watch more live football than practically any other doctor on the planet. This would be utterly unacceptable if I didn't get paid to do it, and one side-effect of this experience is that I will never voluntarily watch any other football match of any kind, ever.

And yet here I am, insanely cheering on the footballing women of Team GB. Even though they're women, and rubbish. I have been the crowd doctor for a number of previous England women's internationals, and witnessed their primary school skills at close hand.

This current enthusiasm of mine is illogical and like some sort of virus – I don't know how to handle it.

Our surgeries remain rammed with 'urgent' extras

We were sort of hoping for an Olympic hiatus in our practice – a bit of a break from the drudgery. Back in 1973 when Sunderland won the FA Cup, the surgeries in our city saw hardly a soul for a month, if legend is to be believed.

But times have changed. There are no enticing empty areas in our practice where we might beguile the hours away with the tennis on the flat-screen in our teaching suite.

The school holidays no longer involve a brief relaxation from the toil of dealing with alcoholics and ineffective parental skills and coughs and pathetic requests for benzodiazepines.

Our surgeries remain rammed with shite, so-called urgent extra after so-called urgent extra. Eight of them this afternoon, and that's not unusual.

I don't see any respite from this, in the present or in the future. That wonderful event, the British Olympics of 2012, remains something I might catch if I see the late highlights on the telly when I get home – if I'm not too tired.

And it's not something that I am happy to miss.

My job, previously my vocation, is dominating my life. There's no space for any fun any more. Something has got to change.

Dr Phil Peverley is a GP in Sunderland

MargaretMcCartney

The lost art of standing still

Even when waiting is the best approach, GPs can find it difficult to justify doing nothing, **Margaret** says

Watchful waiting, expectant management or – my favourite – masterly inactivity.

Not doing something requires description, reassurance, and, if I am honest, a bit of justification. The training of a doctor often emphasises action – when to prescribe, when to operate, when to biopsy. But the art of standing still is a tough one to learn, and tougher still to do.

I find this even when the evidence stacks up to convince us. There is now copious evidence that avoiding intervention can be useful in many circumstances.

For example, recent data showed that palliative care for metastatic lung cancer, rather than ongoing aggressive chemotherapy, led to an equal length of life – but a higher quality of life.[1]

Turning off chemotherapy may seem like a risky business, but keeping it going was shown to be detrimental.

Yet even with the evidence, there are still times when making a rational, informed, collaborative decision not to do something can feel riskier than more aggressive action. Inaction, or less activity, can feel harder to justify – hence the nomenclature medicine has created in trying to frame not doing something as a positive declaration.

But all GPs know the value of time as a diagnostic tool. And, of course, there is the futility of too much of the wrong kind of medicine, used with good intention but to no benefit, at the end of life.

The need to 'do something' has become so embedded in our guidelines and protocols that making a thoughtful decision to dissent feels like an uphill struggle.

The boxes in the QOF seem to push for more – we have to justify each request that we decline to comply with.

And yet the process of beginning medication calls for far less justification – it has become automatic, and I am not sure that the resulting polypharmacy is capable of doing as much good as the extrapolated evidence would have us believe.

The training of a doctor emphasises action – when to prescribe or operate

What I'm looking for, among all the advice to start medication at an earlier and earlier stage in the disease – or worse, pre-disease – is evidence-based, pragmatic, wise guidance about stopping medication and interventions.

The contract dupes me into thinking that the largest risk is not complying with it. Yet the reality is the misery of iatrogenesis.

I worry that preventive medications simply exchange one cause of death for another, with little time to gain between them – and worse, were we to account for side-effects, little or no quality of life achieved for all the effort of swallowing down the tablets.

This is not about rationing or ageism. Not doing some activities – like prescribing – does not necessarily mean that we are doing less. The effort expended in proper joint decision making and attention to evidence for an individual patient is far, far more.

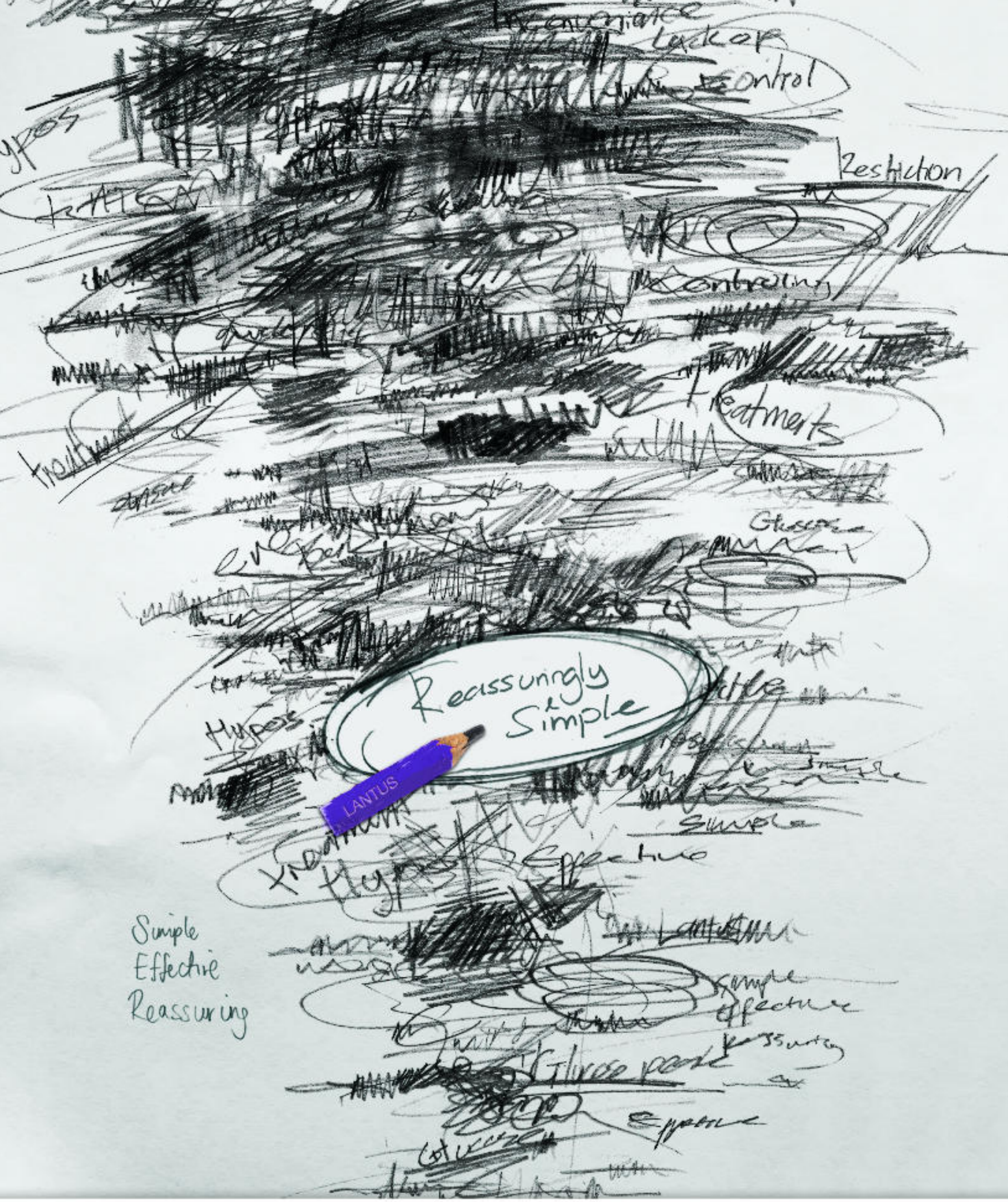
It would be much better if every guideline supporting some kind of medical activity also explained the limits of evidence and who, reasonably and rationally, we should encourage to step firmly off the protocol.

There are small letters somewhere on most guidelines that say that they are only that – a guide. I'd love to see that printed in massive red letters on the front.

Dr Margaret McCartney is a GP in Glasgow

Reference

1 Jennifer S, Temel M, Joseph A et al. Early palliative care for patients with metastatic non small-cell lung cancer. *N Engl J Med* 2010; 363:733-742



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SANOFI DIABETES

We haven't ruled out further pensions action – but now is the time to talk

The BMA had little alternative but to try and resume negotiations with an intransigent Government, writes new chair **Dr Mark Porter**

I became chair of BMA Council at an interesting time, with the medical profession having just entered uncharted territory. Thursday 21 June was an historic day – the first industrial action by UK doctors for four decades.

Whatever happens next, we should not lose sight of its significance and we should remain proud of what we achieved as a profession – acting in unity and sending a strong and clear message of how let down we felt by the attack on our pensions, while ensuring that we put the safety of our patients first.

There is no question that the action and our subsequent decision not to ballot, at this stage, on a possible escalation into a full strike has again emphasised the range of opposing views on industrial action among GPs and hospital doctors.

Since the decision by BMA Council to suspend industrial action and to focus on discussion and campaigning, my postbag has been full of emails and letters from GPs – some of them passionately condemning the decision, and others warmly welcoming it.

Before expanding on that decision, however, I want to address one of the most common questions from GPs – namely, why we ruled out a boycott of commissioning as a form of action against the pension changes.

First of all, I want to assure you that there was no possible form of action that we did not consider. Many were ruled out for legal or ethical issues, because they would be too complex or because insufficient numbers of doctors would have been able to participate. In the case of boycotting commissioning, there are a number of reasons that we decided against.

Taking effective action

The strength of the action on 21 June owed much to the fact that it was simple and that most doctors – in every part of the UK and every part of the profession – could participate.

Advising GPs to withdraw from CCGs would be confined to general practice in one part of the UK, and not all GPs would have the same opportunities to take part in a way that would have meaningful impact.

But more importantly, there are major question marks about how effective it would have been as a form of action. There is a strong argument it would not have influenced the Government and would even have proved counterproductive, creating opportunities for the private sector to become more involved.

After carefully considering the impact of the action on 21 June, the BMA also took the view that a repeat of the 'urgent and emergency care' model would probably not have the same level of impact a second time, as employers would be wiser about how to manage such action.

That left BMA Council with two realistic options: balloting members on an escalation into a strike, with doctors withdrawing their labour and not being at their place of work, or suspending plans for further industrial action and focusing instead on making the most of the opportunities available to seek improvements to the pension changes through discussion.

After considering the scale of the action on 21 June, its impact on public opinion, the views of the wider membership, the chances of the Government agreeing to a serious rethink of its plans and the likely effect on patients of strike action, council decided to suspend plans for further industrial action.

The ongoing campaign

So what now? I would like to emphasise that this decision does not mean we have definitely ruled out future industrial action – on this issue or any other. It means that, for now at least, we are engaging with the talks on offer about the age of retirement and contribution increases in 2013 and 2014.

We will also be working with other unions to campaign for a fairer retirement age for frontline staff over the longer term, especially as the main changes do not come into effect until 2015.

I'm not expecting every GP to agree with this decision. But I hope they can understand that, as a profession, we were faced with an intransigent Government dead set on pushing through these changes, which has at every turn refused any serious negotiation.

Throughout this process, we have sought to listen to and voice the views of our members and to work to get the best possible outcome for them. That hasn't changed.

But for now, we will be working to achieve those aims through discussion and campaigning rather than industrial action.

Dr Mark Porter is the new chair of BMA Council and a consultant anaesthetist at University Hospitals Coventry and Warwickshire NHS Trust

Social care is not the NHS's ugly sister

GPs and commissioners can make integrated care a reality, writes health minister Paul Burstow – and the Department of Health has pledged £300m to make it happen.

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BMA blew it on pensions

LETTER OF THE WEEK

Will the BMA regret backing down over pensions?

From Dr Chris Barringer
Newent, Gloucestershire

It worries me enormously that the profession decided to make a stand on the issue of GPs' pensions and now appears to be backing down ('BMA to consider "all options" on pensions', pulsetoday.co.uk/news).

We are at risk of losing all credibility and influence over Government policy. We will be forevermore pushed around by successive governments who know that the BMA is a weak organisation that backs down in the face of adversity. Never again will threats of industrial action be taken seriously.

The BMA needs to seriously crank up the industrial action as soon as possible – universal boycotting of CQC registration would be the next logical step, as it would have zero impact on patient care. Failure to do this will lead to my complete disillusionment with the BMA and the loss of my membership. I am quite certain that many others will follow suit.

All screening has a cost

From Dr Lester Russell
Portsmouth

I was interested to read your story on NICE's new diabetes screening guidelines ('GPs asked to mass-screen all patients aged 40 years or older for diabetes', pulsetoday.co.uk/news).

Sir Muir Gray, a recognised authority on screening, is fond of pointing out that all screening causes harm – meaning that although there may (or may not) be an overall benefit from a screening programme, some individuals will invariably suffer a disservice, for instance due to the side effects of investigating false positives. It is up to us to predict who might be harmed, how and by how much.

Yet the new NICE guidelines seem devoid of any impact assessment like this. If this was a new pill we were debating, Professor Kamlesh Khunti and his team would be lambasted from all sides.

Will they show us their costing methodology and risk analysis?

Revalidation is still an insult

From Dr Mike Ashworth
Wigan

I was disappointed to read Professor Mike Pringle's defence of revalidation ('Revalidation is a reality GPs must accept', pulsetoday.co.uk/opinion).

The tenet of his article is that there is a loss of public trust in doctors and that somehow his glorious plans for revalidation are going to make everything hunky-dory with the general public.

Let's get real. The general public still has more respect for our profession than any other.

This is despite the best efforts of the *Daily Mail* and politicians of every persuasion who see doctor-bashing as an easy way of selling papers or winning votes.

The assumption that the situation is otherwise undermines our professionalism.

The professor gushes that his plans for revalidation will prevent us from being 'mired in a spiral of mistrust' with politicians and NHS managers.

Really? Am I alone in thinking that the focus of my working day has nothing to do with satisfying the objectives set out here?

Of course we have to accept revalidation as an inevitable result of the march of the clipboard brigade, but we should not for one moment acknowledge that it is going to make us better doctors or improve our service to our patients.

I remain, as I have always been, insulted by this process.

How can we keep patients out of A&E?

From Dr Krishna Chaturvedi
Westcliff-on-Sea, Essex

We have done some analysis as part of work towards the QP12 and QP13 QOF indicators, and also as a part of our CCG's QIPP analysis.

In our peer review, it was encouraging to see that small practices managed extremely well – both in admissions to A&E and outpatient admissions to hospital per 1,000 population.

