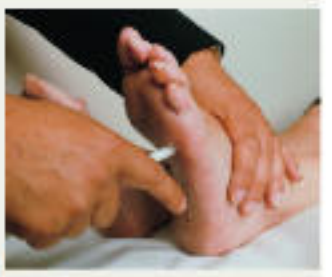
Top 50 GPs

Who is the most influential GP? Read our rundown of the 50 greatest standard-bearers for general practice in our fourth annual list ▶ page 30-42



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PULSE

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BriefingMedia

At the heart of general practice since 1960

LES funding cuts push practices to the brink

Funding cuts of nearly 50% force practices to cut salaried GP sessions and consider shedding staff

EXCLUSIVE
By Jaimie Kaffash

Practices are reducing salaried GP sessions and preparing to shed staff after brutal cuts to local enhanced services funding in some areas have left practices floundering.

A Pulse investigation has revealed cuts in LES funding of nearly 50% in some areas this financial year as managers continue to tighten GP funding.

LMC leaders warn the cuts, after years of actual or near pay freezes, mean practices have been forced to take radical measures to survive.

Figures from 94 primary care organisations across the UK show LES budgets were slashed by 10% from 2010/11 to 2011/12 and have remained at a similar level this year, with a slight increase of 0.34% in 2012/13 compared with the previous year.

But the figures hide huge reductions in some areas with a 40% reduction in LES funding in 2012/13 by NHS Herefordshire, Heart of Birmingham Teaching PCT and NHS Coventry, compared with 2011/12, and reductions of 46% and 47% by NHS Middlesbrough and NHS Redcar and Cleveland this year.

Most PCOs – 50 in total – reduced their LES budgets this year and 40 increased funding overall. Four maintained their level of funding.

A Pulse survey in January revealed that a fifth of practices planned to lay off staff this year.

Dr Nigel Watson, chief executive of Wessex LMCs and a GP in the New Forest, said cuts were forcing GP partners to review their staffing levels.

He said: 'Workload is increasing and when added to the cuts in LES funding, these factors mean practices are looking to make staff or salaried GPs redundant or failing to replace retired partners.'

Dr George Rae, chief executive of Newcastle and Tyneside LMC and a GP in Newcastle – where the LES budget was cut by a further 7% this year after a crippling 46% last year – said his practice was looking at restructuring. He said: 'If the funding isn't there, it is difficult to provide the service. Partnerships are having to look at their structures – we are even doing that in our own partnership.'

Dr Mark Selman, a salaried GP in Totnes, Devon, and deputy chair of the GPC sessional GPs subcommittee, said he had seen salaried GP redundancies from PCT budget cuts in his area. 'We have seen redundancies in the area. If things continue the way they are, we will see further reduced hours, reduced numbers of sessions and redundancies.'

Accountants also warned further funds could be stripped from general practice in 2013/14, because of changes that will require CCGs to use any qualified provider for most LESs. Bob Senior, director of medical services at accountancy firm RSM Tenon, said: 'From 1 April 2013, with CCGs being responsible for LESs, we don't know how that will go.'

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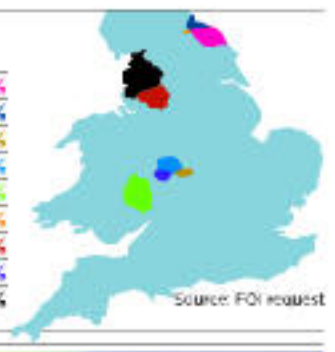
Dr Mark Selman: expects to see more salaried GP redundancies

Worst-hit areas

Change in LES funding from 2011/12 to 2012/13	
NHS Redcar & Cleveland	-47%
NHS Middlesbrough	-46%
NHS Coventry	-40%
Heart of Birmingham	-40%
NHS Herefordshire	-40%
NHS Stockton-on-Tees	-39%
NHS Ashton, Leigh & Wigan	-34%
Solihull PCT	-31%
NHS East Lancashire	-29%



Source: FOI request

The week in general practice

INSIDE

MORE ONLINE

▶ pulsetoday.co.uk/news

Has health secretary Andrew Lansley kept his job? Find out with our coverage of the Prime Minister's cabinet reshuffle
▶ pulsetoday.co.uk/political-news

Top 50 most influential GPs
Read the full profiles of all our top 50 GPs and have your say in the Pulse forum
▶ pulsetoday.co.uk/top50

Top 50 videos
Watch videos of all of our top five most influential GPs
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PULSENEWS

GPC pushes for 'several per cent' rise

Negotiators push for funding increase to cover rising practice expenses despite 1% Treasury pay cap

EXCLUSIVE
By Sofia Lind

GPC negotiators have confirmed they will be pushing for a pay rise for GPs of 'several per cent' in this year's contract talks in order to cover rising practice expenses.

This is despite the Treasury imposing a 1% cap on public sector pay rises, and the Department of Health scrapping the independent pay review for GPs once again this year.

The move comes as the GPC outlined a tough negotiating stance over rising GP workload, with chair Dr Laurence Buckman saying the GPC will argue for 'no changes' to QOF next year.

Health secretary Andrew Lansley wrote to the Doctors and Dentists' Review Body (DDRB) in July to reverse a previous decision allowing the independent body to make recommendations on the expenses and pay for GPs from 2013/14.

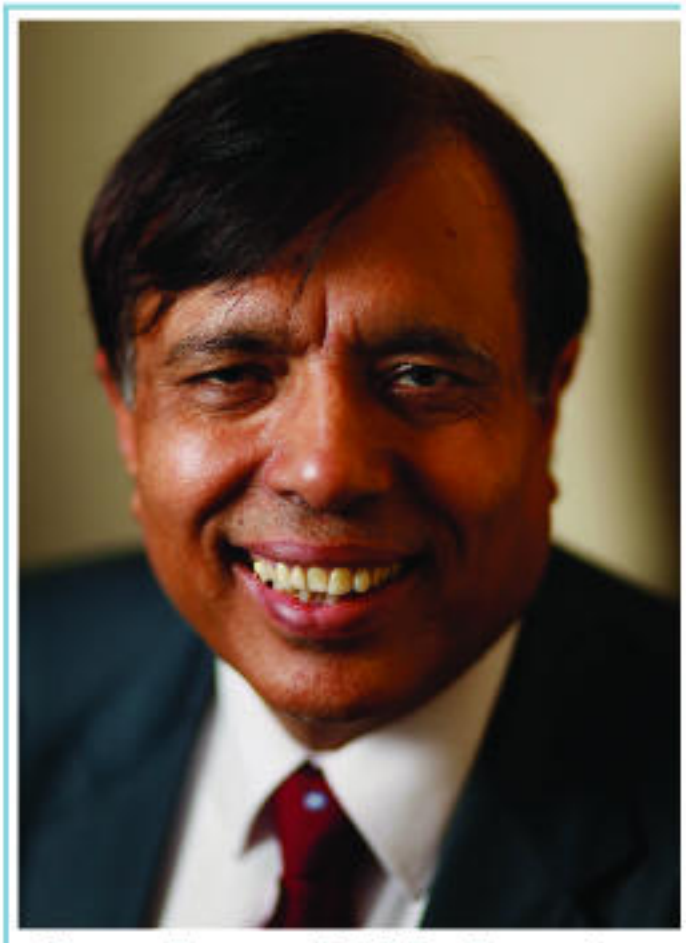
He said there was a 'well-established basis' for imposing the 1% pay rise set by the Treasury across the public sector for the next two years, and that the DH would hammer out any uplift in pay or expenses through negotiations with the GPC. The letter also hinted that further 'quality and efficiency gains' might also be expected from GPs.

The GPC said they would argue that sticking to the 1% cap on public sector pay rises would, in effect, be a further pay cut for GPs, whose rising practice expenses have not been countered by a sufficient rise in practice funding for several years.

GPC negotiator Dr Chaand Nagpaul, a GP in Stanmore, north-west London, told Pulse: 'The Government has to recognise that general practice has not been recompensed for rising expenses for years.

'There is no point talking about an uplift before there is funding for expenses. It would just be a small offset. GPs would still experience a pay cut.

'We just want the same treatment as other doctors. If hospital doctors receive a 1% net increase, the only way GPs can



Chand new BMA deputy

Retired GP Dr Kailash Chand has been elected as deputy chair of BMA Council. He said his priorities would be to improve funding for revalidation and to present a united voice on the Government's health reforms.

Dr Chand was voted in ahead of GP Dr Fay Wilson and chair of the BMA Junior Doctors Committee Dr Tom Dolphin.

He told Pulse: 'The only way we can move forward is if we keep council united. I will concentrate my efforts on us having a united voice.'

Senior GPs lead revalidation

EXCLUSIVE

By Gemma Collins

High-profile GP leaders are expected to be the first to go through revalidation when the process begins in December.

Senior GPs told Pulse they expected to be among the first wave of doctors to be revalidated, together with responsible officers and chief medical officers.

Dr Clare Gerada, RCGP chair, said she would be one of the first to go through the process, and that despite some trepidation, she was pleased she would be able to 'troubleshoot'.

In an exclusive interview, Dr Gerada said: 'I have started to keep my CPD on Excel, but it is more my patient survey because I look after sick doctors and I work at a practice where 90% of my consultations are done through a translator, so it is not easy, but I will try. I am a bit anxious about it – what if I fail?'

Dr Laurence Buckman, chair of the GPC, said he too was expecting to be among the first to be revalidated, although he had not been officially told yet.

I am a bit anxious about revalidation. What happens if I fail?

Dr Clare Gerada

He said: 'I would be happy to be first. It would be good to get it out of the way'.

A report recently released by the NHS Revalidation Support Team said the NHS had made 'impressive' progress on preparing for the rollout of revalidation, with the majority of GPs linked with an organisation that will assess their competence to practise from next year.

The GMC declared itself 'ready' for revalidation in July and signalled its intention to stick to its timetable and begin the rollout in December.

Dr Gerada said now was the time to go ahead with revalidation even if the NHS is not completely ready: 'We have been talking about revalidation in some form or other for about 60 years. So I don't think we will ever be ready, but I think we have to dive in and get on with it.'

Dr Thomas Caldwell, a GP in Worcester, said: 'Good luck, Clare. Please do extensive ironing out before it gets to me.'

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MORE ONLINE
Watch the full interviews with Dr Clare Gerada and Dr Laurence Buckman
pulsetoday.co.uk/videos

Dr Robert Morley: a pay rise of up to 10% is needed

Negotiators' wish list

GP pay
A 'several per cent' uplift to cover years of rising expenses

QOF
'No changes' to the framework this year

Premises
Funding for a major upgrade to premises

Efficiency savings
Minimising impact of further 'quality and efficiency gains' the DH may want from GPs this year

have the same is if expenses are recompensed. I can't give an exact figure but it would certainly need to be several per cent.'

But Dr Robert Morley, a GP in Birmingham and BMA council member, said a rise of up to 10% was needed, which the Government was unlikely to agree to.

He said: 'In order for GPs to get an actual 1% pay rise they would have to increase funding to practices by 5-10% and I can't imagine they will do that.'

A Department of of Health spokesperson said: 'Last year, the Chancellor announced that public sector pay increases would be capped at 1% in 2013/15. Negotiations are ongoing.'

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PULSE 50

GPs WITH INFLUENCE

Which GPs have had the most influence on general practice this year?

▶p30

Call for 'separate deal' for GPs in Scotland

A UK-wide GP contract 'makes little sense' and Scottish practices should have a deal negotiated separately from their colleagues south of the border, says an influential think tank.

In proposals that go much further than the 'tartanisation' proposed by the Scottish government, Reform Scotland said the current contract 'largely reflected circumstances elsewhere' and should be rewritten for Scottish GPs.

The proposals provoked an angry response from the Scottish GPC, who said there was already enough flexibility in the GMS contract for Scottish GPs.

It comes after Pulse revealed last month that the Scottish Government was consulting GPs on which bits of the GMS contract should be localised for Scotland and was developing some Scottish-specific QOF indicators.

The Reform Scotland report said the English and Scottish health system were 'increasingly diverging' because of changes set in place under the Health and Social Care Act.

The report concludes: 'Reform Scotland believes that it makes little sense for Scotland to remain part of the UK GMS contract. Instead, we believe that a separate deal should be negotiated for Scotland.'

It also recommends GP catchment areas are extended.

Scottish GPC chair Dr Alan McDevitt said: 'I would prefer if debate centred on how we can meet the challenges ahead.'

Key questions: A GP's queries on depression answered ▶ page 44

Discharge letters one year late

Hospital trust launches investigation as GPs fear further lost letters and major implications for patients

EXCLUSIVE
By Gemma Collins

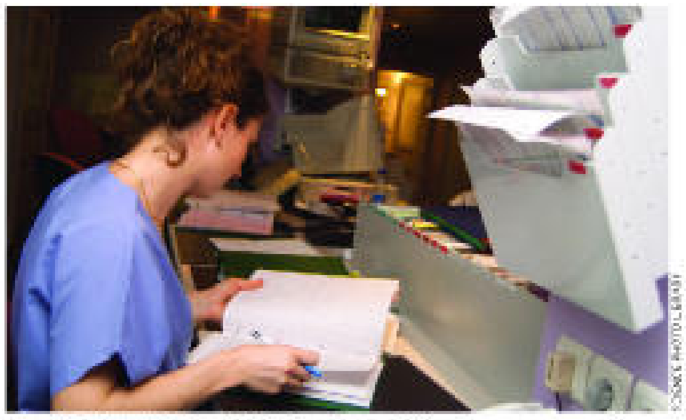
Managers have launched an investigation into administration errors at a hospital trust after GPs received hundreds of discharge letters more than 12 months late.

GP leaders in Manchester LMC called for the investigation after practices received a batch of discharge letters from Pennine Acute Hospital Trust dating back to April and May last year.

The trust, which covers a large area of north Manchester from Oldham to Bury, says it is still investigating the delays, but the LMC claims it was told by the hospital there was a 'fault with the IT system'.

GPs have written to the trust's medical director demanding a full explanation following fears there could be even more letters lost in the system with major implications for the care of hundreds of patients.

The data delays come after Pulse revealed earlier this year that a hospital trust in London was reviewing the deaths of 25 patients after internal 'data reporting' issues which meant more than a thousand patients referred for suspected cancer may not have been seen within two weeks.



Hospital trust is investigating delays in discharge summaries

Dr John Hughes, honorary secretary of Manchester LMC and a GP in Crumpsall, told Pulse a 'huge dump' of 140 late discharge letters arrived at his practice. Staff then had to trawl through to check that patients – one of whom had cancer – had not suffered as a result.

'It could have meant that patients' treatment had changed or that they required further investigations and we wouldn't have been aware of it.'

Dr Hughes said at least five local practices had been affected but none had yet found any major problems with patients, as many had since returned to the hospital for follow-up appointments. But he added there had been problems with delays in receiving discharge letters from the trust for more than 10 years.

He added: 'We are now two months on from receiving the letters and we still haven't had any information.'

A spokesman for Pennine Acute Hospitals NHS Trust said: 'At the end of June this year local GPs alerted us that they had received excessive numbers of discharge summaries generated via our Automated Letter System.

'We immediately started an investigation into this. The investigation is ongoing.'

GPC chair and Leeds GP Dr Richard Vautrey said delayed discharge data is a 'perennial problem', which he hoped CCGs would finally start to tackle.


What's inside?
Clinical evidence
to help reduce digestive discomfort such as bloating
DANONE
ACTIVIA
125g
STRAWBERRY
Activia is a probiotic yogurt containing the exclusive probiotic strain *Bifidobacterium lactis* DN-173 010. Activia has been researched for more than 15 years with **17 publications of clinical studies**. Studies have shown Activia* may help reduce IBS-related digestive discomfort including bloating[1] and distension,[2] and improve GI well-being in women reporting minor digestive disorders.[3] **NICE guidelines** state, "*There is fair evidence to show that some probiotics (single or combination) give a significantly greater improvement in global symptoms of IBS than placebo*"[4] and **Map of Medicine** states, "*Some specific strains, such as Bifidobacterium lactis DN-173 010... have clinical trial evidence of efficacy for bloating [and] distension*".[5]
Review the published evidence at **www.probioticsinpractice.co.uk**
Information for Healthcare Professionals.
DANONE
HEALTH AFFAIRS
References: 1. Guyonnet D et al. *Aliment Pharmacol Ther* 2007;26:475–486. 2. Agrawal A et al. *Aliment Pharmacol Ther* 2009;29:104–114. 3. Guyonnet D et al. *Br J Nutr* 2009;102(11):1654–1662. 4. National Collaborating Centre for Nursing and Supportive Care (NCC-NSC) on behalf of the National Institute for Health and Clinical Excellence (NICE). Irritable bowel syndrome in adults: Diagnosis and management of irritable bowel syndrome in primary care (CG61). 5. Contributors representing the Royal College of Physicians. 2011. Available online at: http://eng.mapofmedicine.com/evidence/map/irritable_bowel_syndrome_ibs_2.html (accessed April 2012).
*Based on studies using two pots consumed daily. Enjoy as part of a healthy diet and lifestyle. Bloating and distension are part of digestive discomfort. ACTV 034 May 2012

Just 10% of GPs joined pensions action, says DH

Only one GP in 10 in England took industrial action over their pensions, according to Government figures published for the first time since the day of action on the 21 June.

A previously unpublished internal DH briefing note reveals only 11.2% of GPs and 10.8% of consultants across England participated in the BMA industrial action over pensions.

The figures – published after a request from Pulse under the Freedom of Information Act – show official figures from all of England's SHA clusters.

GPs still counted for 35.3% of all the 11,494 doctors who took industrial action on the day.

The lowest participation rate was among junior doctors, of whom only 3.9% took part, and public health and community doctors, of whom 2.3% took part.

The DH briefing note concluded that industrial action in England had a 'moderate impact' on patient services, mitigated by continuity planning in anticipation of the strike.

It added: 'The reality is only around 25% of practices are providing an "urgent only" service.'

Field tackles NHS inequalities in new role

Former RCGP chair Professor Steve Field has been appointed deputy national medical director at the NHS Commissioning Board.

The appointment – announced last week – will mean Professor Field will have responsibility for reducing health inequalities in the NHS.

Professor Field is chairing a review of the NHS Constitution as part of his work on the Government's NHS Future Forum, which conducted the listening exercise on the Health and Social Care Bill last year.

He still works as a GP in inner-city Birmingham and is also chair of the Department of Health's National Inclusion Board, whose remit is to tackle inequalities.

Professor Keith Willetts, trauma care tsar at the department, was also appointed to the role of director for acute episodes of care at the NHS Commissioning Board, where he will lead work helping people to recover as quickly as possible from acute illness or injury.

Sir Bruce Keogh, national medical director at the NHS Commissioning Board Authority, said: 'I am delighted that we have been able to secure these two high-calibre appointments'.

▶ Find out where Prof Field features in our Top 50, page 30

The No.1 used INS product in UK Hospitals[1]

NASONEX 50 micrograms/actuation Nasal Spray, Suspension (Phenylethyl alcohol-free formulation)
PRESCRIBING INFORMATION
Refer to Summary of Product Characteristics (SPC) before prescribing

Please refer to the full SPC text before prescribing this product. Adverse events should be reported. Reporting forms and information can be found at www.yellowcard.gov.uk. Adverse events should also be reported to MSD drug safety department on +44 (0)1707 363773.

Presentation: Nasal spray suspension containing mometasone furoate (as monohydrate) 50 micrograms/actuation, a synthetic topical corticosteroid.

Uses: *Adults and children aged 18 and over:* Treatment of nasal polyps. *Adults and children over the age of 12 years:* For the treatment of the symptoms of seasonal allergic rhinitis or perennial rhinitis. *Children 6 to 11 years of age:* For the treatment of the symptoms of seasonal allergic rhinitis or perennial allergic rhinitis. In patients who have a history of moderate to severe symptoms of seasonal allergic rhinitis, prophylactic treatment with Nasonex may be initiated up to four weeks prior to the anticipated start of the pollen season.

Dosage: Nasal Polyposis: *Adults and children aged 18 and over:* The usual recommended starting dose for polyposis is two actuations (50 micrograms/actuation) in each nostril once daily (total daily dose of 200 micrograms). If after 5 to 6 weeks symptoms are inadequately controlled, the dose may be increased to a daily dose of two sprays in each nostril twice daily (total daily dose of 400 micrograms). The dose should be reduced following control of symptoms. If no improvement in symptoms is seen after 5 to 6 weeks of twice daily administration, alternative therapies should be considered. Efficacy and safety studies of Nasonex Nasal Spray for the treatment of nasal polyposis were four months in duration. Seasonal or Perennial Allergic Rhinitis: *Adults and children over the age of 12 years:* Two sprays (50 micrograms/spray) in each nostril once daily (total dose 200 micrograms). Once symptoms are controlled, dose reduction to one spray in each nostril (total dose 100 micrograms) may be effective for maintenance. If symptoms are inadequately controlled, the dose may be increased to a maximum daily dose of four sprays in each nostril (total dose 400 micrograms). Dose reduction is recommended following control of symptoms. *Children 6 to 11 years of age:* One spray (50 micrograms/spray) in each nostril once daily (total dose 100 micrograms). Clinically significant onset of action occurs in some patients within 12 hours after the first dose. Full benefit of treatment may not be achieved in the first 48 hours. Regular use is recommended to achieve full therapeutic benefit.

Contraindications: Hypersensitivity to any of the ingredients. Do not use in the presence of untreated localised infection involving the nasal mucosa. Patients who have experienced recent nasal surgery or trauma should not use a nasal corticosteroid until healing has occurred.

Precautions and Warnings: Use with caution, if at all, in patients with active or quiescent tuberculous infections of the respiratory tract, or in untreated fungal, bacterial, systemic viral infections or ocular herpes simplex. There was no evidence of atrophy of the nasal mucosa following 12 months of treatment. Patients using Nasonex over several months or longer should be examined periodically for changes in the nasal mucosa. If localised fungal infection of the nose or pharynx develops, discontinuance of Nasonex therapy or appropriate treatment may be required. Persistence of nasopharyngeal irritation may be an indication for discontinuing Nasonex. The concomitant use of additional therapy may provide additional relief particularly of ocular symptoms. There is no evidence of HPA axis suppression following prolonged treatment with Nasonex. Patients who are transferred from long-term administration of systemically active corticosteroids to Nasonex require careful attention. The safety and efficacy of Nasonex has not been studied for use in the treatment of unilateral polyps, polyps associated with cystic fibrosis, or polyps that completely obstruct the nasal cavities. Unilateral polyps that are unusual or irregular in appearance, especially if ulcerating or bleeding, should be further evaluated. Patients who are potentially immunosuppressed should be warned of the risk of exposure to certain infections. Very rarely, nasal septum perforation or increased intraocular pressure have been reported following the use of intranasal corticosteroids. Nasonex should only be used in pregnant women, nursing mothers or women of child-bearing age if the potential benefit justifies the potential risk to the mother, foetus or infant. Growth retardation has been reported in children receiving nasal corticosteroids at licensed doses. It is recommended that the height of children receiving prolonged treatment with nasal corticosteroids is regularly monitored. If growth is slowed, therapy should be reviewed with the aim of reducing the dose of nasal corticosteroid, if possible, to the lowest dose at which effective control of symptoms is maintained. In addition, consideration should be given to referring patient to a paediatric specialist. Safety and efficacy of Nasonex Nasal Spray for the treatment of nasal polyposis in children and adolescents under 18 years of age have not been studied. Treatment with higher than recommended doses may result in clinically significant adrenal suppression. If there is evidence for higher than recommended dose being used, then additional systemic corticosteroid cover should be considered during periods of stress or elective surgery. In a placebo-controlled clinical trial in which paediatric patients (n=49/group) were administered Nasonex 100 micrograms daily for one year, no reduction in growth velocity was observed.

Interactions: A clinical interaction study was conducted with loratadine. No interactions were observed.

Side Effects: Adverse effects commonly reported in clinical trials in adult and adolescent patients include headache, epistaxis, pharyngitis, nasal burning, nasal irritation and nasal ulceration. Other less common and rarely reported side effects are listed in the SPC.

Package Quantities: 18g per bottle, supplied with a metered-dose manual spray pump actuator which delivers 50 micrograms per actuation. NHS Price £7.68.
Legal Category: Prescription Only Medicine.