My impression is that small practices are well organised and the staff are extremely helpful, know the patients and accommodate them at a reasonable time as urgent, emergency and often walk-in patients. Frontline staff have been extremely influential and helpful in managing patients' problems.

There was some suggestion from practices that NHS Direct, which advises our patients out of hours and on other occasions, tells patients they should attend A&E.

This practice should be discouraged, and there should be more educational tools and information explaining to patients about the appropriate use of the A&E department.

I have previously written to Pulse arguing that GPs do not have any control over A&E attendances, particularly out of hours.

While we can do our bit on education, we can't be expected to police inappropriate attendances – these messages should come, instead, from the Department of Health as a part of public education and the public health agenda.

I would be interested to know from your readers if they have any different views or suggestions.

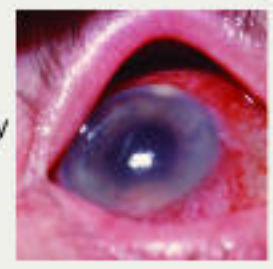
More online

Read more letters to Pulse this week

pulsetoday.co.uk/letters

Pulse Clinical

In this issue



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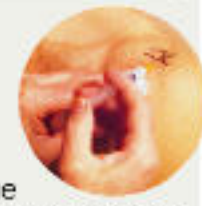
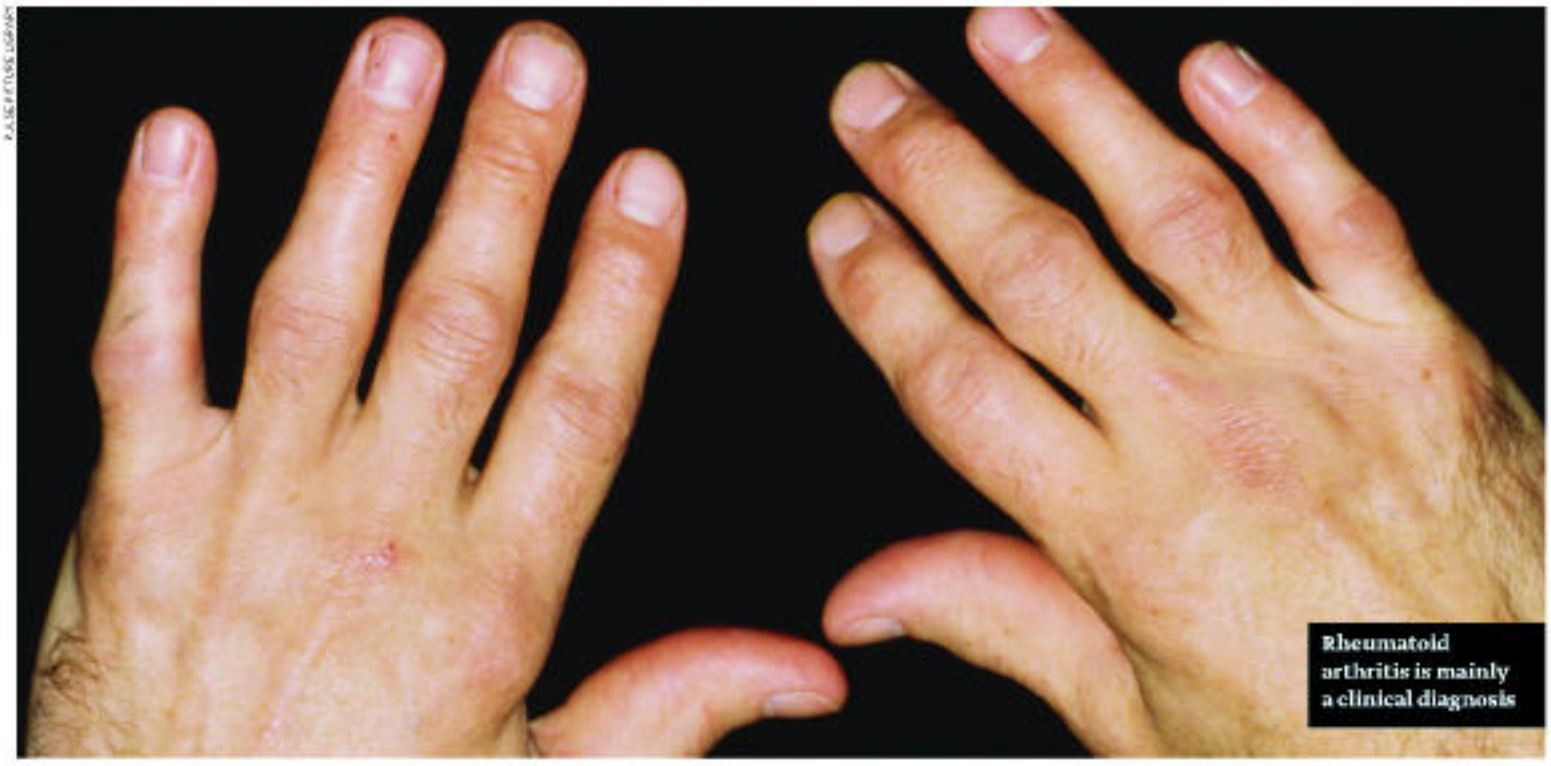


KEY QUESTIONS

Rheumatoid arthritis



Rheumatoid arthritis is mainly a clinical diagnosis

Dr Chris Deighton, consultant rheumatologist, tackles questions from GP Dr Julian Spinks on initial investigations, managing pain and biological therapies

1 What clues in the history and examination of a patient with multiple joint pains would be useful to identify rheumatoid arthritis (RA)?

The first clues to RA are evidence of an inflammatory process in the joints, characterised by joint pain, stiffness (particularly in the morning or after rest), swelling or loss of function. The patient may also feel generally unwell, with fatigue, fevers and sweats. Usually RA begins with the small joints of the hands and feet – particularly metacarpophalangeals and metatarsophalangeals, interphalangeal joints and wrists. The greater the involvement of small joints, the more likely the diagnosis is to be RA. But in some patients, RA will start in a few larger joints before spreading to the smaller ones.

Examination commonly elicits pain and heat on feeling joint lines, along with a boggy feeling caused by increased fluid and thickening of the synovial membrane that lines the inside of the joint. The patient will also have restricted and painful movement in all directions of the affected joints – for example, making a fist may be difficult or impossible. If signs of inflammation in the joints are not obvious, you can do a squeeze test – squeezing the heads of the metacarpophalangeals and metatarsophalangeals together. If this induces pain, particularly bilaterally, it is very suggestive of RA. Some 15% of patients experience explosive, sudden-onset disease, which is easier to detect than gradual-onset symptoms.

2 I generally request rheumatoid factor and C-reactive protein tests in patients who I suspect have RA. How useful are these tests when making a diagnosis, and are there any others you would recommend?

RA is mainly a clinical diagnosis, so if a patient has characteristic symptoms and signs, you should have a low threshold for suspecting it – no tests are required for diagnosis. In this situation, the best approach is to refer promptly so the patient can begin disease modifying antirheumatic drugs (DMARDs) as soon as possible – don't delay referral by waiting for the results of tests to come back.

If there is some diagnostic doubt and the patient is coping with their symptoms, urgent referral may not be so pressing and rheumatoid factor and CRP are sensible tests. But rheumatoid factor is only positive in about 70% of patients with RA, so a negative test does not necessarily mean the patient does not have RA. And there can be false positives too, particularly in the elderly and people with other chronic inflammatory diseases.

Even though CRP is a very sensitive measure of inflammation, it may not be elevated in the early stages of RA – particularly if only small joints are affected.

Some GPs may have access to anti-cyclic citrullinated peptide antibody tests, and this is more specific than rheumatoid factor.

3 NICE recommends rapid referral for patients with likely RA or undiagnosed synovitis, but there is often a delay before these patients are seen. What can a GP do in the meantime to treat pain and other symptoms?

If local specialised services have delays in seeing patients with suspected RA, the local commissioners and providers should be addressing this urgently. Resources should be made available to ensure patients are seen quickly by specialist services when RA is suspected. If a patient develops severe RA, we recommend the GP speaks directly to their local specialist services.

If there are delays, then analgesics and NSAIDs may help. If they do not, an intramuscular injection of 80-120mg

methylprednisolone or triamcinalone may tide the patient over until they can be seen by a specialist – but this is not ideal as it may obliterate physical signs that help with diagnosis and prognosis. Avoid oral steroids as they can be difficult to withdraw.

4 DMARDs are the mainstay of treatment for patients with RA. Could you explain the current thinking about the best way to use these drugs?

For patients with recent-onset aggressive and active disease, the NICE guidelines[1] recommend using combinations of DMARDs – including methotrexate if not contraindicated – along with short-term steroids to rapidly reduce the inflammation. This will tide the patient over while waiting for the slower-acting DMARDs to reduce the damaging components of the disease process.

Combination therapy is recommended because it is the most cost-effective approach to early active disease – it has the best chance of controlling the disease and lessens the chances of having to go onto expensive biological therapies. In head-to-head trials, methotrexate is no more effective than other DMARDs – but patients tend to stay on it much longer than others, suggesting it is generally well tolerated.

There is less evidence for treating milder RA than for very active disease, and until studies have addressed this, using DMARD monotherapy is appropriate. But follow the patient closely to ensure further DMARDs are added if the disease becomes more active.

5 Unfortunately, even the best-controlled patients with RA suffer from disease flares, and they often contact us for help. What should we do when this happens?

When a single joint is affected there is always a chance of sepsis, so refer urgently if this is a possibility. If more joints are affected it is more likely to be a flare-up of RA than sepsis – but it can be difficult to know if it is a genuine flare.

Rheumatology departments should see patients with flares – it is part of RA management and should be adequately financed through the CCG and a care pathway and tariff. But in the current financial climate, specialist follow-ups are being discouraged by some PCTs and CCGs contrary to NICE guidelines, and GPs may be asked to provide intramuscular steroids for polyarticular flares in well-established disease.

If this is the case, it is always helpful to let the specialist service know this has happened – because if it is happening regularly, the DMARDs may need to be adjusted for better disease control.

Other services may have negotiated care pathways that allow direct access for patients – usually to telephone helplines and specialist nurses – and in our opinion this remains best practice so that the patient has access to specialists when things are going badly.

6 Patients often bring newspaper clippings about special diets to help the symptoms of RA. Is there any evidence that any of them work?

Unfortunately, there are no diets that exert a big impact on RA. There is some evidence that a Mediterranean diet – based on fruit and vegetables, olive oil, fish and white meats – might help to control some pain and inflammation, but this is the sort of healthy diet we are all encouraged to follow. Many patients will experiment with their diet and might find some benefit from including or excluding certain foods, but this is all trial and error. There is some evidence that small amounts of alcohol may be beneficial.

The best lifestyle approach that patients can take is to stop smoking – there is a lot of evidence to show that smoking tobacco increases the risk of developing RA, and RA is more likely to remain active in those who smoke than those who don't. Being overweight will make painful joints worse and may discourage the patient from exercising, so patients should be advised to lose weight if necessary.

7 Which patients with RA would benefit from surgery?

Patients who would benefit from surgery are those with pain not responding to conservative approaches, where joint deformity is causing problems with normal daily tasks – for example, toe deformities causing problems with shoes. Ideally patients should be referred for a surgical opinion at an early stage, before joints become so damaged that surgical intervention is more complex or less likely to have good long-term outcomes. Nerve entrapment – such as carpal tunnel syndrome – and tendon ruptures are other indications for surgical referral.

8 What advice would you give to patients about exercise during and between flares of RA?

Exercise is important for patients with RA. Advise patients that continued and sustained exercise, long term, is important in improving and maintaining the range of movement of the joints, muscle power and balance. It enables patients to remain independent and continue with normal daily activities.

Also advise patients on what types of exercise they can do. Traditionally, prescription of exercise has been based on a range of gentle movements to keep joints moving, with the addition of some low-grade specific strengthening exercises. In some cases this approach is still appropriate, though we now also know that patients with RA can tolerate higher levels of exercise without speeding up the progression of their disease.

You should let patients know that it is normal to feel some discomfort or aching after exercising if they are really working effectively – pushing themselves a little to achieve more gradually and as they can – but this should not last for a long time.

During a flare-up patients should do less exercise than normal, but still try to put their joints through their normal range of movement to reduce stiffness and use things like ice packs and a warm shower or bath to relieve symptoms. Ideally, all patients should see a physiotherapist who is experienced in working within a multidisciplinary rheumatology team, although of course not everyone has access to such services.

9 A small number of my patients are taking biological therapies, including TNF inhibitors. What would lead you to use this type of treatment and what are the pitfalls?

Biological therapies such as TNF inhibitors have made a huge difference to the management of patients who have an inadequate response to standard DMARDs.

Unlike conventional DMARDs – which have many effects on inflammatory and immune pathways – the biological drugs are very specific in their mode of action, blocking a single cytokine (such as TNF, or interleukin-6, for example) or attacking cells involved in the autoimmune process.

The main concern for GPs about biological therapies is that they can increase the risk of infection, particularly in the early stages of their use and in patients also taking steroids. Biological therapies can also dampen down the acute-phase response associated with sepsis, so patients can have serious infections but not appear particularly ill. If a patient is generally unwell while taking biological therapies, they should be assumed to have sepsis until proven otherwise and referred to their specialist.

Dr Chris Deighton is a consultant rheumatologist at Derbyshire Royal Infirmary and president of the British Society for Rheumatology
Dr Julian Spinks is a GP in Strood, Kent

Dr Deighton would like to thank Dr Louise Warburton, a GPSI in rheumatology and musculoskeletal medicine for NHS Telford and Wrekin and president of the Primary Care Rheumatology Society, and Mrs Ailsa Bosworth, chief executive of the National Rheumatoid Arthritis Society, for their assistance with this article

The National Rheumatoid Arthritis Society (NRAS) provides support, education, information and advocacy for people with RA, their families, friends and carers. NRAS is also a resource for health professionals with an interest in rheumatology. Its goal is 'a better life for people living with RA' and it seeks to achieve this by raising public and government awareness of the disease, campaigning for equity of access to best treatment and care, facilitating the networking of people with RA and encouraging self-help. For more information go to nras.org.uk or call the freephone helpline on 0800 298 7650.