Marketing Authorisation Number: PL 00025/0367.

Marketing Authorisation Holder: Merck Sharp & Dohme Limited, Hertford Road, Hoddesdon, Hertfordshire, EN11 9BU, UK.

Date of revision of text: July 2011

Nasonex/UK/PI/07-11/09

Reference:
1. IMS Health, HPA | R01A1, February 2010 – January 2011.

09-13 MSX 11 GB 24861 JD

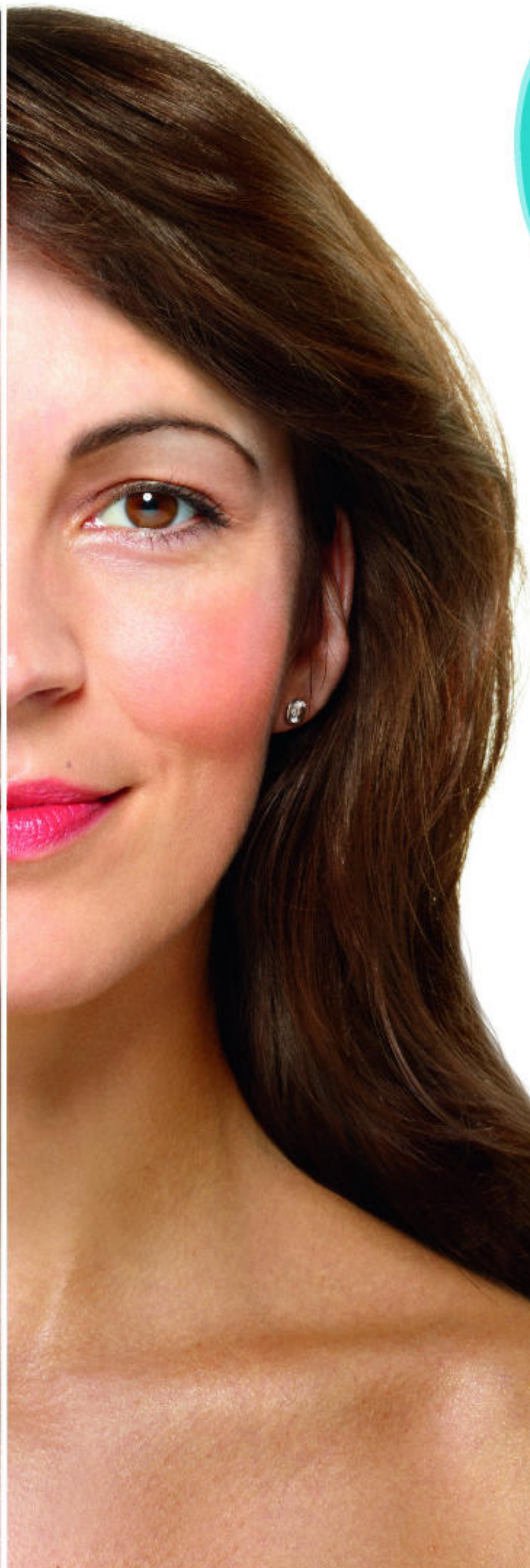
Date of preparation: September 2011

CHAMPIX has more than 18 million treatment courses initiated worldwide[6]

CHAMPIX®▼ Film-Coated Tablets (varenicline tartrate) ABBREVIATED PRESCRIBING INFORMATION – UK (See CHAMPIX Summary of Product characteristics for full Prescribing Information) Please refer to the SmPC before prescribing CHAMPIX 0.5 mg and 1mg. **Presentation:** White, capsular-shaped, biconvex tablets debossed with "Pfizer" on one side and "CHX 0.5" on the other side and light blue, capsular-shaped, biconvex tablets debossed with "Pfizer" on one side and "CHX 1.0" on the other side. **Indications:** CHAMPIX is indicated for smoking cessation in adults. **Dosage:** The recommended dose is 1 mg varenicline twice daily following a 1-week titration as follows: Days 1-3: 0.5 mg once daily, Days 4-7: 0.5 mg twice daily and Day 8 – End of treatment: 1 mg twice daily. The patient should set a date to stop smoking. Dosing should usually start 1-2 weeks before this date. Patients who are not willing or able to set the target quit date within 1-2 weeks, could be offered to start treatment and then choose their own quit date within 5 weeks. Patients who cannot tolerate adverse effects may have the dose lowered temporarily or permanently to 0.5 mg twice daily. Patients should be treated with CHAMPIX for 12 weeks. For patients who have successfully stopped smoking at the end of 12 weeks, an additional course of 12 weeks treatment at 1 mg twice daily may be considered. Following the end of treatment, dose tapering may be considered in patients with a high risk of relapse. **Patients with renal insufficiency;** *Mild to moderate renal impairment:* No dosage adjustment is necessary. *Patients with moderate renal impairment who experience intolerable adverse events:* Dosing may be reduced to 1 mg once daily. *Severe renal impairment:* 1 mg once daily is recommended. Dosing should begin at 0.5 mg once daily for the first 3 days then increased to 1 mg once daily. *Patients with end stage renal disease:* Treatment is not recommended. **Patients with hepatic impairment and elderly patients;** No dosage adjustment is necessary. **Paediatric patients;** Not recommended in patients below the age of 18 years. **Contraindications:** Hypersensitivity to the active substance or to any of the excipients. **Warnings and precautions:** *Effect of smoking cessation:* Stopping smoking may alter the pharmacokinetics or pharmacodynamics of some medicinal products, for which dosage adjustment may be necessary (examples include theophylline, warfarin and insulin). Changes in behaviour or thinking, anxiety, psychosis, mood swings, aggressive behaviour, depression, suicidal ideation and behaviour and suicide attempts have been reported in patients attempting to quit smoking with CHAMPIX in the post-marketing experience. Not all patients had stopped smoking at the time of onset of symptoms and not all patients had known pre-existing psychiatric illness. CHAMPIX should be discontinued immediately if agitation, depressed mood or changes in behaviour or thinking that are of concern for the doctor, the patient, family or caregivers are observed, or if the patient develops suicidal ideation or suicidal behaviour. In many post-marketing cases, resolution of symptoms after discontinuation of varenicline was reported, although in some cases the symptoms persisted; therefore, ongoing follow up should be provided until symptoms resolve. Depressed mood, rarely including suicidal ideation and suicide attempt, may be a symptom of nicotine withdrawal. In addition, smoking cessation, with or without pharmacotherapy, has been associated with the exacerbation of underlying psychiatric illness (e.g. depression). In a trial of patients with stable cardiovascular disease (CVD) certain cardiovascular events were reported more frequently in patients treated with CHAMPIX. Patients taking CHAMPIX should be instructed to notify their doctor of new or worsening cardiovascular symptoms and to seek immediate medical attention if they experience signs and symptoms of myocardial infarction. The safety and efficacy of CHAMPIX in patients with serious psychiatric illness has not been established. There is no clinical experience with CHAMPIX in patients with epilepsy. At the end of treatment, discontinuation of CHAMPIX was associated with an increase in irritability, urge to smoke, depression, and/or insomnia in up to 3% of patients, therefore dose tapering may be considered. There have been post-marketing reports of hypersensitivity reactions including angioedema and reports of rare but severe cutaneous reactions, including Stevens-Johnson Syndrome and Erythema Multiforme in patients using varenicline. Patients experiencing these symptoms should discontinue treatment with varenicline and contact a health care provider immediately. **Fertility, pregnancy and lactation:** CHAMPIX should not be used during pregnancy. It is unknown whether varenicline is excreted in human breast milk. CHAMPIX should only be prescribed to breast feeding mothers when the benefit outweighs the risk. There are no clinical data on the effects of varenicline on fertility. Non-clinical data revealed no hazard for humans based on standard male and female fertility studies in the rat. **Driving and operating machinery:** CHAMPIX may have minor or moderate influence on the ability to drive and use machines. CHAMPIX may cause dizziness and somnolence and therefore may influence the ability to drive and use machines. Patients are advised not to drive, operate complex machinery or engage in other potentially hazardous activities until it is known whether this medicinal product affects their ability to perform these activities. **Side-Effects:** Adverse reactions during clinical trials were usually mild to moderate. Most commonly reported side effects were abnormal dreams, insomnia, headache and nausea. Commonly reported side-effects were increased appetite, somnolence, dizziness, dysgeusia, vomiting, constipation, diarrhoea, abdominal distension, stomach discomfort, dyspepsia, flatulence, dry mouth and fatigue. See SmPC for other less commonly reported side effects. **Overdose:** Standard supportive measures to be adopted as required. Varenicline has been shown to be dialyzed in patients with end stage renal disease, however, there is no experience in dialysis following overdose. **Legal category:** POM **Basic NHS cost:** Pack of 25 11 x 0.5 mg and 14 x 1mg tablets Card (EU/1/06/360/003) £27.30 Pack of 28 1mg tablets Card (EU/1/06/360/004) £27.30 Pack of 56 0.5 mg tablets HDPE Bottle (EU/1/06/360/001) £54.60 Pack of 56 1mg tablets HDPE Bottle (EU/1/06/360/002) £54.60 Pack of 56 1mg tablets Card (EU/1/06/360/005) £54.60 Not all pack sizes may be marketed / marketed at launch. **Marketing Authorisation Holder:** Pfizer Limited, Sandwich, Kent, CT13 9NJ, United Kingdom. **Further information on request:** Pfizer Limited, Walton Oaks, Dorking Road, Tadworth, Surrey KT20 7NS **Last revised:** 03/2012 **Ref:** CI10_0

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 Pfizer Medical Information on 01304 616161.

References: 1. Hughes JR. New treatments for smoking cessation. CA Cancer J Clin 2000; 50:143-151. **2.** Nides M *et al.* Varenicline versus bupropion SR or placebo for smoking cessation: a pooled analysis. Am J Health Behav 2008; 32:664-675. **3.** Boudrez H *et al.* Effectiveness of varenicline as an aid to smoking cessation: results of an inter-European observational study. Curr Med Res Opin 2011; 27:769-775. **4.** Blak BT *et al.* Evaluation of varenicline as an aid to smoking cessation in UK general practice – a THIN database study. Curr Med Res Opin 2010; 26:861-870.
5. CHAMPIX® Summary of Product Characteristics. Last updated April 2012.
6. Data on file – IMS Midas Data: Nov 2011 – June 2011.



Years of smoking... Failing to quit... Time to try CHAMPIX?[1–4]