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References

1 NICE *Rheumatoid arthritis guidelines*. 2009;CG79

Further reading

● Deighton C, O'Mahony R, Tosh J et al. NICE guidelines development group. Management of rheumatoid arthritis: summary of NICE guidance. *BMJ* 2009;16:b702
● Map of Medicine. Rheumatoid arthritis. mapofmedicine.com (accessed 20 July 2012)

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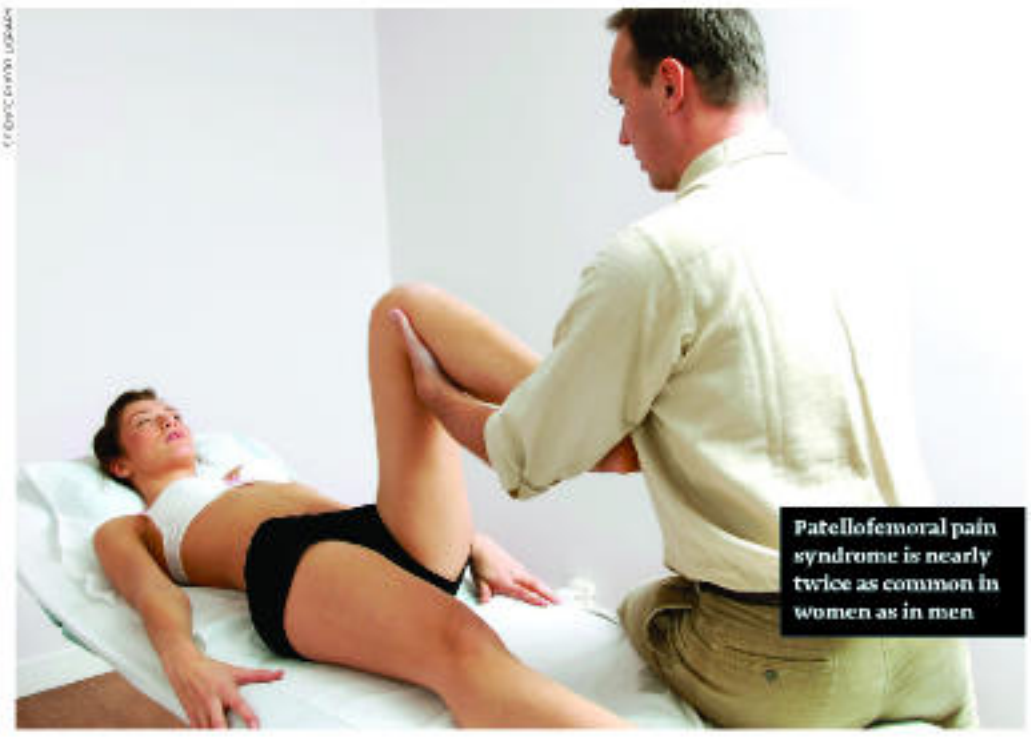
Go online to read an extended version of this article, with the author answering questions on complementary therapies and cardiovascular risk in patients with RA.

THE INFORMATION

Patellofemoral pain syndrome

Professor Fares Haddad, consultant orthopaedic surgeon, and registrar Mr Tony Fayad continue our series of evidence-based lowdowns using PUNs and DENs



Patellofemoral pain syndrome is nearly twice as common in women as in men

THE PATIENT'S UNMET NEEDS (PUNs)

A 16-year-old girl attends complaining of pain in both knees, especially after exercise, for the last six months or so. She is very sporty and is due to represent her county soon in various track and field events, but her mother is worried the symptoms are putting her participation in jeopardy. Periods of rest ease the symptoms, but they flare up again whenever she resumes sport. On examination there is tenderness on the borders of the patella, but otherwise the knees seem normal. You diagnose patellofemoral pain syndrome. Mother and daughter are keen to know the cause and prognosis and to pursue effective treatments.

THE DOCTOR'S EDUCATIONAL NEEDS (DENs)

What is patellofemoral pain syndrome and what is the pathophysiology of the pain?
Patellofemoral pain syndrome is characterised by anterior knee pain involving the patella and retinaculum that excludes other intra-articular and peri-patellar pathology. The pain comes on gradually and symptoms may relate to abnormal contact of the posterior surface of the patella with the femur. Patellofemoral pain syndrome is a broad term that should be used when no other cause can be identified. It is often used interchangeably with 'anterior knee pain' and 'theatre-goer's' or 'cinema knee'.

Patellofemoral pain syndrome is quite common in young people, particularly adolescent girls. It is one of the most common knee problems in female adolescent athletes.[1] Patients are more prone to it if they have a small kneecap or one that sticks out if the feet pronate, and if they have tight muscles or weak quadriceps. It also affects athletes who do a lot of long-distance or hill running, and those who have had a previous knee dislocation.

Patellofemoral pain syndrome is often confused with chondromalacia patellae, where there is softening of the patellar articular cartilage. Chondromalacia patellae only occurs in a subset of patients with anterior knee pain – but both conditions can occur in isolation. It is unclear why some patients with minor chondral softening of the patella have severe pain, while others with chondral fissures and defects can manage high-level sport. So chondromalacia patellae is often bracketed with patellofemoral pain syndrome – the precise cause of the pain is unknown and the management of both conditions is similar.

How often is patellofemoral knee pain the result of another issue, such as joint hypermobility or flat feet? Should we look for underlying causes like this?
Patellofemoral knee pain is usually secondary to maltracking, where a muscle imbalance develops when any of the structures surrounding the knee, which keep the patella sitting centrally in the intercondylar groove, are particularly tight or weak. This causes pain and can lead to patella cartilage damage.

Key points

Cause
- The aetiology of patellofemoral pain syndrome is thought to include abnormal forces or prolonged repetitive compressive or shearing forces on the patellofemoral joint.

Epidemiology
- Patellofemoral pain syndrome accounts for 25% of knee injuries in sports medicine clinics.
- It is approximately twice as common in women than men.

Clinical features
- Anterior knee pain is the most common presentation of patellofemoral syndrome.
- Symptoms often occur during the activity, or may occur later after the activity has been completed, sometimes as late as the next day.

Management
- Physical therapy
- Relative rest
- Ice and NSAIDs
- Knee sleeves and braces, and knee taping
- Footwear and arch support
- Review with a sports physician before surgery is considered
- Surgery.

The patella most commonly runs too laterally in the groove.

All patients should be examined to rule out biomechanical problems. Patients initially should be examined 'from the ground up' while standing in shorts. Assess dynamic patellar tracking by having the patient perform a single leg squat, and then stand with the hip, knee and ankle in a straight line. This is a great test of patella control – for many patients, the problem is muscle weakness, particularly in the glutei and core. Observing the patient's gait may reveal excessive subtalar pronation, which can be a cause of imbalance leading to knee pain. Imbalance between the medial and lateral patellar forces, caused by vastus medialis obliquus dysfunction or lateral structure tightness, can manifest as an abrupt medial deviation of the patella as it engages the trochlea early in flexion, known as the 'J' sign. Lateral deviation of the patella can be seen during the terminal phase of extension.

Foot abnormalities are thought to be a cause of patellofemoral knee pain. Patients with patellofemoral knee pain often have a higher arched foot (cavus), which may produce greater pressures on the patellofemoral joint during running. Genu varum, genu valgum and foot postural abnormalities – excessive pronation, valgus ankles and lowered foot arches – might also increase risk of injuries.[2] Evidence suggests generalised ligamentous laxity increases the total patellar mobility, which alters patellar tracking and causes symptoms. One study found significant generalised ligamentous laxity in patients with chondromalacie patellae.[3] Other structural problems include patella alta (a high patella) and patella baja (a low patella).

What is the outlook for a patient with patellofemoral pain syndrome? Is there any evidence they are at increased risk of subsequent arthritis?
If a relationship between patellofemoral pain syndrome and patellofemoral osteoarthritis can be identified, clinical interventions that address the former could potentially delay progression of the latter. But investigation into the causative link between the two is limited. A recent analysis looking at six small, uncontrolled, observational follow-up studies was unable to confirm a link.

Investigations are designed to find problems such as maltracking, osteochondral lesions and excessive lateral pressure syndrome, all of which warrant intervention. In excessive lateral pressure syndrome, early intervention may reduce the risk of long-term chondral damage.

What simple activities and exercises can be advised to alleviate the problem? What specific treatments would a physiotherapist use and how effective are they?
Treatment with continuous physical rehabilitation programmes, in combination with NSAIDs, is a highly effective non-operative option. Results have shown a high success rate in decreasing the severity of symptoms.[4] Ice, resting, taping the knee and appropriate footwear are also useful.

Rehabilitation exercises can restore patellofemoral joint homeostasis, although the anatomical malalignment may not be corrected. The shape and size of the patella and trochlear groove are limiting factors in the outcome of rehabilitation. The aim of exercise is to build muscle, improve tracking and enhance control without causing pain, which is where the skill of the physiotherapy and rehabilitation team is needed. Quadriceps strengthening is most commonly recommended as the quadriceps play a large role in patellar movement. Gluteal control is key and hip, hamstring, calf and iliotibial band stretching may also be important.

What surgical options are available?
Surgery for patellofemoral pain syndrome is a last resort and should only be considered if a precise anatomical problem is identified that can be addressed. Moreover, surgery alone is never enough – it must be followed by appropriate physiotherapy. Patellar chondral defects may be improved by an arthroscopic surgical procedure to smooth out the surface of the patella or trochlea.

If the problem is clearly caused by excessive lateral tracking secondary to patellar tilt but without patellar subluxation, a lateral release is sometimes appropriate. But other options and treatments should be considered before this. For example, consider whether the lateral tracking could simply be due to a tight iliotibial band or weak quadriceps muscles. Taping the knee to enhance medial glide should be tried. Having the patient wear a quality running shoe or arch support is another measure to try before surgery is contemplated.

Professor Fares Haddad is a consultant orthopaedic surgeon and Mr Tony Fayad is a trauma and orthopaedics registrar at University College London Hospital

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2 Waryasz G and McDermott A. Patellofemoral pain syndrome: a systematic review of anatomy and potential risk factors. *Dyn Med* 2008;7:9
3 Al-Rawi Z and Nessan A. Joint hypermobility in patients with chondromalacia patellae. *Br J Rheumatol* 1997;36:1334-7
4 Kannus P, Natri A, Paakkala T and Järvinen M. An outcome study of chronic patellofemoral pain syndrome. Seven-year follow-up of patients in a randomised, controlled trial. *J Bone Joint Surg Am* 1999;81:355-63

MORE ONLINE
Go to pulsetoday.co.uk/gp-videos to watch a video of an exercise programme for anterior knee pain

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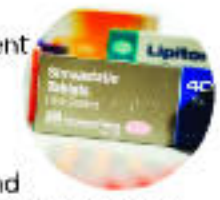

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> Dr Joseph Maguire

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TEN TOP TIPS

Oxygen prescribing

Respiratory specialist Dr John Williams offers his advice on how and when to use oxygen

1 Always do finger oximetry on breathless patients.
Each GP and health professional involved in assessing breathless patients should have a pulse oximeter. These are cheap – at less than £50 – easy to use and a far more accurate way of estimating oxygenation than looking for cyanosis.

2 Be aware of the new oxygen contract.
A new home oxygen contract has been agreed between the Department of Health and a number of providers and will be fully implemented across England and Wales by 2013. There is great emphasis on the establishment of more cost-effective assessment and a prescribing service, by delegating the prescribing of all oxygen therapy to a dedicated home oxygen service assessment and review team, along with a new pricing mechanism. The new contract provides an ideal opportunity to address prescribing issues, deliver value for money and reduce the risks associated with prescribing oxygen.

3 Ensure all patients on oxygen receive regular review.
Oxygen is a powerful, yet potentially lethal, drug. For example, patients with non-COPD causes for hypoventilation – such as the morbidly obese and patients with neuromuscular disease – can die from abolition of the hypoxic drive when excess oxygen is given, so those who are on oxygen need to be closely monitored. There are established guidelines for the content and frequency of these reviews, which can be done by home review teams.

4 Do a risk assessment before referring a patient for oxygen.

Patients on oxygen commonly continue to smoke. Oxygen lingers around the patient for at least 20 minutes after the oxygen flow stops.

There are several cases each year of significant burns and deaths in patients who continue to smoke while on oxygen.

A patient who requires oxygen should have a thorough risk assessment to estimate the risks to the patient, and their carers and neighbours.

Prescribers will need to account, usually to the coroner in fatal cases, for the risk-assessment procedure they carried out should injury occur as a result of oxygen therapy.

5 Do not prescribe oxygen for dyspnoea in the absence of hypoxaemia.

There is no evidence that oxygen is effective at relieving dyspnoea in palliative care or any other type of patient in the absence of hypoxaemia – defined as an oxygen saturation of 92% or less.

If there is no hypoxaemia, either at rest or on exertion, then oxygen therapy is not indicated.

Seek other remedies to correct the dyspnoea. Once oxygen is prescribed in these circumstances, it is very difficult to stop.

6 Understand new prescribing restrictions.

With the new oxygen contract, there is also a new home oxygen order form.

Non-specialists – any prescriber who is not part of an oxygen assessment and review centre or respiratory team (including paediatric) – will only be allowed to prescribe long-term oxygen therapy and static cylinders as a temporary emergency measure prior to an assessment of the patient's needs by an oxygen assessment and review team.

7 The need for long-term oxygen should prompt end-of-life discussions.

Long-term oxygen for lung disease means the patient's respiratory reserve is severely limited.

It should be a trigger for you to consider end-of-life discussions.

8 Only use short-burst oxygen therapy for cluster headaches.

Short-burst oxygen therapy – for periods of around 10-20 minutes at a time – is only the therapy of choice for cluster headaches.

There is no evidence that short-burst oxygen therapy is effective at relieving dyspnoea, and it is an expensive placebo.

Long-term oxygen therapy – more than 15 hours per day – for hypoxaemic patients with COPD prolongs survival, which is a major aim of the NHS Outcomes Strategy for COPD.

The correction of hypoxaemia with supplemental oxygen improves quality of life.

9 Audit your patients on oxygen.

Estimate the current cost of oxygen therapy in your practice. Currently 85,000 patients in England have oxygen at home at a cost to the NHS of around £110m a year.

Between 24-43% of the oxygen that is prescribed to these patients is not used properly or confers no clinical benefit.

10 Understand your legal responsibilities as a prescriber.

Whoever ultimately prescribes oxygen takes clinical and legal responsibility for the patient receiving it and removing it when it is not needed. Prescribers will have to sign a declaration when they order oxygen confirming the accuracy of the form, that they are the registered healthcare professional responsible for the information provided and accepting that providing false information may lead to prosecution or civil proceedings. They also need to confirm that the patient has read and signed the consent form.