- Many of your patients may have tried and failed to quit with willpower or over-the-counter NRT[1]
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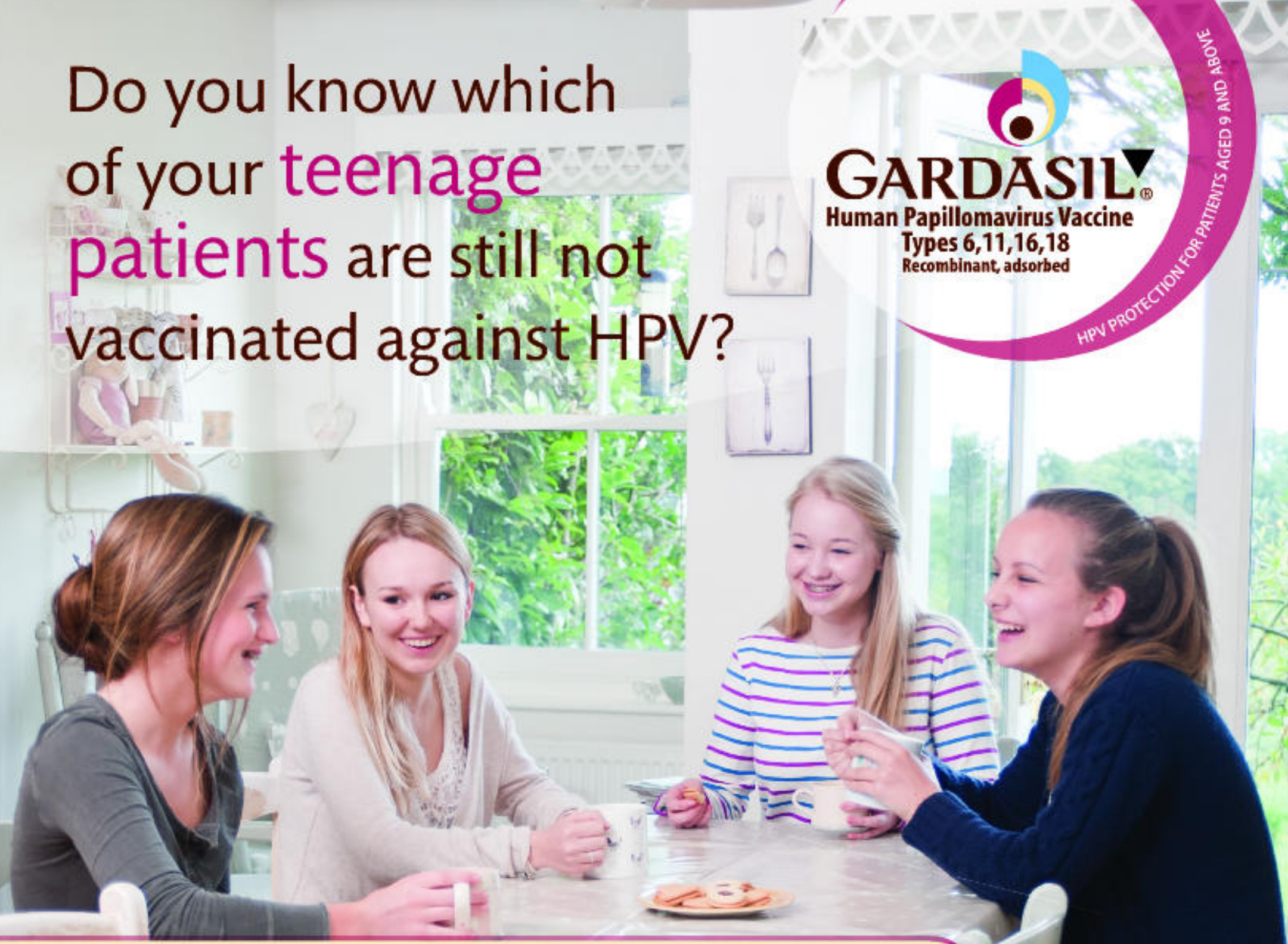
Do you know which of your teenage patients are still not vaccinated against HPV?



GARDASIL®
Human Papillomavirus Vaccine
Types 6,11,16,18
Recombinant, adsorbed

HPV PROTECTION FOR PATIENTS AGED 9 AND ABOVE

In 2010/11, over 10% of eligible girls did not start their course of HPV vaccination.[1]

You have an opportunity to change this. Gardasil® is available at no cost for GP practices through Movianto UK Ltd, for all previously unvaccinated girls aged 12-17.

Identify them, then help protect them.

For further information, contact your local Sanofi Pasteur MSD representative or visit www.gardasil.co.uk

ABRIDGED PRESCRIBING INFORMATION

GARDASIL® (Human Papillomavirus Vaccine [Types 6, 11, 16, 18] (Recombinant, adsorbed)).

Refer to Summary of Product Characteristics for full product information.

Presentation: Gardasil is supplied as a single dose pre-filled syringe containing 0.5 millilitre of suspension. Each dose of the quadrivalent vaccine contains highly purified virus-like particles (VLPs) of the major capsid L1 protein of Human Papillomavirus (HPV). These are type 6 (20 µg), type 11 (40 µg), type 16 (40 µg) and type 18 (20 µg). **Indications:** Gardasil is a vaccine for use from the age of 9 years for the prevention of premalignant genital lesions (cervical, vulvar and vaginal) and cervical cancer causally related to certain oncogenic Human Papillomavirus (HPV) types and genital warts (condyloma acuminata) causally related to specific HPV types. The indication is based on the demonstration of efficacy of Gardasil in females 16 to 45 years of age and in males 16 to 26 years of age and on the demonstration of immunogenicity of Gardasil in 9- to 15-year old children and adolescents. **Dosage and administration:** The primary vaccination series consists of 3 separate 0.5 millilitre doses administered according to the following schedule: 0, 2, 6 months. If an alternate schedule is necessary the second dose should be administered at least one month after the first and the third dose at least three months after the second. All three doses should be given within a 1 year period. The need for a booster dose has not been established. The vaccine should be administered by intramuscular injection. **Contraindications:** Hypersensitivity to any component of the vaccine. Hypersensitivity after previous administration of Gardasil. Acute severe febrile illness. **Warnings and precautions:** The decision to vaccinate an individual should take into account the risk for previous HPV exposure and potential benefit from vaccination. As with all vaccines, appropriate medical treatment should always be available in case of rare anaphylactic reactions. The vaccine should be given with caution to individuals with thrombocytopenia or any coagulation disorder because bleeding may occur following an intramuscular administration in these individuals. Syncope, sometimes associated with falling, has occurred after vaccination with Gardasil; vaccinees should be carefully observed for approximately 15 minutes after vaccination. There is insufficient data to recommend use of Gardasil during pregnancy therefore the vaccination should be postponed until after completion of the pregnancy. The vaccine can be given to breastfeeding women. Gardasil will only protect against diseases that are caused by HPV types 6, 11, 16 and 18 and to some limited extent against diseases caused by certain related HPV types. Vaccination is not a substitute for routine cervical screening. Individuals with impaired immune responsiveness, due to either the use of potent immunosuppressive therapy, a genetic defect, or other causes, may not respond to the vaccine. As with any vaccine, vaccination with Gardasil may not result in protection in all vaccine recipients. There are no safety, immunogenicity or efficacy data to support interchangeability of Gardasil with other HPV vaccines. **Undesirable effects:** Very common side effects include: headache and at the injection site, erythema, pain and swelling. Common side effects include bruising and pruritus at the injection site, pyrexia, nausea, and pain in the extremity. Rarely urticaria and very rarely bronchospasm has been reported. Idiopathic thrombocytopenic purpura, Guillain-Barré Syndrome and hypersensitivity reactions including, anaphylactic/anaphylactoid reactions have also been reported. For a complete list of undesirable effects please refer to the Summary of Product Characteristics. **Package quantities and basic NHS cost:** Single pack containing one 0.5 millilitre dose pre-filled syringe with two separate needles. **NHS cost:** £86.50 per dose. **Marketing authorisation holder:** Sanofi Pasteur MSD SNC, 8 rue Jonas Salk, F-69007, Lyon, France **Marketing authorisation number:** EU/1/06/357/007 (pre-filled syringe with two separate needles) **Legal category:** POM ® Registered trademark **Date of last review:** May 2012

References: 1. Department of Health, Third Annual Report on HPV coverage. http://immunisation.dh.gov.uk/annual-hpv-vaccine-coverage-in-england-in-201011-report/ Date accessed August 2012.

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

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UK15592 a 08/12

GPs warned over statin dose with CCB

MHRA tells GPs to cut simvastatin dose with amlodipine to 20mg

By Gemma Collins

The medicines regulator has recommended that GPs should switch all patients who take simvastatin 40mg in combination with the calcium channel blocker amlodipine to a lower dose of statin – or another statin altogether – because of the risk of muscle damage.

The warning from the MHRA changes the dosage recommendations for patients taking simvastatin in conjunction with diltiazem, or amlodipine, to a maximum dose of 20mg a day.

The latest update – issued in the MHRA's August drug safety update – also warns that simvastatin is now contraindicated with ciclosporin, danazol and gemfibrozil.

The dosage change and additional contraindications were prompted by analysis of clinical trial data that found 'these interactions may increase plasma concentrations of simvastatin which is associated with an increased risk of myopathy and/or rhabdomyolysis', according to the MHRA.

The changes come after the MHRA issued a warning in May 2010 about the increased risk of myopathy associated with the use of 80mg simvastatin.

GPs said the new advice from the medicines regulator would have a big impact as the drugs affected were among the most widely prescribed in primary care.

Dr Kathryn Griffith, a GP in York and GPSI in cardiology, said the dosage change was going to affect a 'huge number' of patients.

'It is a complete pain,' she said. 'We are now going to have to search for the patients, write to them all and reduce their doses.

'The pain is that the PCT has been trying to encourage us to switch from atorvastatin to simvastatin because of the cost and now we are going to have to switch back.'

She added: These patients are stable. There is not a big risk of myopathy.'

Dr John Allingham, a GP in Dover and medical secretary at Kent LMC, said that as simvastatin 40mg was the 'standard dose' for primary prevention the move would affect many of his patients being treated for hypertension.

'Practices will have to identify their patients, write to them and then change them over,' he said. 'I think most GPs will change them over to atorvastatin instead.'

Dr Terry McCormack, a GP in Whitby, North Yorkshire, said the advice was 'surprising'. 'Amlodipine is such an excellent antihypertensive that it will continue to be prescribed. We will just need to prescribe different statins with it.'

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SEMINAR
Diabetes and CVD update
pulse-seminars.com

Myopathy risk from amlodipine or diltiazem interaction

The MHRA's advice

Considering the risk of myopathy associated with simvastatin, recent analysis of clinical trial data, spontaneously reported cases and drug-drug interaction studies have resulted in further changes to the simvastatin prescribing information. Key points to note are that:

- **simvastatin is now contraindicated with ciclosporine, danazol and gemfibrozil**
- **the maximum recommended dose for simvastatin in conjunction with amlodipine or diltiazem is now 20mg per day**

Source: MHRA, *Drug Safety Update* August 2012

Four ways to make prescribing data work for you
▶ page 58

Lead analyst of flagship DH pilot warns against hasty rollout after conflicting evidence on mortality

TELEHEALTH

Caution urged on telehealth

By Madlen Davies

GP commissioners should be cautious about rolling out telehealth initiatives too quickly as they may have 'negative consequences' for patients, according to the lead investigator of the Government's flagship pilot.

The admission comes despite recent evidence from the Government's Whole Systems Demonstrator (WSD) pilot showing telehealth programmes can reduce mortality and hospital admissions.

In an exclusive interview with Pulse, Adam Steventon, senior research analyst at the Nuffield Trust and project lead on the WSD programme, said the evaluation was producing 'interesting findings'.

But he admitted that even when the full pilot results are published it would be premature to expect the benefits seen to be reflected in routine practice.

Preliminary results released last year prompted the DH to launch a '3millionlives' campaign to encourage GP commissioners to extend the use of telehealth and telecare technologies to three million people over the next five years.

In June, the first two of five academic papers were published detailing the results of the WSD trial, the largest randomised controlled trial of telehealth and telecare in the world.

They showed a 19% reduction in emergency admissions in patients provided with telehealth compared with controls. Mortality was 4.6% compared with 8.3% in controls.

The UK telehealth pilot has reduced admissions and deaths but other trials have seen the opposite

But Mr Steventon said conflicting results from different trials of telehealth meant any extension of its use should be tracked so its impact in different settings could be monitored.

He said: 'The [WSD] evaluation findings will only relate to telehealth as implemented in this particular trial in these areas of England. We don't know what impact it would have if implemented outside of a trial setting in other areas.

'A [separate] study, which looked at patients with multiple chronic conditions, found that more deaths were associated with telehealth than the control group. While the mortality finding [from the WSD trial] is a strong incentive to roll out telehealth, [we] must understand why telehealth has this effect in this setting and the opposite in another – how can we avoid the negative consequences?'

A spokesperson for the DH insisted the WSD trial provided the evidence to support the 3millionlives initiative. He said: 'It shows changes in utilisation are a reality and mortality can be significantly improved as well as care being better planned.'

Dr David Jenner, a GP in Cullompton, Devon, and senior policy adviser at the NHS Alliance, said telehealth could have benefits, but added: 'There's always a danger with Government-funded trials that it's policy-based evidence rather than evidence-based policy. Unless costs for primary care and other problems are tackled, widespread rollout may not produced the desired results.'

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MORE ONLINE
Watch The Big Interview with the Nuffield Trust's Adam Steventon
pulsetoday.co.uk/videos

VIEWPOINT

How we gave telehealth a vital human element

Telehealth is very good but it needs a human face. Our practice started a management scheme for patients with dementia using telemonitoring, which we expanded to other clinical areas when it was found to be successful.

We hired 'primary care liaison officers', local people we paid to be the patient's advocate and help them use the telehealth technology. This meant patients had a single point of contact and weren't isolated.

They collected all the data we needed and brought it back to the outreach centre where a psychiatrist or the GP created a treatment plan, which the liaison officer explained to the patient.