Dr John Williams is a respiratory consultant at Warrington and Halton Hospitals NHS Foundation Trust and co-lead of the North West SHA respiratory pathway team

This article was co-authored by Dr Ruth Hunter, assistant commissioner for NHS Merseyside.

The Primary Care Respiratory Society UK (PCRS-UK) is the UK-wide professional society committed to improving respiratory care in primary care. PCRS-UK is a registered charity, led by its members through a range of committees and faculties dedicated to meeting the vision of 'optimal respiratory care for all' by providing education, policy support and research. As a member you'll have unlimited access to a wealth of specialist respiratory care information, expertise and resources, plus practical everyday tools to help you make a difference in respiratory care. For more information about PCRS-UK and how to join, go to pcrs-uk.org/join.

Further reading

- Primary Care Respiratory Society. *Home oxygen therapy*. Opinion Sheet 2011;32. pcrs-uk.org
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POST-OP PROBLEMS

Ophthalmology

Mr Nick Astbury, consultant ophthalmologist, and Dr Tsveta Ivanova, ophthalmology SpR, discuss post-operative complications of a common elective procedure – cataract surgery

Cataract surgery with implantation of an intraocular lens remains the most common elective procedure in the UK, with some 340,000 operations per year. It is now almost exclusively performed as a day-case procedure. Overall, the results of cataract surgery are excellent, with 95% of patients (without pre-existing macular degeneration, glaucoma or diabetic retinopathy) achieving 6/12 vision or better.[1]

But there are a number of factors that can increase the risk of an unsuccessful outcome – such as a patient who can't keep still, an eye that is deep set and small or difficult-to-access pupils. The average age for cataract surgery is 75, so the risk of some ocular comorbidity is also high, with less chance of a successful outcome.

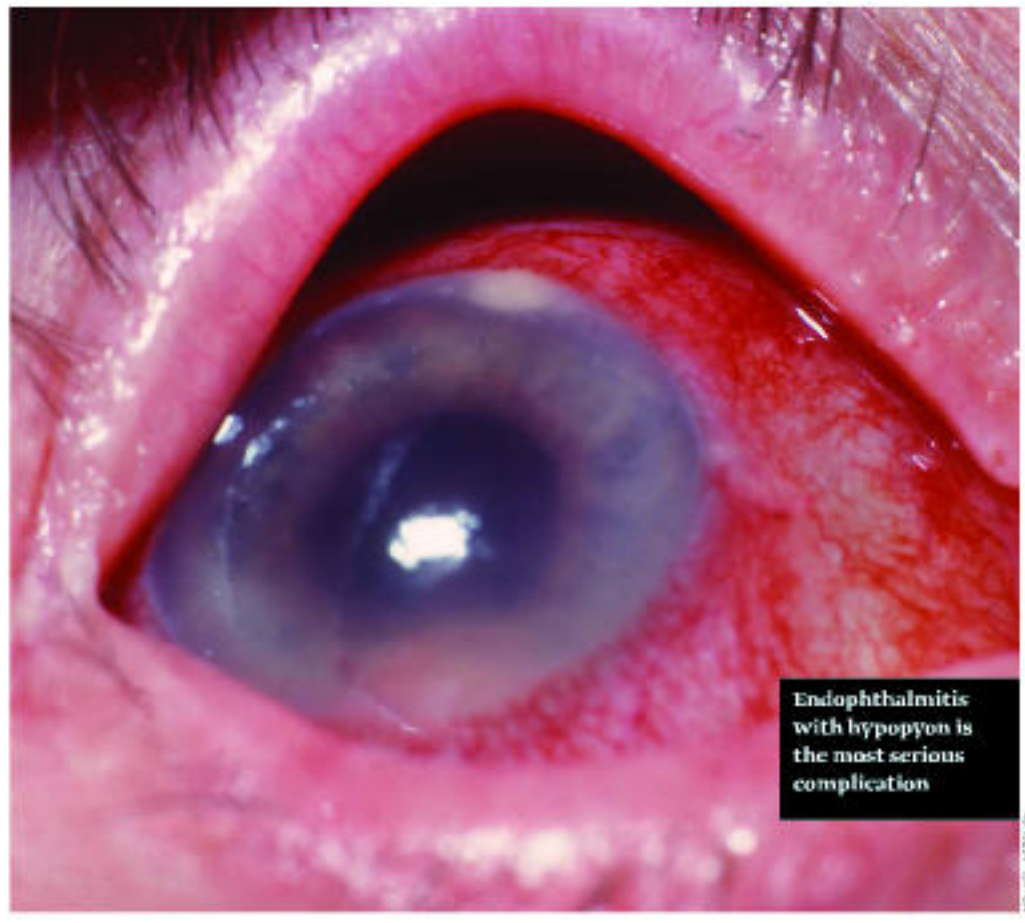
If the thin posterior capsule is ruptured and the vitreous jelly prolapses – which occurs in 2-4% of cases – there is a higher risk of post-operative complications such as endophthalmitis, retinal detachment or macular oedema.

The patient should have been given comprehensive information before surgery, and the nurses on the cataract day unit advise them about post-operative problems and give out an information sheet with a telephone number to ring if necessary (see the box, below right, for a typical template[1]).

Yet many patients still do not have a clear idea of what a cataract actually is or the potential complications. So it is important that GPs know the basics of what the operation entails and what can go wrong to enable any post-operative

Classification

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



Endophthalmitis with hypopyon is the most serious complication

problems to be appropriately referred.

Potentially blinding complications such as endophthalmitis are rare, but must be recognised early. Patients with longer-term problems, such as reduced vision caused by posterior capsular opacification or associated with comorbidity, may need to be referred to the optometrist or directly back to the eye clinic.

Complications are rare and in most cases can be treated effectively. In a small proportion of cases, further surgery may be needed. Very rarely some complications can result in blindness. As a general rule, pain, redness or reduced vision should trigger referral.

Immediate/early

- *Mild irritation* is unlikely to indicate a problem. Most patients go home shortly after surgery with the eye covered with a plastic shield to discourage touching the eye and to reduce discharge. Mild irritation usually settles down over one to two days and the eyesight gradually improves – so a watch-and-wait approach here is fine. But severe pain is unusual and may indicate raised intraocular pressure or the start of an infection, so this requires urgent referral.
- *Bruising or swelling of the eyelids* or sub-conjunctival swelling may occur if a sub-Tenon's or peribulbar local anaesthetic injection has been given, and will settle over a week to 10 days. But intraocular haemorrhage – hyphaema – caused by a bleeding wound or iris is rare and requires referral.

Early

- *Allergic reaction* to the steroid or antibiotic drops prescribed post-operatively is rare. The patient will present with itching, local erythema and oedema around the eye. Stopping the drops or using 1% hydrocortisone cream will allow it to settle.
- *High pressure inside the eye* is common post-operatively and may be caused by retained viscoelastic jelly used to facilitate the surgery. It usually settles without treatment. Patients with pre-existing glaucoma are more susceptible to this complication, so a review on the day after surgery is arranged for these patients.
- A *leaking wound* requires referral – suturing may be necessary. Cataract surgery involves a very small sutureless self-sealing incision through which the lens is broken into small pieces using ultrasound phacoemulsification and suction. A three-step corneal incision is performed and its edges are often hydrated at the end of the procedure to ensure a tight seal. But larger wounds sometimes leak, causing the eye to be soft. The eyesight may be blurred and there is an increased risk of infection.
- *Clouding of the cornea* may occur after a prolonged operation, on dense cataracts that require a lot of ultrasound energy or if there is a pre-existing corneal dystrophy. This will usually clear gradually over a few weeks or, rarely, months. In the rare cases that the cornea does not clear spontaneously, corneal transplant surgery may be necessary.
- *Decentration or dislocation of the implanted intraocular lens* may present with blurred vision or pain. If the intraocular lens haptics (loops) have been misplaced the lens may be decentred, or if the operation has been complicated and the posterior capsule ruptured, the intraocular lens may have fallen back into the eye. Blurred vision and pain are worrying symptoms, so the patient needs referral – unless the ophthalmologist has said that nothing more can be done.
- *An incorrect power implant* is inserted in approximately 5-10% of lens implantations. Most are caused by human error and are avoidable. Accurate pre-operative biometry and strict adherence to protocol should prevent the wrong intraocular lens being implanted. With the introduction of phacoemulsifation, the main incision is very small – approximately 2.5mm – so that astigmatism is minimal compared with the older extracapsular procedure and a larger incision.
- *Eye infection* (endophthalmitis) is the most serious complication and has an incidence of 0.14%. It can develop acutely in two to five days. Pain is a prominent symptom, and ciliary injection (redness around the cornea) and conjunctival chemosis occur. Pus in the eye (hypopyon) may be visible in the anterior chamber. Immediate referral for culture and intravitreal antibiotics may save the eye.

Late

- *Cystoid macular oedema* is often the cause of unexpected visual loss and may become evident three or four weeks after surgery. It is more likely if the operation has been complicated or associated with diabetic retinopathy or pre-existing macular scarring. It may resolve spontaneously over weeks or months and is often treated with topical steroids or NSAIDs. As a precaution, most patients suffering from diabetic retinopathy or epiretinal membranes (pre-existing scarring at the macula) are given anti-inflammatory medication prophylactically after their surgery.
- *Retinal detachment* may occur weeks or months after surgery, and is more common in highly myopic people or after complicated surgery. The symptoms may include 'flashes and floaters' and a peripheral 'shadow' across the vision. Refer immediately.
- *Posterior capsular opacification* occurs in 10% of cases within two years of surgery, and is the most common reason for further intervention after cataract surgery. It is caused by lens epithelial cells migrating across the normally clear posterior capsule of the lens and leads to blurred vision and glare. A routine referral for treatment with YAG laser in the eye clinic is appropriate.

Mr Nick Astbury is a consultant ophthalmologist and chair of VISION 2020 UK and Dr Tsveta Ivanova is an SpR in ophthalmology at Norfolk and Norwich University Hospital NHS Trust

VISION 2020 UK is a cross-sector initiative that works to reduce avoidable sight loss by 2020. For more information, including free guidance on commissioning eye care services, go to vision2020uk.org.uk/UKVisionstrategy.

Reference

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Further reading

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MORE ONLINE
Go to the online version of this article at pulse-learning.co.uk for pictures of a decentred intraocular lens, posterior capsular opacification, an allergic reaction to eye drops and intraocular haemorrhage

A typical patient information sheet

If you have discomfort, we suggest you take a pain reliever such as paracetamol every four to six hours – but not aspirin, as this can cause bleeding. It is normal to feel itching, sticky eyelids and mild discomfort for a while after cataract surgery. Some fluid discharge is common. After a few days, even mild discomfort should disappear.

In most cases, healing will take about two to six weeks, after which new glasses can be prescribed by your optician.

You will be given eye drops to reduce inflammation. The hospital staff will explain how and when to use them. Please don't rub your eye. Certain symptoms or signs could mean that you need prompt treatment, including:

- **excessive pain**
- **loss of vision**
- **increasing redness of the eye.**

You will be given an emergency telephone number to ring in case you develop any of the above or should you need urgent advice about your eye.

26 PULSESERVICES
TRAVEL VACCINATIONS & MALARIA PROPHYLAXIS

Updated: July 2012

Destination	Hepatitis A & typhoid	Cholera	Polio	Diphtheria	Tuberculosis	Hepatitis B & rabies	Yellow fever	Tick-borne encephalitis	Japanese encephalitis/ Meningo/ACWY	Risk areas and seasons	Malaria: Recommended regimen	Malaria: Alternative regimen	Main parasitic hazards
Abu Dhabi	S	R			S		S	S			No		Le
Afghanistan	R	R	S	R	R	S	S	S	C		Yes, below 2,000m, May–Nov	ME or DO or MON	PC Le
Albania	S	R					S	S	C		S No		Le
Algeria	R	R			S	S	S	S	C		Yes, area around Biskra	W	Sh Le
Angola	R	R	S	R	R	S	S	S	M		Yes, high risk	ME or DO or MON	PC Sh Ta
Antigua & Barbuda		S					S		C		No		
Argentina	S	R					S	S	S		Yes, rural areas near ME border with Bolivia and NW border with Brazil and Paraguay	C	P
											Other areas very low	W	
Armenia	S	R			S	S	S	S			S No	W	
Australia									C	S	No		
Austria											S No		
Azerbaijan	S	R				S	S	S			S Variable risk at SW border Jun–Oct	C	P Le
Bahamas		R					S		C		No		
Bahrain	S	R				S	S	S	C		No		Le
Bali	R	R			R	S	S	S	C	S	Yes, low risk	W	
Bangladesh	R	R	S		R	S	S	S	C	S	Yes, SE and Chittagong Hill Tracts. Elsewhere, low risk	ME or DO or MON W	PC Le
Barbados		S			S		S		C		No		
Belarus		R			S	S	S	S			S No		
Belize	S	R				S	S	S	C		Variable risk in south, low risk Belize City	C	P
Benin Republic	R	R	S	R	S	S	S	S	M	S	Yes, high risk	ME or DO or MON	PC Sh Le
Bermuda		S					S				No		
Bhutan	R	R	S			S	S	S	C	S	Yes, southern districts	ME or DO or MON	DPF Le
Bolivia	R	R			R	S	S	S	R		Yes, high risk in Amazon basin. Variable risk on Paraguayan and Argentine borders	ME or DO or MON PC	PC DPF
Borneo	R	R	S		S	S	S	S	C	S	Low risk, coastal areas of Malaysian Sarawak and Sabah. Indonesian Kalimantan, high risk all areas	W ME or DO or MON PC	PC PC
Bosnia		R			S	S	S	S			S No		Le
Botswana	R	R	S		S	S	S	S	C		Yes, northern half only Nov–June	ME or DO or MON	PC Sh Ta
Brazil	S	R			S	S	S	S	R		High risk in NW half in Amazonia states. Elsewhere, very low	ME or DO or MON W	PC Sh Le Tc
Brunei		R				S	S	S	C	S	No		
Bulgaria		R				S	S	S		S	No		
Burkina Faso	R	R	S	R	R	S	S	S	M	S	Yes, high risk	ME or DO or MON	PC Sh Le Ta
Burundi	R	R	S			S	S	S	M		Yes, high risk	ME or DO or MON	PC Sh Ta
Cambodia	R	R	S		R	S	S	S	C	S	Yes Yes, significant risk elsewhere. Minimal risk Phnom Penh, Angkor Wat, Siem Reap	DO or MON ME or DO or MON W	PC PC
Cameroon	R	R	S		R	S	S	S	M	S	Yes, high risk	ME or DO or MON	PC Sh Ta
Canada											No		
Cape Verde Islands	R	R			S	S	S	S	C		Yes, very low risk Aug–Nov	W	Le
Cayman Islands		S					S				No		
Central African Rep.	R	R	S	R	R	S	S	S	M	S	Yes, high risk	ME or DO or MON	PC Sh Ta
Chad	R	R	S	R	R	S	S	S	R	S	Yes, high risk	ME or DO or MON	PC Sh Ta
Chile	S	R					S	S			No		Tc
China (Mainland)	S	R	S	R		S	S	S	C	S	S Yes, in Yunnan and inland Hainan. Elsewhere, very low/no risk	ME or DO or MON W	PC Sh
China (Hong Kong)		R				S	S				No		
China (Macao)		R				S	S	S		S	No		
Colombia	S	R					S	S	R		Yes, high Eastern half. Variable risk elsewhere <1,600m. Very low around Medellín, Bogotá & Cartagena	ME or DO or MON PC W	PC Le Ta DPF
Comoros	R	R	S		S	S	S	S			Yes, high risk	ME or DO or MON	PC Le
Congo	R	R	S	R	R	S	S	S	M		Yes, high risk	ME or DO or MON	PC Sh Ta
Congo Dem. Rep.	R	R	S	R	R	S	S	S	M	S	Yes, high risk	ME or DO or MON	PC Sh Ta
Cook Islands		R					S				No		
Costa Rica		R			S		S	S	C		Small variable risk area on East coast. Rest of country, low risk	C W	P Le Tc
Croatia		S					S	S			S No		Le
Cuba		R					S	S			No		
Cyprus		S									No		Le

Destination	Hepatitis A & typhoid	Cholera	Polio	Diphtheria	Tuberculosis	Hepatitis B & rabies	Yellow fever	Tick-borne encephalitis	Japanese encephalitis/ Meningo/ACWY	Risk areas and seasons	Malaria: Recommended regimen	Malaria: Alternative regimen	Main parasitic hazards
Czech Republic		S					S			S	No		
Djibouti	R	R	S		S	S	S	S	C		Yes, high risk	ME or DO or MON	PC Sh Le
Dominican Republic	R	R	S		R	S	S	S			Yes, high risk along Haitian border, variable risk elsewhere	C	P Sh Le
Dubai	S	R			S		S	S			No		Le
East Timor (Timor Leste)	R	R			S	S	S	S	C	S	Yes, high risk	ME or DO or MON	PC Le
Ecuador	R	R				S	S	S	R		Yes, high risk Esmeraldas and rainforest/jungle areas bordering Colombia and Peru. Elsewhere, low risk	ME or DO or MON W	PC Tc
Egypt	R	R					S	S	C		No		
El Salvador	R	R					S	S	C		Yes, low risk	W	
Equatorial Guinea	R	R	S		R	S	S	S	R		Yes, high risk	ME or DO or MON	PC Sh Ta
Eritrea	R	R	S		R	S	S	S	C	S	Yes, high risk (no risk in Asmara)	ME or DO or MON	PC Sh Le
Estonia		S					S	S		S	No		
Ethiopia	R	R	S		R	S	S	S	R	S	Yes, high risk below 2,000m (low risk in Addis Ababa)	ME or DO or MON	PC Sh
Falklands (Tristan da C.)											No		
Fiji	S	R			R		S		C		No		
Finland										S	No		
France										S	No		Le
French Guiana	S	R			S	S	S	S	M		High risk inland and border areas, coast and islands, low no risk	ME or DO or MON	PC Sh Tc
French Polynesia		R					S				No		
Gabon	R	R	S	R	R	S	S	S	M		Yes, high risk	ME or DO or MON	PC Sh
Gambia	R	R				S	S	S	R	S	Yes, high risk	ME or DO or MON	PC Sh Ta
Georgia	S	R				S	S	S		S	Yes, v. low risk SE villages Jul–Oct	W	
Germany										S	No		
Ghana	R	R	S		R	S	S	S	M	S	Yes, high risk	ME or DO or MON	PC Sh Ta
Goa	R	R		R	R	S	S	S	C	S	Yes, variable risk	PC	DPF Le
Greece and Islands		S					S			S	No		Le
Greenland		R			S		S	S			No		
Grenada		S					S	S	C		No		
Guadeloupe		S				S	S		C		No		
Guam		R				S	S				No		
Guatemala	S	R				S	S	S	C		Yes, some risk below 1,500m	C	P
Guinea	R	R	S	R	R	S	S	S	R	S	Yes, high risk	ME or DO or MON	PC Sh Ta
Guinea Bissau	R	R	S		S	S	S	S	M	S	Yes, high risk	ME or DO or MON	PC Sh Ta
Guyana	S	R				S	S	S	R		Yes, high risk all areas except coastal strip	ME or DO or MON	PC Sh
Haiti	R	R	S		R	S	S	S	C		Yes, high risk throughout country	ME or DO or MON	PC
Hawaii							S				No		
Honduras	R	R				S	S	S	C		Yes, risk variable	C	P Le
Hungary							S			S	No		
India	R	R	S	R	R	S	S	S	C	S	Yes, high risk Assam Yes, low risk in southern states, Delhi, Jaipur, Agra, Mumbai Yes, elsewhere	ME or DO or MON W PC	PC Le DPF
Indonesia	R	R	S		R	S	S	S	C	S	Yes, high in Lombok Very low in Bali and cities Yes, variable elsewhere	ME or DO or MON W PC	PC Sh DPF
Iran	S	R	S		S		S	S	C		Yes, rural SE provinces Mar–Nov	ME or DO or MON	PC Sh Le
Iraq	R	R	S		R	S	S	S	C		Yes, v. low risk rural north May–Nov	W	P Sh Le
Israel		R					S	S			No		Le
Italy		S					S			S	No		Le
Ivory Coast	R	R	S	R	R	S	S	S	M	S	Yes, high risk	ME or DO or MON	PC Ta
Jamaica		R			S		S		C		No		
Japan							S			S	S No		Sh
Jordan	S	R					S	S	C		No		Le
Kazakhstan		R			R	S	S	S	C		S No		Le
Kenya	R	R	S	R	R	S	S	S	R	S	Yes, high risk (Nairobi and highlands low risk)	ME or DO or MON	PC Sh Le Ta
Kiribati	S	R			S	S	S		C		No		
Korea (North)	R	R			S	S	S	S	C	S	Yes, limited risk extreme south	W	
Korea (South)	S	R				S	S			S	Yes, limited risk extreme south	W	
Kosovo		R				S	S	S		S	No		Le
Kuwait	S	R			R		S				No		
Kyrgyzstan	S	R		R	R	S	S	S		S	Yes, low risk some S to W areas	W	Le
Laos	R	R	S		R	S	S	S	C	S	Yes, high risk (minimal risk Vientiane)	ME or DO or MON	PC
Latvia	S	S			S	S	S	S		S	No		

Key

- **M** = immunisation mandatory
- **R** = immunisation recommended as risk of infection is substantial
- **S** = immunisation sometimes recommended:
  - for more than three visits in a one-year period
  - a stay of more than three months in a rural area
  - for high-risk occupational groups
  - for backpackers staying more than one month
  - when entering the limited geographical risk area for the target disease
- **C** = See Yellow fever, next column

Where **S** appears for cholera, it indicates that only high-risk travellers, usually healthcare workers in areas of known epidemics, should be immunised.

Vaccinations information

Tetanus
Five tetanus doses are considered protective for life by the DH, although there is no evidence base for this. Travellers at risk of tetanus-prone wounds should be given 10-yearly boosters if they are going to poorer countries in Africa, Asia and South America where specific immunoglobulin may be unavailable.

Polio
All travellers should have completed the British vaccination schedule for polio immunisation in childhood or as adults.

Yellow fever
● An international certificate of vaccination may be required for those entering from, or transiting through airports in YF endemic countries where **C**, **S**, **R** or **M** appears indicated in the yellow fever column. For details consult: http://wwwnc.cdc.gov/travel/yellowbook/2012/chapter-3-infectious-diseases-related-to-travel/yellow-fever-and-malaria-information-by-country.htm#seldyfm298

● **M** = Mandatory generally indicates that all travellers aged >12 months should carry an international certificate of vaccination. Country specific ages are indicated in the web site above.

Information source and updates
This chart is based on information from the UK TRAVAX website and other databases. TRAVAX is an information service provided by Health Protection Scotland (www.travax.scot.nhs.uk; telephone 0141 300 1130).

The chart is updated regularly. Readers are advised to use the latest chart only, to ensure that their practice reflects the most recent advice.

Travel vaccinations and malaria information author
Dr Michael Jones, consultant physician, Regional Infectious Disease Unit, Western General Hospital, Edinburgh

Parasitic infections

Short-term travellers staying in good conditions are usually at low risk of acquiring parasitic infections. Schistosomiasis is common and potentially serious. Leishmaniasis and trypanosomiasis are less common but potentially lethal. Expatriates in remote areas at risk of other rare diseases are not shown in this chart.

Sh = schistosomiasis. Travellers should avoid swimming in freshwater lakes and rivers in endemic areas.

Ta = African trypanosomiasis (sleeping sickness). Transmitted by tse-tse flies, and a risk in some African game parks and rural areas. Travellers should use insect repellents, close windows if fly swarms approach and seek medical attention for any signs of infection around bites one to three weeks later.

Tc = South American trypanosomiasis (Chagas' disease). Transmitted by reduvid bugs that feed at night and reside in the thatch and crevices of rural dwellings. Travellers should avoid sleeping in huts.

Le = leishmaniasis. Transmitted by sandflies in arid areas (including Mediterranean coastal areas), mostly at night. Travellers should use insecticide-impregnated mosquito nets and insect repellent.

Travel medicine update

Measles in Ukraine and Russian Federation
By the end of May, 10,000 cases of measles had been reported in Ukraine, most in the western regions bordering Poland, but also in the Russian Federation – where since the start of 2012, the incidence of measles has increased over 22 times compared with the same time period in 2011. In Russia, this is mostly in the Central, Southern and Northern Caucasus federal districts. GPs should be aware of the increased risk to unimmunised travellers, particularly football fans returning from Euro 2012. Any unimmunised adults born since 1970 planning travel should be offered two doses of MMR vaccine.

Leptospirosis in Thailand
Leptospirosis has long been a particular risk for travellers venturing into the forests of Malaysia and Thailand. Health officials in north-east Thailand have reported an outbreak of leptospirosis during this rainy season, and since January over 700 cases, causing 17 deaths, were recorded. Leptospirosis is caused by contact with fresh water, wet soil or vegetation that has been contaminated by urine, often from rats, but also dogs, cattle and pigs. An additional benefit of doxycycline antimalarial prophylaxis, where indicated, is its action preventing leptospirosis.

Cholera in the Philippines
An outbreak of cholera in the province of Catanduanes in the Philippines has been declared, with over 1,300 cases and eight cholera-related deaths recorded since January 2012. The worst-affected area is the town of Virac, with 748 cases and six deaths reported. Travellers should maintain a high standard of food, water and personal hygiene. The oral vaccine may be considered for those likely to be in direct contact with cholera cases or who cannot maintain safe food and water precautions.

Source
travax.nhs.uk

Specialist advice

For advice on complex itineraries and other queries, use the following helplines:
Birmingham 0121 424 0357/ 3354/2357
Edinburgh, Western General Hospital 0131 537 2822
National Travel Health Network and Centre (Monday to Friday, 9am-12pm, 2pm-4.30pm) 0845 602 6712 (local call rate)

PULSE

Xifaxanta™ gets to work...

...here and only here[1,2]

The first and only virtually non-absorbed antibiotic licensed for the treatment of non-invasive Travellers' Diarrhoea[3]

LICENSED For Travellers' Diarrhoea

Xifaxanta™

Rifaximin-α

XIFAXANTA™ Prescribing Information
REFER TO FULL SUMMARY OF PRODUCT CHARACTERISTICS (SmPC) BEFORE PRESCRIBING.
Presentation: Film-coated tablet containing rifaximin 200 mg. **Uses:** Xifaxanta is indicated for the treatment of travellers' diarrhoea that is not associated with fever, bloody diarrhoea, eight or more unformed stools in the previous 24 h, occult blood or leucocytes in the stool. **Dosage and administration:** Adults over 18 years of age: 200 mg every 8 hours for three days (total 9 doses). Rifaximin must not be used for more than 3 days even if symptoms continue and a second course of treatment must not be taken. Not recommended in children under 18 years of age. **Contraindications:** Hypersensitivity to the active substance, to any rifamycin (e.g. rifampicin or rifabutin) or to any of the excipients. **Warnings and precautions for use:** Not recommended for the treatment of travellers' diarrhoea caused by invasive enteric pathogens. If symptoms worsen, treatment with rifaximin should be interrupted. If symptoms have not resolved after 3 days of treatment, or recur shortly afterwards, a second course is not recommended. The potential association of rifaximin treatment with *Clostridium difficile* associated diarrhoea and pseudomembranous colitis cannot be ruled out. **Interactions:** Due to the negligible gastrointestinal absorption of orally administered rifaximin (less than 1%), the systemic drug interaction potential is low. Rifaximin should not be administered concomitantly with other rifamycins and the tablets should not be administered for at least two hours after the administration of charcoal. **Pregnancy and lactation:** Rifaximin is not recommended during pregnancy and in women of childbearing potential not using contraception. The benefits of rifaximin treatment should be assessed against the need to continue breastfeeding. **Undesirable effects:** Common effects reported in clinical trials are dizziness, headache, abdominal pain, constipation, defecation urgency, diarrhoea, flatulence, bloating, distension, nausea, vomiting, rectal tenesmus and pyrexia. Other effects that have been reported are candidiasis, herpes simplex infections, clostridial infections, palpitations, increased blood pressure, liver function test abnormalities, blood disorders (e.g. thrombocytopenia) and anaphylactic reactions, (e.g. angioedemas, hypersensitivity and skin reactions). **Licensing and legal category:** Legal category: POM. **Cost:** Basic NHS price £15.15 (9 tablets). **MA number:** PL 20011/0021. **For further information contact:** Norgine Pharmaceuticals Limited, Norgine House, Moorhall Road, Harefield, Middlesex, UB9 6NS. 01895 826606. E-mail: medinfo@norgine.com. **Date of preparation/revision:** XIF/2960/JUN/12.