We gave patients a tablet which worked on a mobile or wifi network. When a district nurse or a carer came in, they touched the tablet with their Blackberry, and the tablet informed them of a ticklist of tasks we thought they should be doing. If that didn't happen, the doctors and family were notified. If you had a parent who was vulnerable, you'd want to know if they weren't getting cared for.

Similarly, with patients who were on the brink of an unscheduled admission for different problems, we created treatment plans, then decided who between the GP and the family was responsible for each part of the care.

The treatment plan gave advice such as 'this ulcer should clear up in x days'. The family would monitor this, and if they or the patient deemed the plan wasn't working, we'd be notified electronically and bring them in and change it.

The scheme saved £1.5m out of a budget of £8m. This was by rationalising care by following the patient journey; asking whether patients needed all these outpatient appointments and whether the family valued them.

Telehealth on its own doesn't work, but telehealth with a workforce that's going to support it can help people take responsibility for their own health.

Dr Ian Greaves is a GP in Stafford, whose practice has used telemonitoring technology in a management scheme for patients with dementia

MANAGEMENT ALLOWANCE

Quality premium to be £5 per patient

The Government has revealed CCGs will be given up to £5 per head of population to share among practices if they achieve their targets 'with no caveats' at all.

The Government's national director of commissioning development Dame Barbara Hakin said the money could be given to practices with 'no caveats at all', or be distributed to them by their CCG 'with certain caveats'.

The £5 quality premium payment will be paid alongside a management allowance of £25 per patient.

Speaking in an NHS Commissioning Board webinar last week, Dame Barbara said that 'up to £5 a head' will be dependent on CCGs meeting Commissioning Outcomes Framework (COF) targets and achieving 'financial balance'.

Final regulations, expected before Parliament in October, will set out which targets CCGs will need to deliver on to achieve the premium, which is fiercely opposed by the GPC.

'Premium should be added to management allowances'
Dr Chaand Nagpaul

The regulations will also stipulate whether the premium will be linked to financial performance, and how the money will be distributed to member practices.

Dame Barbara said: 'One could imagine that that money could be handed out to practices with no caveats at all, or it could be for the CCG to use in a different way, or it could be for the CCG to hand out to practices, but with certain caveats.'

The outcomes framework will assess CCGs across eight areas, including mortality for cancer and respiratory disease, patient experience of GP out-of-hours services and emergency admissions. The quality premium will be brought in from 2014.

GPC negotiator Dr Chaand Nagpaul said the £5 per patient should be added to the CCGs' management allowances, rather than being paid to practices, as it could skew their priorities away from local populations.

He said: 'We would have wanted CCGs to have £30, based on PCTs getting £30-35 [per patient] and the greater pressure that will be put on CCGs. We don't think it should be a premium or an add-on.'

GP ENGAGEMENT

Concern as CCGs fail to engage with salaried GPs

Concerns have been raised that CCGs are failing to engage with salaried GPs after a survey found fewer than a fifth of salaried GPs were asked to get involved in commissioning.

A report based on a survey by Leeds LMC revealed only 18% of salaried GPs had been invited to contribute to their local CCG.

The survey also found that one of the seven salaried GPs involved in a CCG was involved 'against her wishes' while another was expected to contribute in his own time, according to the survey of 40 doctors.

Dr Richard Fieldhouse, chief executive of the National Association of Sessional GPs, said the feeling of disengagement was a 'big concern' across the whole country. He said: 'There are some practices who think that if they are going to have GPs involved with CCGs, it should be partners rather than salaried GPs. But there are a lot of good reasons why it is a fantastic opportunity for salaried GPs, particularly as they don't have any conflicts of interest.'

Dr Vicky Weeks, chair of the GPC's sessional GPs subcommittee, said: 'Some CCGs lack understanding of the GP workforce.'

PUBLIC HEALTH

Free vitamin D can halve deficiency rate

Public health campaigns offering free vitamin D supplements to at-risk groups can significantly reduce deficiency rates, say UK researchers.

The analysis shows a scheme in Birmingham offering vitamin D supplements to all pregnant and breastfeeding women and the under-fives resulted in a 59% reduction in cases of symptomatic vitamin D deficiency in four years.

The study – published in *Archives of Disease in Childhood* last month – comes after the Chief Medical Officer wrote to all GPs in January to remind them to advise pregnant and breastfeeding women and under-fives to take vitamin D supplements.

The CMO's letter has been criticised by CCGs over fears it could lead to 'excessive' prescribing costs. Recent data showed the number of prescriptions for vitamin D leapt 16% in the year to January.

In the new study, public health officials in Birmingham made free vitamin drops available to all eligible women and children through GP surgeries and health visitors in an inner-city population where 75% of the population were from at-risk ethnic minority groups.

Dr Nicholas Shaw, consultant paediatric endocrinologist at Birmingham Children's Hospital, said: 'As far as we know, the only previously published evidence for success of a public health campaign to tackle vitamin D deficiency in children was from Glasgow over 25 years ago.'

By prescribing we medicalise a problem we can sort in other ways
Dr Anthony Everington

Dr Anthony Everington, a GP in Bow, east London, said: 'The vast majority of vitamin D deficiency relates to lifestyle. Is there a risk we're medicalising a problem we need to sort in other ways?

Ready for revalidation

Dear Doctor

We're getting ready to start revalidating doctors from December onwards, subject to the Secretary of State's decision to go ahead with revalidation this year.

Organisations across the UK are getting ready to support doctors; the systems the GMC needs to start revalidation are in place; and patients say they've waited long enough for the assurance that revalidation will give them.

As licensed doctors, we can get ready in the following ways:

- **Know the organisation that will give you a regular appraisal and support you with revalidation.** The responsible officer of this organisation – your 'designated body' – will be the person who makes a revalidation recommendation about you.
- **Make sure you have a regular appraisal based on *Good Medical Practice*.** If you're a doctor in training, you should take part in the ARCP process as normal.
- **Start collecting your supporting information.** You will need six types for your appraisal, including evidence of CPD. Many doctors collect this information already for their practice.

Your first revalidation

We will give you plenty of notice and plan to start telling you the date of your first revalidation in December. Most doctors will revalidate between April 2013 and March 2016.

Professor Sir Peter Rubin
Chair of the GMC

Our website has guidance and more information to help you prepare for revalidation. Please visit www.gmc-uk.org/ready4reval

General Medical Council

Regulating doctors
Ensuring good medical practice

With a long-term record of success in reducing symptoms, exacerbations and hospitalisations vs placebo, SPIRIVA® is a LAMA you can count on to help lead your COPD patients to everyday victories.[1,2]

LAMA = long-acting muscarinic antagonist.

References: 1. SPIRIVA® 18 µg Summary of Product Characteristics. http://medicines.org.uk/emc. Accessed August 2012. 2. Tashkin DP *et al.* for the UPLIFT Study Investigators. A 4-year trial of tiotropium in chronic obstructive pulmonary disease. *N Engl J Med* 2008;359:1543–1554.

Prescribing Information (UK) SPIRIVA® (tiotropium) Inhalation powder, hard capsules containing 18 microgram tiotropium (as bromide monohydrate). **Indication:** Tiotropium is indicated as a maintenance bronchodilator treatment to relieve symptoms of patients with chronic obstructive pulmonary disease (COPD). **Dose and Administration:** Adults only age 18 years or over: Inhalation of the contents of one capsule once daily from the HandiHaler® device. **Contraindications:** Hypersensitivity to tiotropium bromide, atropine or its derivatives, or to the excipient lactose monohydrate which contains milk protein. **Warnings and Precautions:** Not for the initial treatment of acute episodes of bronchospasm, i.e. rescue therapy. Immediate hypersensitivity reactions may occur after administration of tiotropium bromide inhalation powder. Caution in patients with narrow-angle glaucoma, prostatic hyperplasia or bladder-neck obstruction. Inhaled medicines may cause inhalation-induced bronchospasm. In patients with moderate to severe renal impairment (creatinine clearance ≤ 50 ml/min) tiotropium bromide should be used only if the expected benefit outweighs the potential risk. Patients should be cautioned to avoid getting the drug powder into their eyes. They should be advised that this may result in precipitation or worsening of narrow-angle glaucoma, eye pain or discomfort, temporary blurring of vision, visual halos or coloured images in association with red eyes from conjunctival congestion and corneal oedema. Should any combination of these eye symptoms develop, patients should stop using tiotropium bromide and consult a specialist immediately. Tiotropium bromide should not be used more frequently than once a day. Spiriva capsules contain 5.5 mg lactose monohydrate. **Interactions:** Although no formal drug interaction studies have been performed, tiotropium bromide inhalation powder has been used concomitantly with other drugs without clinical evidence of drug interactions. These include sympathomimetic bronchodilators, methylxanthines, oral and inhaled steroids, commonly used in the treatment of COPD. The co-administration of tiotropium bromide with other anticholinergic-containing drugs has not been studied and is therefore not recommended. **Fertility, Pregnancy and Lactation:** No documented clinical data on exposed pregnancies are available. The potential risk for humans is unknown. Tiotropium bromide should therefore only be used during pregnancy when clearly indicated. It is unknown whether tiotropium bromide is excreted in human breast milk. Use of tiotropium bromide during breast feeding is not recommended. A decision on whether to continue or discontinue breast feeding or therapy with tiotropium bromide should be made taking into account the benefit of breast feeding to the child and the benefit of tiotropium bromide therapy to the woman. Clinical data on fertility are not available for tiotropium. **Effects on ability to drive and use machines:** No studies have been performed. The occurrence of dizziness, blurred vision, or headache may influence the ability to drive and use machinery. **Undesirable effects:** Common (≥ 1/100 to <1/10) Dry mouth. Uncommon (≥ 1/1000 to <1/100) Dizziness, headache, taste disorders, vision blurred, atrial fibrillation, pharyngitis, dysphonia, cough, gastrooesophageal reflux disease, constipation, oropharyngeal candidiasis, rash, dysuria, urinary retention. Serious undesirable effects consistent with anticholinergic effects include glaucoma, constipation and intestinal obstruction including ileus paralytic as well as urinary retention. An increase in anticholinergic effects may occur with increasing age. Prescribers should consult the Summary of Product Characteristics for further information on side effects. **Pack sizes and NHS price:** Combopack HandiHaler device and 30 capsules (3 blister strips) £34.87 Refill Pack 30 capsules (3 blister strips) £33.50. **Legal category:** POM. **MA Number:** PL 14598/0062. **Marketing Authorisation Holder:** Boehringer Ingelheim International GmbH, D-55216 Ingelheim am Rhein, Germany. Prescribers should consult the Summary of Product Characteristics for full prescribing information. **Prepared in** August 2012.

Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard. Adverse events should also be reported to Boehringer Ingelheim Drug Safety on 0800 328 1627 (freephone).

Date of preparation: August 2012 UK/SPI-121330

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Founded on a decade of proven success

Top tips to optimise elderly care
▶ page 55

Talks start to merge PMS and GMS

PMS could 'disappear' into GMS contract as GPC begins negotiations with DH on single funding model

By Sofia Lind

A single GP contract could become a reality before the end of the coalition Government's term, the GPC chair believes.

In an exclusive interview with Pulse, Dr Laurence Buckman said the current assumption was that the new single contract 'will look like GMS', indicating that PMS could be subsumed. But he said it was too soon to say exactly what the model would look like.

Dr Buckman confirmed that negotiations with the Government on how to achieve the target of a single GP contract – first set out in the Government's 2010 health white paper – have started.

The plans will affect about 40% of GP practices in England, which currently operate under locally negotiated PMS deals. But the talks are not expected to affect APMS contracts.

PCTs across England have increasingly moved to slash local PMS budgets in a bid to save costs.

Dr Jane Lothian: Local flexibility needed on any new contract

Dr Buckman said: 'If we could make it work so it was financially fair, then [a single contract] is what we would like to see. Whether PMS will disappear into GMS I don't know, but I think the new GMS contract has a lot to commend it and I would like to see it continue.'

He said the complex process would require extensive advice from economists and lawyers: 'We would really like to do it very carefully to make sure no practice is damaged as a result. It is going to take a lot of time before we get this right, but I believe it is worth doing.'

A Department of Health spokesperson said: 'Developing a single contract for GPs is part of our plan to provide a consistent quality of care for patients and fairness for all practices. Negotiations are ongoing and any legislation will need to be approved by Parliament.'