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 Medical Information at Norgine Pharmaceuticals Ltd on 01895 826606.

References
1. Jiang ZD *et al.* Antimicrob Agents Chemother 2000;44(8):2205-2206.
2. Descombe JJ *et al.* Int J Clin Pharmacol Res 1994;14 (2):51-56.
3. Xifaxanta™ Summary of Product Characteristics.

NORGINE

XIF/3019/AUG/12 Date of preparation: August 2012

PULSESERVICES
TRAVEL VACCINATIONS & MALARIA PROPHYLAXIS

Updated: July 2012

Destination	Typhoid	Hepatitis A	Cholera	Polio	Diphtheria	Tuberculosis	Hepatitis B	Rabies	Yellow fever	Meningitis/ACWY	Japanese enceph	Tick-borne encephalitis	Malaria: Risk areas and seasons	Malaria: Recommended regimen	Malaria: Alternative regimen	Main parasitic hazards
Lebanon	S	R			S		S	S	C				No			Le
Lesotho	R	R	S		S	S	S	S	C				No			Sh
Liberia	R	R	S	R	S	S	S	S	M				Yes, high risk	ME or DO or MON	PC	Sh Ta
Libya	S	R			S	S	S	S	C				No risk			Le
Liechtenstein		S					S					S	No			
Lithuania		S				S	S	S				S	No			
Macedonia		R					S	S				S	No			Le
Madagascar	R	R			S	S	S	S	C				Yes, high risk	ME or DO or MON	PC	Sh
Madeira		S					S						No			
Malawi	R	R	S			S	S	S	C				Yes, high risk	ME or DO or MON	PC	Sh Ta
Malaysia	R	R	S		S	S	S	S	C		S		Yes, high risk Sabah and deep forests of peninsular Malaysia	ME or DO or MON	PC	
Maldives	R	R				S	S	S	C				No			
Mali	R	R	S	R	R	S	S	S	M	S			Yes, high risk	ME or DO or MON	PC	Ta
Malta and Gozo		S					S		C				No			Le
Martinique		S				S	S		C				No			Sh
Mauritania	R	R	S	R	R	S	S	S	R	S			Yes, high risk all year in south Low risk in far north	ME or DO or MON	PC	Sh Le
Mauritius		R					S		C				No	W		
Mayotte	R	R				S	S	S	C				Yes, high risk	ME or DO or MON	PC	Le
Mexico	R	R					S	S					Yes, southern rural areas only Elsewhere and tourist areas	C W	P	Tc
Moldova	S	R			S	S	S	S				S	No			
Mongolia	S	R				S	S	S				S	No			
Montenegro		R				S	S	S				S	No			Le
Montserrat		S					S		C				No			
Morocco	R	R				S	S	S					No	W		Le
Mozambique	R	R	S		R	S	S	S	C				Yes, high risk	ME or DO or MON	PC	Sh Ta
Myanmar (Burma)	R	R	S		R	S	S	S	C		S		Yes, Kayin and East Shan state Yes, elsewhere Low/no risk Mandalay & Yangon	DO or MON ME or DO or MON W	PC PC	
Namibia	R	R	S		S	S	S	S	C				Yes, north-east third only Yes, all year – along Kavango and Kunene Rivers	ME or DO or MON	PC	Sh
Nepal	R	R	S	R	R	S	S	S	C		S		Yes, below 1,500m (no risk in Kathmandu)	PC	DRF	Le
Neth Antilles		S					S		C				No			
Netherlands													No			
New Caledonia	S	R					S		C				No			
New Zealand													No			
Nicaragua	R	R				S	S	S	C				Yes, variable risk in north, low risk in south	C	P	Le Tc
Niger	R	R	S	R	R	S	S	S	M	S			Yes, high risk	ME or DO or MON	PC	Sh Ta
Nigeria	R	R	S	R	R	S	S	S	R	S			Yes, high risk	ME or DO or MON	PC	Sh Ta
Norway		S										S	No			
Oman	S	R					S	S	C				Sporadic, imported risk	W		Sh Le
Pakistan	R	R	S	R	R	S	S	S	C		S		Yes, significant below 2,000m	ME or DO or MON	PC	PC
Panama	R	R			S	S	S	S	R				Yes, high risk NE coast & Colombia border Variable risk east & west of Canal	ME or DO or MON C	PC P	
Papua New Guinea	R	R	S		R	S	S	S	C		S		Yes, high risk below 1,800m	ME or DO or MON	PC	
Paraguay	R	R			S	S	S	S	R				Yes, extreme eastern areas, Oct-May	C	P	Le Tc
Peru	R	R				S	S	S	R				Yes, high risk in Amazonian Loreto Dept. Variable risk SE area bordering Brazil & Bolivia, and around Tumbes & Piura	ME or DO or MON C	PC P	Le Tc
Philippines	R	R	S		S	S	S	S	C		S		Yes, many rural areas below 600m No risk – Cebu, Bohol, Catanduanes	PC W	DRF	Sh
Poland		S					S	S				S	No			
Portugal		S					S						No			
Puerto Rico		R			S		S	S					No			Sh Le
Qatar	S	R				S	S	S					No			Le
Reunion		R				S	S		C				No			Sh
Romania	S	R				S	S	S				S	No			
Russian Federation	S	R			S	S	S	S	C		S	S	No			
Rwanda	R	R	S			S	S	S	M				Yes, high risk	ME or DO or MON	PC	Sh Ta
Sabah	R	R	S		S	S	S	S	C		S		Yes, high risk inland Low risk coastal area and Kota Kinabalu	ME or DO or MON W	PC	
Samoa	S	R			S		S	S	C				No			
Sao Tome	R	R	S			S	S	S	M				Yes, high risk	ME or DO or MON	PC	Sh Le
Saudi Arabia	S	R			R		S	S	C	S M			Yes, SW region, rural areas of W region Elsewhere (no risk Mecca, Medina)	ME or DO or MON W	PC	Sh Le
Senegal	R	R	S	R	R	S	S	S	R	S			Yes, high risk	ME or DO or MON	PC	Sh Ta
Serbia		R				S	S	S				S	No			Le
Seychelles	S	R				S	S		C				No			
Sierra Leone	R	R	S	R	R	S	S	S	M				Yes, high risk	ME or DO or MON	PC	Sh Ta
Singapore		S					S		C		S		No			
Slovakia		S					S	S				S	No			
Slovenia		S					S	S				S	No			
Solomon Islands	R	R			S	S	S		C				Yes, high risk	ME or DO or MON	PC	
Somalia	R	R	S		R	S	S	S	R				Yes, high risk	ME or DO or MON	PC	Sh Le
South Africa	S	R	S		S	S	S	S	C				Yes, NE rim bordering Zimbabwe, Mozambique & Eastern Swaziland, including Kruger, Kosi Bay & Jozini	ME or DO or MON	PC	Sh Ta
Spain		S					S						No			Le
Sri Lanka	R	R				S	S	S	C		S		Yes, far north and NE, north of Anuradhapura to Polonnaruwa Elsewhere	PC W	ME, DO DRF	
St Helena & Ascension		S							C				No			
St Kitts & Nevis		S					S		C				No			
St Lucia		S					S		C				No			
St Vincent & Grenadines		S					S		C				No			
Sudan	R	R	S	R	R	S	S	S	R	S			Yes, high risk	ME or DO or MON	PC	Sh Le
South Sudan	R	R	S	R	R	S	S	S	R	S			Yes, high risk	ME or DO or MON	PC	Sh Le
Surinam	S	R			S	S	S	S	R				Yes (except Paramaribo and coast)	ME or DO or MON	PC	Sh Le
Swaziland	R	R	S		S	S	S	S	C				Yes, high risk, eastern areas	ME or DO or MON	PC	Sh
Sweden		S										S	No			
Switzerland		S										S	No			
Syria	S	R			S		S	S	C				No			Sh Le
Taiwan		R				S	S				S		No			
Tajikistan	R	R	S			S	S	S				S	Yes, Jun-Oct variable on NW & SW borders	PC	ME, DO or MON	
Tanzania	R	R	S		R	S	S	S	R				Yes, high risk	ME or DO or MON	PC	Sh Ta
Thailand	S	R	S		S	S	S	S	C		S		Yes, on extreme fringe of international borders Elsewhere	DO or MON W		
Tibet	S	R	S	R	R	S	S	S	C		S		No			
Tobago		S			S		S	S	C				No			Tc
Togo	R	R	S		S	S	S	S	M	S			Yes, high risk	ME or DO or MON	PC	Sh Ta
Trinidad		S			S		S	S	R				No			Tc
Tunisia	R	R					S	S	C				No			Le
Turkey	S	R					S	S					Yes, Syria border May-Oct Elsewhere	C W	P	Le
Turkmenistan		R			S	S	S	S				S	No			
Uganda	R	R	S	R	R	S	S	S	R	S			Yes, high risk	ME or DO or MON	PC	Sh Ta
Ukraine	S	R			R	S	S	S				S	No			
United Arab Emirates	S	R			S		S	S					No			Le
Uruguay		R					S	S	C				No			Tc
USA													No			
Uzbekistan	S	R				S	S	S				S	Yes, very low risk extreme SE	W		Le
Vanuatu	S	R			S	S	S						Yes, high risk	ME or DO or MON	PC	
Venezuela	S	R			S		S	S	R				Yes, high risk to south of Orinoco River Variable/low risk north of Orinoco No risk Caracas or Margarita	ME or DO or MON C W	PC P	Le Tc
Vietnam	R	R	S		S	S	S	S	C		S		Low risk in cities, coast between Ho Chi Minh & Hanoi, Mekong Delta Elsewhere	W ME or DO or MON	PC	
Virgin Islands		S					S						No			
West Papua (formerly Irian Jaya)	R	R			R	S	S	S	C		S		Yes, high risk below 1800m	ME or DO or MON	PC	Sh Ta
Yemen	R	R	S		R	S	S	S	C				Yes, but no risk in Sana'a city	PC	DRF	Sh Le
Zambia	R	R	S		S	S	S	S	S				Yes, high risk	ME or DO or MON	PC	Sh Ta
Zimbabwe	R	R	S		S	S	S	S	C				Yes, high risk Zambezi valley Yes, elsewhere below 1,200m Nov-Jun Negligible risk Harare and Bulawayo	ME or DO or MON ME or DO or MON W	PC PC	Sh Ta

Key to malaria prophylaxis regimens

Regimen MON
Malarone (atovaquone/proguanil), one tablet daily. Begin 1-2 days before departure, continue while in malarious area and for 7 days after return. ACMP suggest Malarone is safe for periods in continuous use of at least 1 year and possibly longer. Safety in pregnancy has not been established, and use in pregnancy should only be considered if benefit to the mother outweighs risk to foetus. Children use paediatric tablets.

Regimen PC
Proguanil (Paludrine) 200mg daily plus chloroquine 300mg or 310mg base weekly (=Avloclor 2x250mg). Begin 1 week before travel and continue for 4 weeks after return.

Regimen ME
Mefloquine, 1x250mg tablet weekly. ACMP suggest it is safe in continuous use for periods of at least 3 years. Begin at least 2½ weeks before travel (at least 3 doses before arriving in malarious area). Avoid in first trimester of pregnancy and do not start pregnancy until 3 months after stopping mefloquine. Inadvertent use in first trimester is not an indication for termination. If pregnant women must travel to chloroquine-resistant falciparum area, seek expert advice and conduct careful risk-benefit analysis. Use in any trimester may be justified.

Regimen C
Chloroquine 300mg or 310mg base weekly (=Avloclor 2x250mg). Begin 1 week before travel and continue for 4 weeks after return.

Regimen P
Proguanil (Paludrine) 200mg daily. Begin 1-2 days before travel and continue for 4 weeks after return.

Regimen W
No chemoprophylaxis but be aware of risk. Avoid mosquito bites and carry standby treatment if going to be far from medical facilities.

Regimen DO
Doxycycline, 1 tablet of 100mg daily. Begin 1-2 days before travel and continue for 4 weeks after return. Not for children or pregnant women. Be aware of oesophageal ulceration, photosensitivity and very rare intracranial hypertension risk. Take with food or milk and avoid ingestion in late evening.

Regimen DRF
In the alternative regimen column, **DRF** is Drug-Resistant-Falciparum regimen. **DRF** = **ME** or **DO** or **MON**

Primaquine
A causal prophylactic that may be used when G6PD deficiency has been excluded in travellers with contra-indications to other anti-malarials. Active against all species. Adult dose 30mg daily. Start 1-2 days before departure and continue for 7 days after return.

Children's doses of antimalarial prophylactics

Weight in kg	Chloroquine Proguanil	Mefloquine	Age
Under 6.0	0.125 adult dose ¼ tablet	not recommended	term to 12 weeks
6.0 to 9.9	0.25 adult dose ½ tablet	0.25 adult dose ¼ tablet	3 months to 11 months
10.0 to 15.9	0.375 adult dose ¾ tablet	0.25 adult dose ¼ tablet	1 year to 3 years 11 months
16.0 to 24.9	0.5 adult dose 1 tablet	0.5 adult dose ½ tablet	4 years to 7 years 11 months
25.0 to 44.9	0.75 adult dose 1½ tablets	0.75 adult dose ¾ tablet	8 years to 12 years 11 months
45kg and over	Adult dose 2 tablets	Adult dose 1 tablet	13 years and over

Doxycycline only above 12 years and the adult dose is given

Children's doses

Paediatric malarone for prophylaxis

Weight in kg	Number of tablets daily
11-20	1 paediatric tablet
21-30	2 paediatric tablets
31-40	3 paediatric tablets
Above 40	1 adult tablet

Specialist advice

For malaria advice

Malaria Reference Laboratory
020 7636 3924 (health professionals only)
Birmingham 0121 424 0357/ 3354/2357
Edinburgh 0131 537 2822
Glasgow 0141 300 1130
Liverpool 0151 708 9393
Oxford 01865 225 214

TIP OF THE MONTH
A new quadrivalent menigococcal conjugate vaccine

GSK have just launched Nimenrix, a new quadrivalent conjugate meningococcal vaccine that also protects against invasive meningococcal disease caused by serogroups A, C, W-135 and Y. It can be given to individuals from 12 months of age, including those who may have previously received meningococcal ACWY polysaccharide (ACWY-PS) vaccine. The licence for Menveo, another quadrivalent conjugate meningococcal vaccine that launched two years ago, is for active immunisation of adolescents from 11 years of age and adults. The Joint Committee on Vaccination and Immunisation decided to recommend off-label use of Menveo, specifically in that a conjugate vaccine is recommended in preference to a plain vaccine in children under five years of age.

The data sheet for Nimenrix describes the trials supporting the licence application and indicates that this vaccine is non-inferior to ACWY-PS vaccines, and produces a better antibody response in young children. Responses for serogroup C are non-inferior to monovalent Men C conjugate vaccine. No side-by-side randomised controlled trials have yet been reported comparing Nimenrix with Menveo or Menactra, and these are eagerly awaited. Although we await further comment from JCVI, we now have a conjugate vaccine which is fully approved for use in small children travelling to areas where the quadrivalent vaccine is indicated.

References

1 dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_133117.pdf
2 medicines.org.uk/EMC/medicine/26514/SPC/Nimenrix/

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How analysing appointment data helped us free up GP time

Dr Joyce Robertson explains how the Peterhead Practice used tools in the Productive General Practice pilot to adjust skill mix and improve patient access

The problem

Peterhead is a large practice in a town near Aberdeen, with 12 GPs covering over 20,000 patients. I suspected we had inefficiencies in our day-to-day workflow, and knew from previous experience that in a large practice small changes often have big outcomes.

Like many other practices, we were keen to respond to the rising pressure being placed on us to deliver services.

We wanted to retain personal lists, which we felt contributed greatly to continuity of care. As continuity of care is also linked to the patient experience, we felt this was important to consider when obtaining and analysing data as part of the Productive General Practice (PGP) pilot.

PGP is a programme designed by the NHS Institute for Innovation and Improvement. Developed with GPs from NHS Scotland, it focuses on recent research by the King's Fund and Dr Stewart Mercer, chair of primary care research at the University of Glasgow, which found continuity of care improves the quality of care as well as practice productivity. Scottish practices like ours can register to use the programme free of charge and English, Welsh and Northern Irish practices can sign up through the NHS Institute for a fee starting from £2,100.

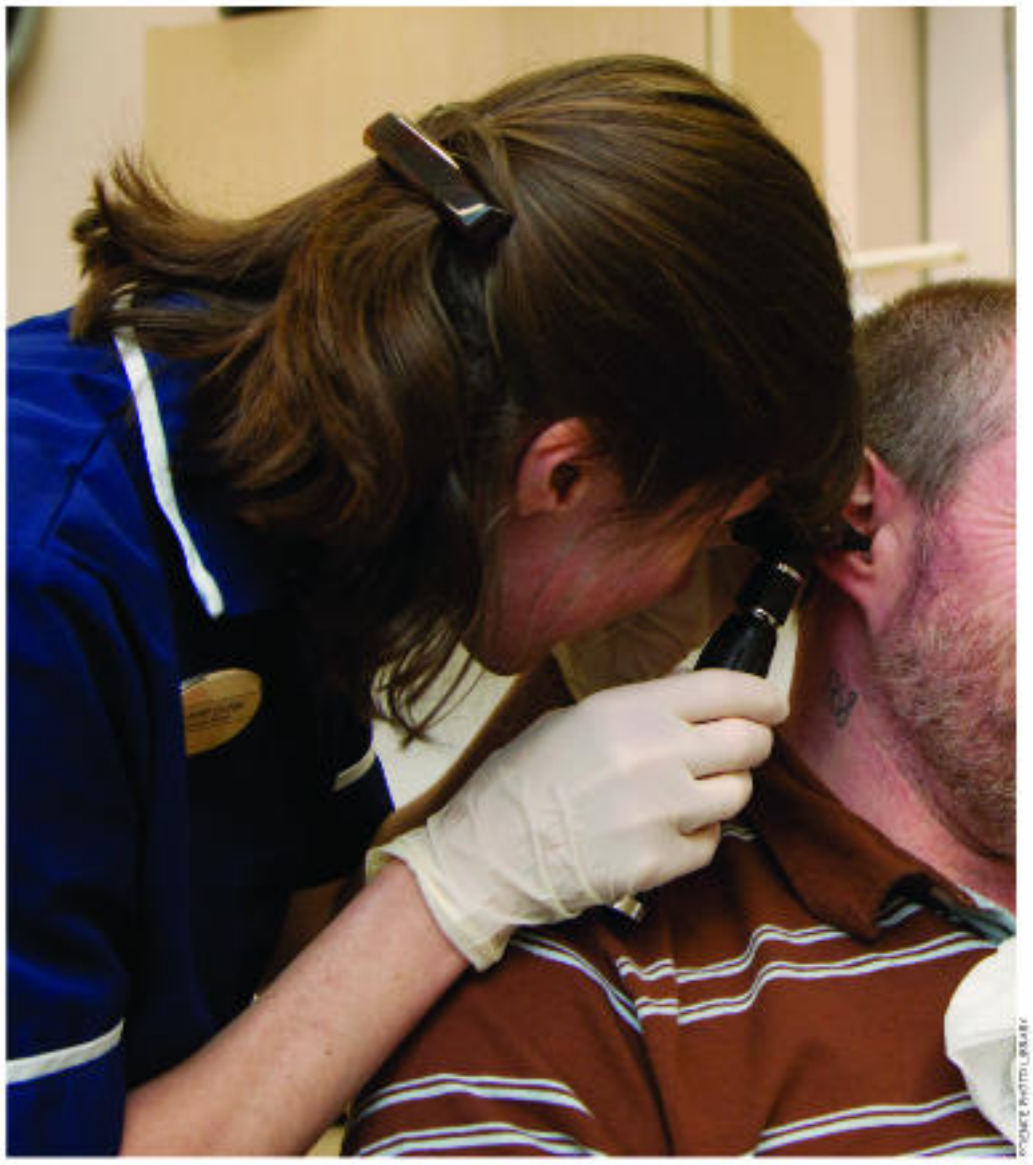
The GPs and practice manager at Peterhead were starting to question whether it was sustainable to maintain personal lists while trying to support the delivery of a house call service.

On any given day, there could be two GPs visiting patients at the same time and in the same street or nursing home. The equivalent number of patients that could be seen during one surgery is three to four times greater than the number seen in house calls during the same period. But the home-visiting service is vital for our frail and vulnerable patients.

Our main aim was to create a more appropriate appointments system – so if an appointment could be done by a nurse, it should be, so that GPs were freed up for non-acute problems and long-term conditions.

This would mean better use of our GPs and nurse practitioners, and in the long run the practice could then take on more enhanced services and be more responsive to opportunities.

We also wanted to explore whether we could organise management of house calls differently, possibly by initiating a rota whereby GPs were allocated a day and/or time to undertake house calls. This would mean patients requiring house calls would be seen by any GP.



What we did

Peterhead Practice started implementing PGP modules in September 2011. First, information was gathered looking at appointment activity and capacity.

We ran a staff survey, a survey of patients to collect their views on the services provided and a quantitative survey of appointments and personal lists. The GPs and staff completed a questionnaire that identified how happy they were about innovation and change.

The data we gathered was then analysed, summarised and presented back to the team in graphs using PGP tools and data analysis apps.

Before any change was made to our systems, it was crucial for us to gather data to support our assumptions and ideas for the future. Informal feedback from our

30

Our main aim was to create a more appropriate appointments system

29 patients had indicated that there were difficulties with obtaining appointments at the surgery. Patients had said they were not always able to see their own GP at the surgery.

The patient experience survey, however, did not suggest this was the case, and showed that patients were in fact pleased with all aspects of patient access.

Towards to the end of the process, we started to discuss ways of ensuring patients requesting an appointment could be seen by their registered GP in order to maintain an appointment system based on personal lists.

GPs reported that demand on their time was increasing, so it was imperative patients were able to get an appointment with their registered GP.

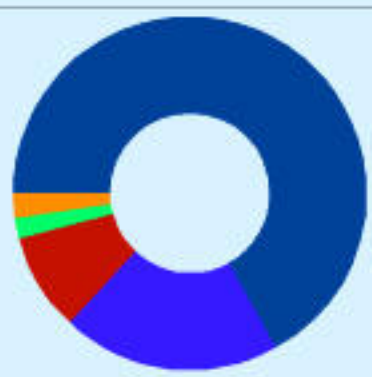
This is usually difficult unless the GP in question is continuously available – when they are not, patients are seen by other GPs who may be unfamiliar with their case history. This in turn leads to appointment time being squeezed and repeat appointments being booked.

We went on to use the same methodology and the principles contained within PGP to undertake an analysis of the process and the demand for house calls.

We also looked at the appropriateness of each call to determine whether the request was being made for an ongoing condition and whether the request could have been handled by another healthcare provider.

Having gathered and analysed our data, we realised there was a great deal of predictability within our service and the data collection exercise had made organising and managing the service a great deal easier.

Was a GP appointment appropriate?



Out of a total of 631 patients seen:
Appropriate appointments (424) 67%
Should have been seen by a nurse practitioner (128) 20%
Should have had a phone appointment (51) 9%
Shouldn't have been seen at all (14) 2%
Should have been seen by a nurse (14) 2%
Source: Peterhead Practice analysis, January 2012

The findings

Using the quantitative survey of appointments, we looked at what the total number of appointments available would be if GPs only saw patients and had no other commitments – such as prison visits, cardiology clinics, administrative work and so on.

Then we looked at how many appointments were available after the commitments were added. Looking at the data from the two-week period, we found that 30% of patients who had requested and were given an appointment were not seen by their registered GP – equating to just over 200 appointments.

By removing all other commitments and redirecting that capacity into the appointment system, the total number of available appointments increased from 899 to 1,377 per week.

Out of the appointments that were not deemed to be appropriate to be seen by a GP, we broke the information down to show how the appointments could have been managed.

We found that 33% of patients seen by GPs were either inappropriate appointments or could have been seen by another healthcare professional – almost always a nurse practitioner.

The data provided our team with the necessary evidence to support what patients had been saying informally.

Requests for house calls are a significant demand on GP time. We identified that 83% of house call requests were made between 8am and 10am, with Monday being the busiest day for requests and visits.

The exercise also showed that 73% of home visit requests were for ongoing conditions, while 13% could have been dealt with by a district nurse.

House calls were being delivered on a personal list basis. Given the capacity needed to deliver the service, we had questioned whether personal lists for house calls were a luxury we could still afford.

Could we manage resources more effectively by introducing a system of triage? This would direct requests accordingly, but without jeopardising quality or continuity of care.

The potential time savings identified only reflected face-to-face time with patients. The average time spent in face-to-face house call consultations was 20 minutes. Along with travel time, a GP on a house call spent around half an hour with each patient.

If we could effectively reduce house calls and demonstrate continuity of care would not be lost by moving to a shared house call service, it would release time that could be spent on improving patient and staff experience at the practice.

The future

We now plan to develop skills and expertise within our own team to allow them to start managing and shaping the current demand.

Our next steps will be to:

- develop the nurse practitioner, practice nurse and triage nurse roles
- extend training of practice nurses to include contraceptive counselling and to take over fitting of coils and implant clinics.

Developing roles will allow us to put in place a system of triage to manage both our appointments and house calls.

We chose to look at appointments and house visits in our PGP exercise and, although there was not a specific module within PGP to deal with this, we adapted the existing tools to our purpose.

We have, as a result, planned our future workforce to include more nurse practitioners, with the aim of triaging appointments and house visits more appropriately. This should free up GP time for more complex face-to-face consultations.

We hope to train up our workforce in the next six to 12 months.

Dr Joyce Robertson is a GP at the Peterhead Practice in Peterhead, Scotland

Key questions on CCG constitutions

GPC negotiator Dr Chaand Nagpaul advises practices on what they should check before they sign up

In order for CCGs to be authorised, the NHS Commissioning Board requires each group to have a constitution in place by April 2013.

The document must:

- specify arrangements made by the group to discharge its responsibilities for commissioning care to its local population
- provide details of the group, including its name, the membership (all constituent GP practices), and the geographical area it covers
- describe the organisational structure of the group and its governing principles (including the electoral and appointment process for the governing board and other lead positions), and the procedures to address probity, conflicts of interest, and public involvement
- outline operating arrangements, including how the governing body makes decisions and how it relates to member practices.

This article aims to answer all the main questions practices will have about constitutions and what they should look for in the documents before signing them. You can also go online to see a sample constitution document, which has been annotated to give you an idea of what clauses your local constitution should and shouldn't contain.

1 Where do CCG constitutions come from?

The NHS Commissioning Board believes that, as CCGs are membership organisations, a constitution should be developed jointly between the CCG board and its member practices. Each CCG can develop its own constitution tailored to its needs – although the board has drawn up a model constitution, available on its website.[1] It is important to recognise that the board's model constitution is simply a template and that the final constitution will vary from CCG to CCG. There is therefore no single 'standard' national constitution. Many CCGs have found the model constitution to be long and complex in presentation, and have developed shorter and more simply worded constitutions with assistance from their LMC or lawyers. BMA Law provides a service in developing and checking constitutions.

2 Do I have to sign one?

In many areas, member practices have been presented with a document from their CCG board to sign. It is important that practices understand this is a document owned by the membership that will impact on their working arrangements, and if they sign it they are agreeing to its terms. No practice should feel coerced to sign a constitution without fully understanding and agreeing with its contents. Practices should be able to challenge and suggest amendments to a proposed constitution.

The NHS Commissioning Board's guidance on the authorisation of CCGs states that constitutions should have 'sign-up of member practices' as a requirement for authorisation.[2] There has been varying interpretation of this requirement, although it would stand to reason that a CCG could only function effectively if its constitution and contents have the support of all member practices. If there is dissent from member practices and they refuse to sign a constitution, it would jeopardise the CCG being authorised – so it is in the interest of each CCG to develop a constitution that is acceptable to its practices.

3 Are there any clauses that should not be in the constitution?

There should be no clauses relating to monitoring or performance managing the GP contract. The NHS Commissioning Board will have sole responsibility for the administration and management of practice contracts. There should be no obligation on practices to undertake work beyond their contractual requirements. Any CCG-related activity beyond the requirement to be a member of the CCG – such as participating in meetings or peer review – should be additionally resourced, as it is outside the core contractual responsibility of practices. There should be no 'expulsion' clauses, since CCGs will have no powers to expel a practice.

4 Should I look for mention of third parties in the document?

LMCs are statutory bodies representative of all constituent GPs and practices. The GPC strongly recommends practices ensure constitutions specifically recognise the role of LMCs and formally involve them in all relevant matters affecting GPs. Some constitutions have co-opted an LMC member as an observer on the governing board, for example. The GPC also recommends practices should consult their LMC before they sign a constitution.