Dr Jane Lothian, a GP in Ashington and medical secretary of Northumberland LMC, who works under a PMS contract, said: 'There should be room for local flexibility if there is a single contract. If we are creating a new contract, there is lots of room for improvement.'

@sofialind_Pulse

▶ Where does Dr Laurence Buckman feature in our Top 50 GPs? Find out on page 30

PMS: highs and lows

- APR 04 – PMS becomes a permanent alternative to GMS contract
- MAR 08 – Proportion of profession working under PMS (47%) reaches peak
- JUL 10 – White paper pledges to establish 'single funding model' for GPs
- JUL 11 – London GPs lose High Court battle to prevent PCTs unilaterally terminating PMS contracts

Scots plan 'doomed' to fail without GPs

GP leaders in Scotland are warning that radical plans to integrate health and social care into one organisation must engage GPs or be 'doomed to failure'.

Pulse has learned BMA Scotland's response to the Scottish Government's ongoing consultation on proposed changes to replace the unpopular community health partnerships (CHPs) will warn that GPs need to be 'at the heart' of these changes or they will walk away.

The Scottish Government plans to replace CHPs with new health and social care partnerships (HSCPs), which will have a much wider remit to plan and deliver health and social care through shared budgets and targets.

BMA Scotland will say the new partnership boards must have a central role for GPs, for example, by including LMC leaders.

It will also warn the Scottish Government that the overhaul must not result in the shift of more work from secondary care into primary care, further increasing the workload of GPs.

Dr Douglas Colville, Scottish GPC member, medical secretary for Glasgow LMC and a GP in the city, said: 'GPs are at the front-line of care, and if they are being disenfranchised it is doomed to failure. Some of the new proposals are good, but it will only work if they involve GPs.'

The deadline for responding to the public consultation, which was launched in July, has been extended to 11 September.

IN BRIEF

Revalidation warning

GPs who do not engage with revalidation could lose their licence to practise, according to new GMC guidance for responsible officers.

Full story ▶ pulsetoday.co.uk/practicenews

SGPC re-elects deputy

Perthshire GP Dr Andrew Bulst has been re-elected as the Scottish GPC's deputy chair.

Full story ▶ pulsetoday.co.uk/politicalnews

CQC visits Buckman

GPC chair Dr Laurence Buckman says it was 'almost a pleasant experience' to be visited by the CQC, after taking part in an inspection pilot.

Full story ▶ pulsetoday.co.uk/practicenews

1 in 4

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

ZOSTAVAX®▼

Shingles (herpes zoster) vaccine (live)

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

ABRIDGED PRESCRIBING INFORMATION

ZOSTAVAX® powder and solvent for suspension for injection [shingles (herpes zoster) vaccine (live)] *Refer to Summary of Product Characteristics for full product information.*

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

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

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

* The need for a second dose is currently unknown

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UK15206a c 06/12

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Dr Phil Peverley: The tale of a spurned lover
▶ page 22

Alert on partnership agreements

LMCs report increase in disputes between partners could be prevented by robust practice agreements

By Madlen Davies

A quarter of practices could be working without formal partnership agreements, leaving them at risk of legal disputes and possible dissolution, LMC leaders have warned.

Dr Nigel Watson, chief executive of Wessex LMCs, said between 20% and 30% of the 400 practices in his area were working without a legally binding agreement, which had led to an increase in partner disputes.

Other LMC leaders reported similar trends, with some practices working under outdated agreements and others not adding new partners to the contract.

BMA advice warns that practices operating without a partnership agreement leave themselves open to being dissolved by managers, sale of premises and an equal split of any assets in the event of a dispute between partners.

Dr Watson, a GP in the New Forest, Hampshire, said 10 practices that were considering a partnership split had come to his LMC for advice this year, with the number of disputes rising as GPs' workload and stress increased and income fell.

Dr Mohammed Jiva: practices are working without agreements

He said some practices were making an active decision to work without a partnership agreement as they believed it meant there would be fewer obligations or they were worried about the legal cost.

He said: 'We've seen minor problems escalate into major problems, and with no rulebook this rumbles on to the point where they want a partnership split. If you have a practice agreement, there's a standard agreement to refer to if disputes about the practice arise.'

Dr Mohammed Jiva, a GP in Middleton, Lancashire, and medical secretary of Rochdale and Bury LMC, also said 'plenty of practices' in his area were working without partnership agreements.

Dr Prakash Chandra, chair of Newham LMC, said: 'I'm sure some [practices] have not renewed partnership agreements – a new partner comes along and they don't change it when they're supposed to.'

@madlendavies

BMA advice on partnership agreements

- A partnership without an agreement is a 'partnership at will' and can be dissolved at any time
- Notice may be given without consent
- A split could result in the sale of the surgery premises
- All staff may be made redundant, incurring large financial liabilities
- All partners could be deemed to have equal profit shares, unless clear evidence to the contrary is provided

Premises legal advice urged

GP practices operating out of PCT-owned premises under a 'licence to occupy' have been urged to ensure they obtain legal advice on the terms of any lease agreement offered to them.

PCT-owned GP practices are due to be transferred to the Government's new independent property company – known as PropCo – or other NHS providers before PCTs are abolished in April 2013.

As part of this transfer, the GPC has warned GP practices without a current lease agreement – such as those operating under a licence – are likely to be offered a commercial lease with potentially worse conditions.

The GPC said this may leave practices vulnerable to higher rents, increased maintenance and repair costs and even possible eviction from their premises.

GPC chair Dr Laurence Buckman said practices should ensure they have a copy of their lease, but that the changes would particularly affect those under a licence to occupy. He said: 'We don't know what protection will be offered when the takeover happens, and that's why GPs need to get a lawyer to look over their agreement and ask: "Can the landlord kick us out within two months and build a Tesco?"

'It is not in PropCo's financial interest to evict GPs from their practices, but GPs need to be aware that a transfer from a licence to occupy to a lease might lead to less advantageous terms.'

Complaints against GP practices up by 8%

Complaints against GPs in England have increased by 8.2% in a year, official figures show.

A new report by the Health and Social Care Information Centre showed there were 54,870 written complaints against general practice (including dental) health services in 2011/12 compared with 50,708 in 2010/11.

But the figures showed that 33.8% of complaints were upheld.

The majority of complaints were around clinical issues, which attracted 19,336 complaints in 2011/12, 35.4% of the total.

Communication and attitude attracted the second highest number of complaints, with 11,650, 21.7% of the total. This was followed by general practice administration, with 9,924 complaints, some 18.5% of the total.

Dr Barry Moyse, secretary of Somerset LMC, said he felt the increase was symptomatic of general practice being seen as a consumer service.

He said: 'General practice is increasingly looked at as a commodity.

'Governments have encouraged that view. Therefore it is no surprise that people should come forward more often.'

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

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

* The need for a second dose is currently unknown

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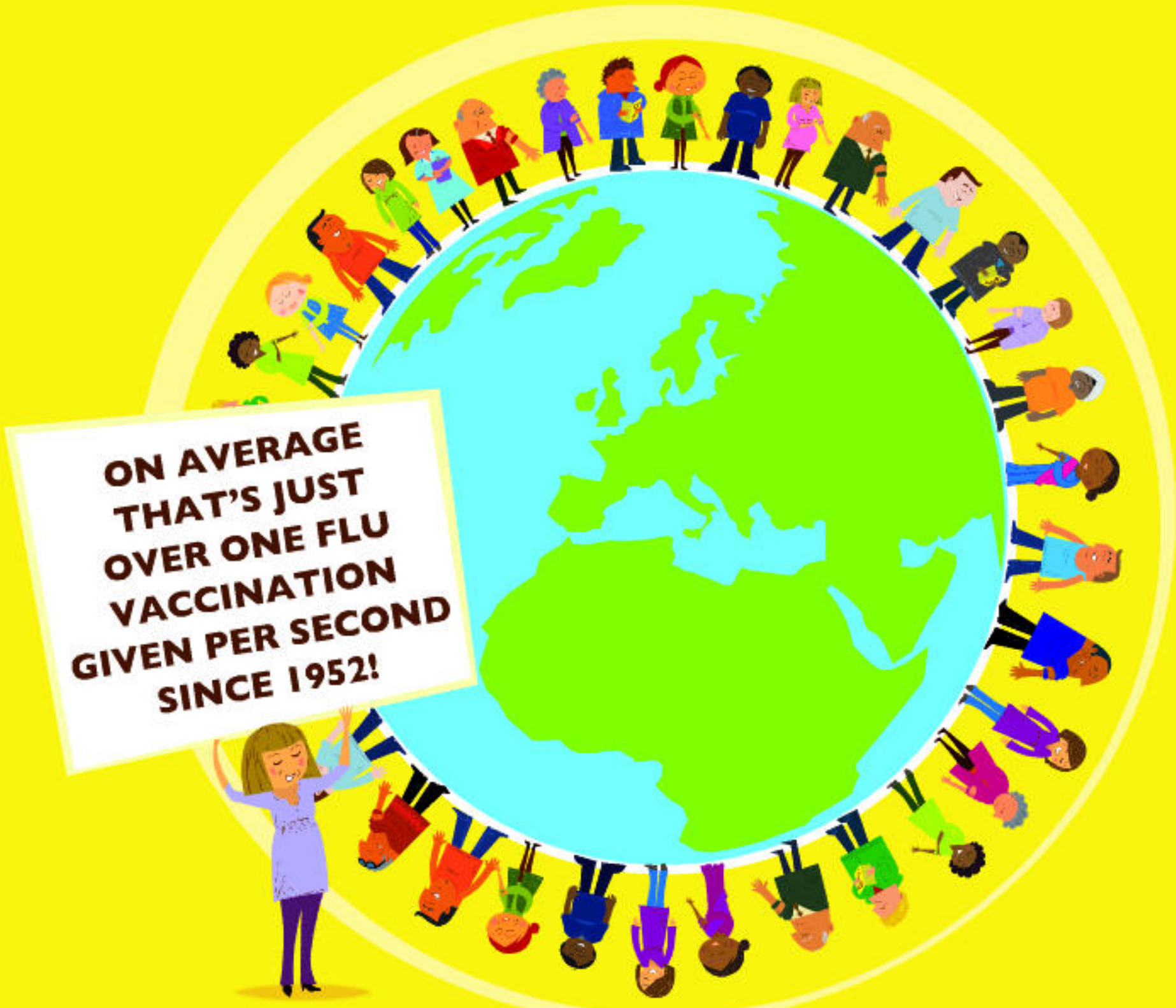

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Refer to Summary of Product Characteristics for full product information. **Presentation:** Inactivated Influenza Vaccine (Split Virion) BP contains 15 micrograms of antigen (per 0.5 millilitre) from each of the three virus strains recommended by the World Health Organization for the present influenza season. It is supplied as single dose prefilled syringes each containing 0.5 millilitre of suspension for injection. The vaccine may contain traces of eggs, such as ovalbumin, neomycin, formaldehyde and octoxinol 9 which are used during the manufacturing process. **Indications:** Prophylaxis of influenza especially in those who run an increased risk of associated complications. Inactivated Influenza Vaccine (Split Virion) BP is indicated in adults and children from 6 months of age. **Dosage and administration:** Adults and children from 36 months should receive one 0.5 millilitre dose. In children aged 6 months to 35 months clinical data are limited and dosages of 0.25 or 0.5 millilitre have been used. Children who have not been previously vaccinated should receive a second dose of vaccine after an interval of at least 4 weeks. Doses should be administered intramuscularly or deep subcutaneously. **Contraindications:** Hypersensitivity to the active substances, to any of the excipients, to eggs, chicken protein, neomycin, formaldehyde, and octoxinol 9. Immunisation should be postponed in patients with febrile illness or acute infection. **Warnings and precautions:** Do not administer intravascularly. Medical treatment should be available in the event of rare anaphylactic reactions following administration of the vaccine. Immunosuppressed subjects may not produce adequate antibodies. Other vaccines may be given at the same time at different sites, however adverse reactions may be intensified. **Pregnancy and lactation:** Inactivated influenza vaccines can be used in all stages of pregnancy. May be administered during lactation. **Undesirable effects:** Common side effects include: injection site reactions (redness, swelling, pain, ecchymosis, induration) and systemic reactions (fever, malaise, shivering, fatigue, headache, sweating, myalgia, arthralgia). These usually disappear within 1 to 2 days. Other serious side effects have been reported and include, allergic reactions (in rare cases leading to shock, angioedema), convulsions, transient thrombocytopenia, vasculitis with transient renal involvement and neurological disorders such as encephalomyelitis, neuritis and Guillain-Barré syndrome.
For a complete list of undesirable effects please refer to the Summary of Product Characteristics. **Package quantities and basic NHS cost:** Single dose prefilled syringes in single packs, basic NHS cost £6.59; packs of 10 single dose prefilled syringes, basic NHS cost £65.90. **Marketing authorisation holder:** Sanofi Pasteur MSD Limited, Mallards Reach, Bridge Avenue, Maidenhead, Berkshire, SL6 1QP. **Marketing authorisation number:** PL 6745/0095
Legal category: POM. Date of last review: April 2012

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UK15944 c 07/12

'GPs can help cut antenatal care bill'

Specialists say GPs could take on more unscheduled antenatal care and discourage expensive birth options

By Sofia Lind

GPs should take a greater responsibility for unscheduled antenatal care to save the NHS money, according to the Royal College of Obstetricians and Gynaecologists (RCOG).