5 What rights should I request through the constitution?

The constitution should ensure two-way accountability between member practices and the governing board. The board is accountable to member practices, and practices should ensure there are mechanisms by which they can hold the board to account. The constitution should specify how the board involves and communicates with member practices – for example, seeking approval on proposed policy – and how member practices can influence board policies and strategy. In addition, the GPC recommends that the constitution should specify how it can be altered by member practices.

The constitution should also specify how member practices can have a 'power of recall' of members of the CCG's board, if they feel that individual members or the board collectively are failing to deliver the wishes of the membership. Some constitutions have specified this could occur if a certain percentage of constituent GPs or practices call for an annual general meeting for this purpose.

6 How might the constitution affect election to CCG boards?

There should be a clear process laid out in the constitution for how GPs are elected or appointed onto the governing board or to lead positions, including the tenure of these. There should be clarity about any screening process for required competencies. Any panel undertaking screening should include GP representatives. GPC guidance suggests there should be full equity of opportunity for all GPs of contractual status to stand for any CCG position. The GPC also recommends all GPs in a CCG area should be entitled to vote in elections, on a 'one GP, one vote' basis.

7 Will constitutions affect my personal or practice finances?

The constitution will specify the remunerative arrangements for GP board members. There should also be recognition of remuneration for non-board GPs holding lead roles in the CCG, and also for GP practices' workload in contributing to and engaging with CCG activity, since such work is over and above the contractual responsibility of practices.

The rate of remuneration should be at the same scale as that afforded to GP board members, so there is an equitable and consistent approach to valuing GP time.

8 What should I do before my practice signs a constitution?

Practices must approach the constitution as a document they own and that they have full entitlement to question, challenge and change rather than view it as a fixed document. This will require practices to understand the contents of the constitution, some of which can be quite detailed with information not directly relevant to practices.

The GPC recommends all practices read its guidance on CCG constitutions as well as a practice constitution 'checklist'[3], which is available at pulsetoday.co.uk/commissioning. The GPC also recommends all practices seek formal advice from their LMC regarding proposed constitutions, and some LMCs have arranged legal support to assess CCG constitutions.

BMA Law and other legal advisers can also provide CCGs and practices with guidance and help check constitutions. It is important that even after taking advice, practices only sign a constitution if they are in agreement with it.

Dr Chaand Nagpaul is the GPC's lead negotiator on commissioning and a GP in Stanmore, Middlesex

References

1 NHS Commissioning Board. *Model framework*. 2012. tinyurl.com/7cthu2e
2 NHS Commissioning Board. *Constitution guide*. 2012. tinyurl.com/bw98sdd
3 BMA. *CCG constitution: checklist for practices*. 2012. tinyurl.com/7q75w82

More online

A longer version of this article is available online, and you can also use our interactive analysis of a sample constitution to spot the phrases to look out for in your local document. You can also download a checklist designed by the GPC for helping practices make sense of CCG constitutions.

pulsetoday.co.uk/commissioning

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DOCTORS/GPS REQUIRED

Avenue House Surgery, Chesterfield

Vacancy for full time GP Partner

Due to retirement we are seeking a FT partner starting April 2013.

We are a friendly, patient centred training practice that achieves well in all performance areas.

The practice of 10,000 patients is situated in the market town of Chesterfield and surrounded by the beautiful peak district. There are good local schools and easy access to Sheffield, trains and motorway.

An ideal candidate would be a qualified trainer or be willing to commit to future training, have an interest in commissioning and be willing to represent the practice in the local CCG. An interest in IT development would be welcomed.

For further details please contact or apply in writing to:-
Janette Moran, Practice Manager
Avenue House Surgery
109 Saltergate, Chesterfield S40 1LE
Tel: 01246 244040

Bungay Medical Practice

Salaried GP

Norfolk/Suffolk Border

This well organised, thriving and friendly practice situated in a market town has a vacancy for one and a half GPs. They would be joining a team of nine – a mixture of salaried GPs and partners (many of whom were previously salaried in the practice).

- **Modern purpose-built premises with dispensary**
- **Personalised patient lists (total list size 10,500)**
- **Community Hospital**
- **Teaching medical students, F2s and GP Trainees**
- **Research Practice**
- **High QOF achiever**

Practice details can be viewed on our website:
www.bungaymedical.co.uk

For more information, or to arrange an informal visit, contact Sarah Harris, Practice Manager, Bungay Medical Practice, 28 St John's Road, Bungay, Suffolk NR35 1LP. Telephone 01986 891727 or email sarah.harris2@nhs.net

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Are you looking for a unique opportunity as a salaried GP?

Gnosall Surgery are wishing to recruit two enthusiastic and motivated salaried GPs to join our friendly, innovative and award winning team. We are looking for 1 full time and 1 part time or 2 part time salaried GPs.

Situated in the Staffordshire countryside Gnosall Health Centre is an award wining purpose built modern health care facility. We are a high achieving rural practice committed to providing high quality, compassionate holistic care.

We offer outstanding facilities and services including Psychiatry a nd counselling on site, consultant led Memory clinic, consultant l ed 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

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 10,600*
- *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 5UA

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

HARBOURSIDE FAMILY PRACTICE
PORTISHEAD, nr BRISTOL

GP Partner(s)

We are a growing, high achieving PMS Practice in Portishead - on the coast just south of Bristol, with a rapidly expanding list currently at 8,700 patients. We are a forward-thinking Practice with a strong emphasis on team work and patient-centred care.

Due to our growth we are looking for an additional enthusiastic and committed GP Partner(s) to join our team. Working 6 – 8 sessions per week, the ideal candidate will be keen to take on a challenge and help shape a new and innovative service:

- *New, purpose built premises*
- *Outstanding QOF results*
- *Established Nurse led CDM and minor illness support*
- *Excellent ancillary/administrative support infrastructure*
- *EMIS clinical system*
- *Aspiring to become a teaching practice*

For more information about this exciting opportunity please refer to the comprehensive Candidate Brief that can be accessed on the GP Care UK Ltd. website:
http://www.gpcare.org.uk/site/about/recruitment/recruitment_index.htm

Closing date: 18th August 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 6 SESSION GP

CHESHUNT, HERTFORDSHIRE.

The practice is seeking an enthusiastic and flexible GP for 5 days a week, to maintain the good standards we have achieved. £8K/session. This is a new position due to our growing list size. Closing date is 31st August 2012.

- 13,500 patients
- 4 F/T Partners
- 1 existing salaried doctor
- 2 nurse practitioners
- 3 nurses
- High QOF achievement
- Research practice
- EMIS LV
- Active member of local commissioning group

Please send your application to the Practice Manager, Stockwell Lodge Medical Centre, Rosedale way, Cheshunt, Herts EN7 6HL. Tel: 01992 624408. Applications can be emailed to applications.slmc@nhs.net

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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

The Consulting Rooms, Watford
www.theconsultingroomsnorthorbey.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 07824212147 or email paul.drinkwater@nhs.net

DOCTORS/GPS REQUIRED

EASTBOURNE G.P. PARTNERSHIP

Here at Princes Park Health Centre, we are a friendly, hardworking, high earning PMS training practice situated on the South – East coast. We are now looking to employ a full time GP to join the practice with a six month period of mutual assessment.

Occupying 2000 sq - meters of purpose built medical premises (on one site) our 9 Doctor Team provides a wide range of services to its 14500 patients. The facilities that we offer, which includes onsite X – ray, MRI and DXA scanning, make us stand out as a progressive practice. We also provide a wide range of Enhanced services and Nurse lead clinics.

The Practice also has close links with Brighton and Sussex Medical School and is actively involved in teaching Medical students at all levels; together with being an established Training Practice with ST3 Doctors working with us.

For more information please go to www.princesparkhealthcentre.co.uk

If you are a well-motivated, enthusiastic and committed GP and this unique opportunity interests you, then please contact:

Mr Graham Willoughby (Practice Manager)
Graham.willoughby@nhs.net
Dr Stockton and Partners
Princes Park Health Centre
Wartling Road, Eastbourne, East Sussex BN22 7PG
01323 744644

Closing date:17th August

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 salujabally@hotmail.com

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 C.V. to:
Practice Manager: Ann Atherton aathertona@nhs.net
For any further information please ring Ann on 01942 883794

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 informal chat please call Maureen Rowland, on 01274 691502
Or check out the web site for more information on: www.lowmoormp.co.uk

No agency calls, thank you

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.

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

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Now open for applications

Applications close on
Tuesday 9 October 2012

*Logo not included

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

Willow Bank Surgery

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

DOCTORS/GPS REQUIRED

Malling Health

Maternity Cover for 2 x Full-Time Salaried GP's
fixed term contracts

Telford & Wrekin – Immediate start
Kent – October/November start

We are a GP owned and managed Primary Healthcare Provider seeking 2 x full-time salaried GP's. We provide convenient, local and easy to access healthcare for everyone in the area.

You will have clinical and strong communication skills, enthusiasm and drive. Please refer to our website www.mallinghealth.co.uk for further details on the vacancies.

Please send your CV and covering letter to Claire Kattner – HR Manager by emailing: mallinghealthrecruitment@nhs.net

Closing date: 17 August 2012

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

MATERNITY LOCUM REQUIRED – BRENTFORD,

- *SEPTEMBER-NOVEMBER 2012*
- *6 SESSIONS PER WEEK*
- *GMS PRACTICE WITH 7,400 PATIENTS*
- *SYSTMONE CLINICAL SYSTEM*
- *NO EXTENDED HOURS OR OUT OF HOURS WORK*
- *HIGH QOF ACHIEVERS*
- *WELL-ORGANISED, FRIENDLY AND DEDICATED PRACTICE TEAM*
- *PURPOSE-BUILT PREMISES*

We are looking for a friendly, competent doctor for three months' maternity cover.

Closing Date:- 20th August 2012

Please submit covering letter and c.v. to:-
Linda Clubb, Practice Manager, Brentford Group Practice Brentford Health Centre, Boson Manor Road, Brentford, Middlesex, TW8 8DS
or brentfordgrouppractice@nhs.net

For further information on the practice please visit our website www.brentfordgrouppractice.co.uk

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*
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Closing Date: Wednesday 5th September 2012

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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

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

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
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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 Sootia Heights with support from the Consultant in Rehabilitation Medicine.

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- 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

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

Ladbroke Grove, London

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Direct line to Practice Manager – 01902 859503 Email: gill.bowers@nhs.net

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SALARIED GP

With possible partnership opportunity
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For further information please contact:
Lisa Dilling, Practice Manager, 01959 574488

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Please contact our practice manager on 023 8021 0292 or email to barbara.clark1@nhs.net for more information, or to arrange an informal visit.

Please send a letter of application and your C.V. to Barbara Clark, St Marys Surgery, 1 Johnson Street, Southampton, SO14 1LT

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EDITOR'S CHOICE

A new way for GPs to network

Last month saw the first face-to-face meeting of the UK's largest GP-only Facebook group, writes Pulse online producer Jessica Baron – but if you're not a member, you may never have heard of it

TGG members met in real life at an 'EduSocial' event in July

Set up in June 2011 by Dr Kartik Medha, Tiko's GP Group (known to its Facebook 'friends' as TGG) currently has 1,128 members – and counting.

Dr Modha, a GP in Kentish Town, north London, felt that as a locum and part-time out-of-hours GP, he might be missing out on support and the opportunity to share ideas. So Dr Modha decided to found a community hub for GPs.

It may seem odd to be writing an article about Facebook eight years after its inception, two years after the film *The Social Network* came out and four years after 102-year-old Ivy Bean was celebrated as the oldest Facebook user in the UK.

But Facebook is fast becoming the social media network of choice for GPs – more so than Twitter, despite RCGP chair Dr Clare Gerada's powerful presence, and LinkedIn, the 'professional' social network.

Dr Modha says: 'The generation of GPs that we have at the moment is a Facebook generation.

'Maybe in 10 or 15 years they will be a Twitter generation, but at the moment health professionals have a hard time on Twitter because it is so open.'

And therein appears to lie the key to TGG's success.

Unlike the groups set up by the RCGP – the RCGP's First5 Facebook group has only 345 members by comparison – and the BMA, which are open to the public, TGG is a GP-only Facebook group. Which means you have to be invited or request to join and then be vetted via your GMC number before you can access its hallowed wall.

And TGG moved from the virtual world to the real world at a formal 'EduSocial' event at the Landmark Hotel in central London in July.

'If people make virtual bonds online and then meet, this reinforces a positive relationship in real life, creating links and bonds between GPs in different CCGs,' says Dr Modha. 'It's important to see that this is the way forward.'

MORE ONLINE
To read the full feature, go to pulsetoday.co.uk/off-duty. You can also follow Pulse on Facebook at facebook.com/PulseToday.co.uk

VIDEO

Our new video series The Big Interview talks to some of the biggest names in general practice. Subjects so far include Professor Helen Lester, who has helped shape the QOF, and RCGP cancer lead Professor Greg Rubin, while an interview with Londonwide LMCs' chief executive Dr Michelle Drage (pictured) goes online this Thursday.
▶ pulsetoday.co.uk/videos

WHAT YOU'VE BEEN SAYING

▶ pulsetoday.co.uk/forum

> **Again, those of us who work in deprived areas will be penalised.**
> ... on the quality premium being tied to mortality targets

> **Why don't we all threaten to resign from the pension scheme at the same time?**
> ... on the BMA's struggle to secure a better pensions deal

> **This is the thin edge of a very big wedge.**
> ... on Department of Health plans for a composite diabetes QOF indicator

GP PROVIDERS

Tendering for an NHS contract

Our short interactive guide to the NHS service contract tendering process offers an overview of each stage for GPs as potential providers.

MORE ONLINE
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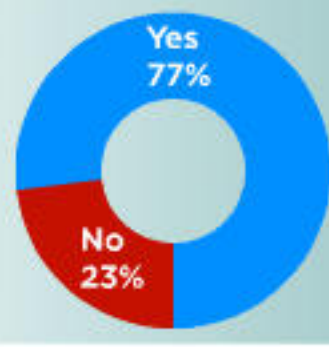
THIS ISSUE'S POLL

Is the QOF changed too frequently?
Vote at ▶ pulsetoday.co.uk/polls

Last issue's poll
Should all CCG boards have a GP majority?



Turn inside for this week's Phil Peverley and Margaret McCartney columns
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