Unscheduled care of pregnant women currently accounts for almost half of all spending on maternity care and GPs could help reduce this, says the report, produced in collaboration with the Royal College of Midwifes and parenting charity NCT.

Making sense of commissioning maternity services in England also urged GPs to play a role in discouraging women from caesareans and epidurals, and encouraging them to give birth in midwife-led units and, where appropriate, at home.

The report said women with 'low-level' conditions such as swollen ankles and UTIs could have more of their care in general practice.

'This will ease the pressure on busy maternity units and save commissioners money,' the report concluded.

It found that preventing a single caesarean section would save the NHS £1,200 in tariff price alone.

The report added: 'Women must receive consistent, positive information and advice from their health professionals if they are to have confidence in a normal birth.

'The first messages they receive will often be from their GP and these will powerfully influence their approach to their pregnancy.'

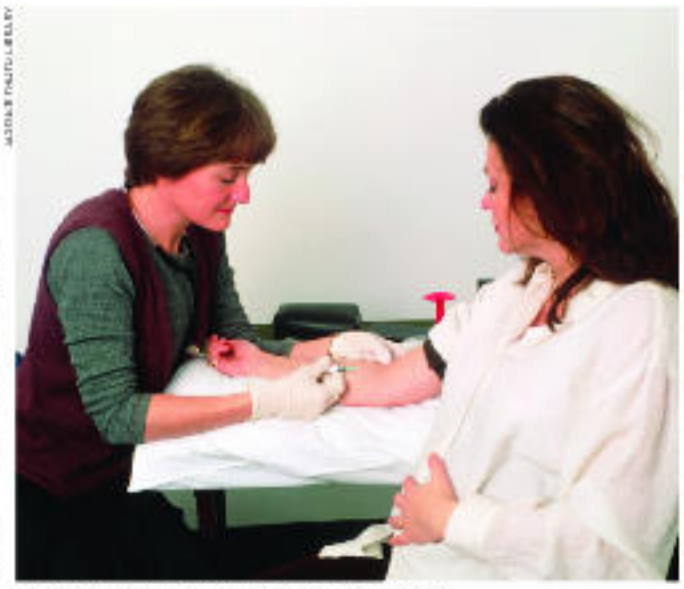
The guidance defines a normal birth as one without induction, without the use of instruments, not by caesarean section and without general, spinal or epidural anaesthetic before or during delivery.

Dr Sarah Jarvis, a GP in Hammersmith, West London, said she favoured GPs taking on more responsibility for antenatal care, but some GPs had become unskilled in obstetrics.

'Very few GPs are qualified to provide intrapartum care and cases need careful selection, with appropriate availability of a trained midwife and back-up emergency services,' she said.

'Most GPs are wary about home deliveries because of lack of personal experience and lack of up-to-date knowledge about services.'

@sofialind_Pulse



Have GPs become unskilled in obstetrics?

How maternity care should change

- Emphasis on pregnancy and birth as 'normal' processes
- Commitment to seamless service for women who require obstetric support
- Establishment of multi-profession partnership across antenatal, intrapartum and postnatal care
- Clarification of GPs' role as professionals involved in maternity care and commissioners of pathway

Source: RCOG. *Making sense of commissioning maternity services in England*. 2012

Infant schedule hit by IT blunder

GPs are having to follow up babies who may have missed childhood vaccinations after software problems at a local trust failed to recall those who missed appointments.

Buckinghamshire Healthcare NHS Trust has identified a problem with its software where infants who failed to attend their first immunisation appointment were not automatically recalled.

The trust took over the management of the child immunisation call and recall service a year ago, but has had to 'put other processes in place' so that GPs follow up patients affected by the IT error.

Dr Paul Roblin, chief executive of Buckinghamshire and Oxfordshire LMC, said the trust had failed to send some letters, sent some twice to the same child and sent some to incorrect addresses: 'It's their job to generate call lists and get the right children along. But they've invested in too few staff. Administratively, it's a dog's dinner.'

A spokesperson from Buckinghamshire Healthcare NHS Trust said: 'All patients continue to receive their first appointment letter inviting them to attend for their immunisations.

'A small minority fail to attend this first appointment and a small problem with the software enabling automatic recalls has been identified.

'We are continuing to work closely with our partners to resolve the issue as soon as possible.'

Cases of measles 'nearly double' in the past year

Parents are being urged to contact their GP to check if their child had both doses of MMR vaccine, after Health Protection Agency (HPA) figures show cases of measles have almost doubled in the past year.

The latest figures from the HPA show that 964 cases of measles were reported in the first six months of 2012, almost twice as many cases as in the same period in 2011, when 497 cases were reported.

Instances of rubella have also soared. The 57 cases reported between January and June this year exceed the annual totals for each of the previous nine years.

Dr Mary Ramsay, head of immunisation at the HPA, issued a message to parents: 'If you are unsure if your child has had two doses of the vaccination, speak to your GP, who will have a record.

'Although uptake of the MMR has improved in recent years some children do not get vaccinated on time and some older children, who missed out when uptake was lower, have not had a chance to catch up.'

Key questions: depression
▶ page 44

New study prompts expert to suggest tiotropium may be best option in patients with vascular risk factors

COPD

LABAs raise arrhythmia risk in COPD

By David Swan

Long-acting ß-agonists are associated with a raised risk of cardiac arrhythmias in patients with COPD, with the risk most marked in the first two months of taking the inhaler, conclude two new studies.

The findings prompted Europe's leading respiratory expert to suggest tiotropium may be a better option than salmeterol in patients with cardiac comorbidities and vascular risk factors.

The two new case control studies used a large Canadian patient database to compare use of short- and long-acting bronchodilators with risk of cardiac arrhythmias in patients with COPD and matched controls.

The larger of the two studies found new use of a LABA was associated with a 47% increased risk of arrhythmia, compared with controls. New use was defined as a gap of 60 days or less between starting the bronchodilator and suffering from the arrhythmia event. The study analysed data on 76,661 patients with COPD aged 67 years or more.

GPs are being encouraged to consider cardiac comorbidities when selecting drugs for COPD

Some 5,307 cases of arrhythmia were reported, including 621 deaths, over an average follow-up period of 6.7 years.

The smaller study, on a database of 6,018 patients with COPD aged 55 or over, found new use of a LABA was associated with a statistically significant 4.5-fold increased risk of arrhythmia compared with controls – although the data was based on just four cases.

The findings on other bronchodilators were more equivocal. The larger study reported a 27% increased risk with new use of a short-acting ß-agonist compared with controls, but the smaller study found no significant increase. Among new users of ipratropium, the larger study found a slightly – but not statistically significant – raised risk compared with controls, while the smaller study reported a 2.4-fold increased risk.

Study leader Professor Samy Suissa, director of pharmacoepidemiology at McGill University in Canada, said: 'Patients should be warned about and monitored for the onset of arrhythmia when instituting any new bronchodilator therapy.'

In an accompanying editorial, Professor Klaus Rabe, president of the European Respiratory Society and professor of medicine at the University of Kiel, Germany, said the evidence base was evolving, but it was important to consider comorbidities when selecting drugs in COPD: 'For cardiac comorbidities and vascular risks, the available evidence suggests that, first, anticholinergic drugs exhibit a favourable safety profile and, second, tiotropium appears preferable over ipratropium and salmeterol if you consider efficacy and safety together.'

But Dr John Ashcroft, a GP in Derbyshire and clinical lead for Erewash CCG, said he would want to see further trials confirming the findings before changing his practice and added: 'The research suggests there may be an increased risk of arrhythmia – and if it is a real effect, it's more an issue around starting [the medication].'

Chest 2012;142:298-311

david.swan@pulsetoday.co.uk

Increase in rate of cardiac arrhythmia

+27%
Short-acting ß agonists

+47%
Long-acting ß agonists

Data from case control study of 76,661 COPD patients. Risk relates to first 60 days of use.

Source: *Chest* 2012;142:305-11

CKD

CKD doubles bleeding risk with anticoagulants

Patients with chronic kidney disease have more than double the risk of bleeding from anticoagulation therapy compared with patients without CKD, according to Danish researchers.

Their study looked at 132,000 patients discharged from hospital with a diagnosis of atrial fibrillation over 12 years and found 3% had non end-stage CKD. They then determined the patients' pharmacotherapy and found that among those on anticoagulation, patients with CKD had more than twice the risk of bleeding compared with patients without renal disease. Patients who required renal-replacement therapy also had more than twice the risk of bleeding when taking anticoagulants, compared with patients without CKD.

Among patients taking warfarin plus aspirin, those with CKD had a 61% higher risk of bleeding than those without renal disease.

For warfarin alone, CKD raised the risk by 33% and for aspirin by 17%.

The researchers concluded: 'The net clinical effect of warfarin treatment requires careful assessment in patients with CKD.'

***N Eng J Med* 2012, online 16 August**

CVD

High-potency statins link with muscle damage

GPs should consider prescribing a lower-potency statin if a patient experiences a muscle-related adverse event, concludes a major analysis of US data.

The study analysed all case reports of muscle-related adverse events with statins from the US Food and Drug Administration's adverse event reporting system over six years.

Of the 57,000 case reports identified, rosuvastatin was found to have the highest risk of muscle-related adverse events compared with all other statins.

With rosuvastatin designated a 100% relative risk to the other statins, the next highest risk statin was atorvastatin with a 55% risk of events, followed by simvastatin at 26%, pravastatin at 17% and lovastatin at 7.5%.

These risks were found to approximately track with milligram potency, meaning the relative potency of each statin appeared to be a predictor of muscle adverse effect reporting risk. The exception was fluvastatin, which had a 74% risk of adverse events compared with rosuvastatin.

The study authors concluded: 'If statin reinitiation is considered after muscle-related adverse events, lower potency should be preferred.'

***PLoS One* 2012, online 22 August**

DIABETES

Diabetes 'raises risk of UTIs'

Patients with type 2 diabetes have a 60% increased risk of developing a UTI compared with those without diabetes, concludes a US study.

The study involved 135,000 patients with diabetes from the UK General Practice Research Database who were matched with a similar number of controls without diabetes.

The adjusted two-year risk of UTI for all patients with diabetes was 61% higher than matched controls. The absolute incidence of UTI among patients with diabetes was 46.9 per 1,000 person-years, compared with 29.9 in patients without diabetes. Patients with a new diagnosis of diabetes – defined as those with diabetes recorded six months or later than database registration – had a lower UTI incidence, at 45.5 per 1,000 person-years, than those with a diagnosis at registration or within six months, whose UTI incidence was 58.8 per 1,000 person-years.

The US researchers – including employees of the pharmaceutical company Bristol-Myers Squibb – concluded: 'Patients with diabetes are at an increased risk of developing UTIs across all age categories.'

***J Diabetes Complications* 2012, online 13 August**

CONFERENCE ROUND-UP

Obesity increases risk of AF

Obesity increases the risk of atrial fibrillation compared with those with a 'healthy weight', conclude researchers from Denmark. They looked at 271,000 women between 20 and 50 years of age and found the risk of developing the disease was over two times greater in obese women with a BMI over 35kg/m² compared with those with a normal BMI.

European Society of Cardiology Congress 2012

Psoriasis linked with diabetes

Patients with psoriasis are at higher risk of new-onset diabetes than those who do not have the disease, concludes a large analysis of four million people. Danish researchers found patients with mild psoriasis were 49% more likely to acquire new-onset diabetes, compared with those without the disease.

European Society of Cardiology Congress 2012

Stroke risk in women with AF

Female gender increases the risk of stroke in elderly patients with atrial fibrillation by 20%, say Danish researchers. They studied 87,202 patients with non-valvular atrial fibrillation, and for patients aged over 75 years, female gender was associated with a 20% increased risk of stroke after one year of follow-up.

European Society of Cardiology Congress 2012

HYPERTENSION

Antihypertensives 'no use' in mildly raised BP

Antihypertensive medication for patients with mildly elevated blood pressure is no better at preventing cardiovascular events than placebo, according to a systematic review of the latest evidence.

The analysis from the Cochrane Collaboration looked at four trials totalling 8,912 patients aged 18 or older with mild hypertension and no history of cardiovascular disease. Mild hypertension was defined as systolic blood pressure of 140-159mmHg and/or diastolic blood pressure of 90-99mmHg.

After four to five years, antihypertensive treatment did not significantly reduce total mortality compared with placebo, despite a risk ratio reduction of 0.85, and nor did it significantly reduce the risk of stroke (0.51) or total cardiovascular events (0.97).

The Canadian and French researchers concluded: 'This review does not show significant benefit of antihypertensive drug therapy in reducing mortality.'

***Cochrane Collaboration* 2012, online 15 August**

CPD TIP OF THE WEEK

Heparin safest in pregnancy for VTE

Low molecular weight heparin (LMWH) should be the drug of choice for prophylaxis of venous thromboembolism in pregnant women, according to a new case-based learning module. Reviews have concluded that LMWH is the safest choice for use in pregnancy with no cases of heparin-induced thrombocytopenia. Heparin-induced thrombocytopenia is a complication of heparin use, and is higher in unfractioned heparin. SIGN recommends all patients started on LMWH should have a platelet count the day before treatment is initiated, and then counts every two to three days. If there is a fall in platelets of more than 30%, specialist advice should be sought.

The list that paints a portrait of a profession in flux

When Pulse asked a panel made up of the leading lights of general practice to nominate names for our fourth annual Top 50 list of GPs with influence, their responses threw up some surprises.

When we sat down to look at the list of names suggested, some were very familiar - but the number of new names thrown into the ring this year was unexpected.

Far from being a run-down of the grey-haired elders of the profession - although there remain a number of respected veterans - the list shows a younger more vibrant group of GPs than ever before. Nearly half of the names in the list are new entrants this year.

In many ways, the list is a portrait of a profession in flux, with many of the names that dominated the profession for years - notably Dr Julian Tudor-Hart and Dr David Colin-Thomé - dropping out to be replaced by new faces. It is refreshing to see GP trainees, such as Dr Krishna Kasaraneni and Dr Stuart Sutton, representing the future of the profession in such distinctive ways, and giving them a powerful voice at the top table.

Perhaps inevitably though, it's the well-known name of Dr Clare Gerada who tops our list. She has had a defining year in terms of representing the values of the profession and voicing the concerns of GPs against the Government's NHS reforms, so the RCGP chair's place at the top of the list is well deserved. Other notable campaigners against the health bill, now the act, have also made their names this year, while others are included in the list for the opposite reason.

Nigel Praities
Deputy editor

NAPC chair Dr Charles Alessi has risen through the rankings, largely for providing a rational voice on the need for clinically led commissioning while remaining critical about some of the Department of Health's ideas. There are many other commissioners on the list who are demonstrating incredible leadership in their local areas and are being recognised nationally for this. There are many LMC leaders who do great work managing the excesses of NHS managers in their local areas, and whose influence spreads well beyond their geographical remit. The list also includes a number of GP researchers recognised as doing important work that is having a national impact.

This year's list shows a younger and more vibrant group than ever before

As we approach the opening of a new parliamentary session and a new academic year, it seems appropriate to look back through a tumultuous year for general practice and ahead to what is bound to be another one. Pulse's Top 50 list puts a spotlight on the faces that have come to define the profession on a local and a national stage.

For the first time, we have also included a list of GPs whose star is rising but who just missed out on the Top 50 - and there are some really interesting names in there who I'm sure will make an appearance in forthcoming years. And that is perhaps the most compelling message from this list - that there are talented GPs waiting in the wings to take general practice forward. At this critical point in the future of the profession, perhaps more than at any other, that is to be welcomed.

Have we got the list right? Let us know - email nigel.praities@pulsetoday.co.uk

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The tale of a spurned lover

The relentless demands of patients and an increasing tax burden have forced **Phil** to consider the unthinkable – going part time

Indulge me with a little career reflection. I've been behind this desk a long time now, and I want to share some memories with you.

A couple of weeks ago, I celebrated 25 years as a qualified doctor. Well I say celebrated. I just raised a quizzical eyebrow when I was reminded of this somewhat dubious anniversary. I note that not one of my contemporaries, the Newcastle University class of 1987, is clamouring to commemorate this historic occasion.

I cast my mind back to my first day as a qualified doctor at Hartlepool General Hospital. I was rigid with fear when I discovered I had to perform a minor surgery list that afternoon, alone. Work experience meant something in those days.

Having said that, I wasn't truly on my own. The surgical registrar hung around to make sure I didn't hack randomly at arterial sites and the lovely nursing sister would cock an approving eyebrow when my hand hovered over the appropriate surgical tool.

There were no such things as portfolios, competencies or being observed doing a procedure. I'm not necessarily saying it was better in those days. Even though it bleedingly obviously was.

I consider myself lucky. Dropped in at the deep end, at least I was familiar with this array of puzzling tools, having spent a few of my teenage years assembling Airfix models with the help of my (biology teacher) dad's dissecting kit. My medical career took off.

About that time, I formulated my Career Plan. It was, basically, to never say no to anything I was asked. I realised at the time it was likely to be time-consuming, but back in those days it appeared that I had a lot of time.

As a result, I worked in New Zealand and Australia, as a football club doctor for Sunderland and then Hartlepool, as an LMC member, as a practice-based commissioning board member and as a columnist for *Doctor* magazine and now *Pulse*. I'm happily married and I have three fine teenage sons.

So why am I baling out now to go part-time?

You could have had me for life if you'd treated me right

The mantle of general practitioner, which 18 years ago I willingly took on, is now drilling out my soul.

Under pressure

When I started out, four of us could cover 8,000 patients and still have an afternoon off. These days, the same number of patients demand twice as many appointments and we have twice as many doctors in the practice. The demand is relentless.

For seven years now, the money that I can take home has remained exactly the same. However, the amount I have to send back has basically doubled.

This year it is 55%.

There is no such tax rate, so how am I paying it? My accountants are opaque on the subject, other than assuring me I have to cough up.

In three weeks' time I'm turning the tap off. I'm just not prepared to bow to these absurd rules, this abuse of my public duty. In 25 years I have had literally one-and-a-half days off sick – the afternoon of my cardioversion and the day after to recover (and even then I felt guilty about not going in, even though the blisters from the burns were adhering to my shirt).

Modern-day medicine as a career? Piss off. I'm like a spurned lover. You could have had me for life, if you'd treated me right. But you haven't.

Dr Phil Peverley is a GP in Sunderland

The commercialisation of birth

Instead of trying to encourage pregnant women to buy things they don't need, why can't we just give good pregnancy advice? **Margaret** asks

It's pink, it's glossy, and it's probably somewhere in your practice. It may even be on your shelves, in your cupboards, or – heaven forbid – on your desk. It's *Emma's Diary* – 'your week-by-week guide to your pregnancy'.

It is designed for women who attend to tell their doctor that they are newly pregnant. Into this happy scene, 'presented with the compliments of your GP' and stamped with the logo of the RCGP, *Emma's Diary* is where the commercialisation of pregnancy and childbirth begins.

You only have to read the cover – free gift packs from Argos and Boots; the leaflets that fall out are for Sanatogen vitamins (and this is not just plain old folic acid, but supplements for the 'father-to-be' too), complete with a money-off voucher to sweeten the deal.

There are adverts for breast pads, expressing machines, stretch mark cream, special extra-safe-for-baby cars, baby bank accounts, car seats, nappy creams, disposable nappies, 'the essential baby checklist' (from Argos), stain removers, life insurance, baby swimming classes, organic pureed food, baby monitors and a pram, which is pictured with a roughly size-eight woman beaming while wearing pale clothes and 10cm heels. In what life do we need all this stuff? What right do GPs have to hand women an implied aspirational shopping list? It makes me furious.

Oh yes, there is the science bit. It's at the back, and it's a sliver of the magazine's total content – 25 pages out of 144. This is the RCGP-approved information and in fairness, there are three lines somewhere at the start saying 'no endorsements of the products, services or websites advertised in *Emma's Diary* is implied or intended by the RCGP'.

That's three lines, though, in a big book.

The problem for pregnant women in the consulting room is that they are a captive audience. GPs are trusted, and we hand over what is effectively a book of adverts just as the thin blue line of maternity has declared itself. This stuff costs so much money and most of it is unnecessary. I worry that the invitation we give women when we hand over *Emma's Diary* is that of unattainment. What better way to sow seeds of self-doubt and guilt?

We should ditch the adverts and give good, evidence-based information

I am not going to mention the content of the *Emma's Diary* website – complete with its 'celebrity pregnancy news' – except to say that it is not the strongest feminist statement you will read this year. Why are we involved in this?

Even some maternity hospitals – rather than protecting women from unneeded interruptions and allowing them time to recover from labour and birth – have large sample packs from commercial companies, made up like a 'gift', delivered to new mothers at the bedside.

The current leadership in the RCGP makes me proud to be a GP. *Emma's Diary* makes me cringe. We should ditch the adverts and give good information via an evidence-based app or a website, and we could work with not-for-profit agencies to achieve it.

We could support women and their families by being clear that, for example, 'during pregnancy, all kinds of organisations will want to sell you things. The good news is that you or your baby don't need most of them'. Wouldn't that be better for all of us?

Dr Margaret McCartney is a GP in Glasgow

Advertisement Feature

Next steps in antidepressant selection

What to consider when first line pharmacological treatment for depression does not succeed

Drug treatment of depression frequently involves switching to find a drug that works well for the individual patient, either because of adverse events or poor response to the first line agent.[1]

Regular review of patients receiving antidepressants can help to ensure that patients who are not responding are considered for further treatment, referral or alternative medication.[2]

The first treatment selected may not achieve remission of symptoms, and a number of treatment steps may be needed.[1] However successive trials of therapy can result in lower remission rates and higher relapse rates (Fig 1).[3]

NICE guidelines (CG90) for drug treatment recommend initial use of a generic Selective Serotonin Re-uptake Inhibitor (SSRI), but if response is limited or absent, or side effects occur, consider switching to an alternative antidepressant.[4] When switching antidepressants, NICE recommends considering, initially, a different SSRI or a better tolerated newer –generation antidepressant.[4] Use of the SSRI Cipralex (escitalopram) in the care pathway, in such circumstances, is consistent with national guidelines (NICE CG90).[4]

Use of Cipralex in patients who have not responded to initial therapy makes clinical and financial sense.

An independent meta-analysis conducted in nearly 26,000 patients with major depression showed that Cipralex was one of two antidepressants judged to have achieved the best possible balance between efficacy and acceptability.[5] Cipralex was also superior to citalopram ($p \leq 0.02$) in achieving acute response and remission in major depression (after 6-12 weeks) in an independent Cochrane review.[6]

In their health economic analysis, NICE found Cipralex to be one of the most cost-effective SSRIs (after sertraline) in both moderate and severe depression.[4] In a UK primary care record database study, usage of Cipralex in patients with severe depression was associated with fewer hospitalisations (all causes) compared with generic SSRIs and venlafaxine.[7] The overall cost of treatment was no higher with Cipralex than with generic SSRIs and was significantly lower ($p<0.0001$) than with venlafaxine in patients with severe depression (Fig 2).[7]

Use of Cipralex can represent a good use of NHS resources.

More information on depression and Cipralex can be found at: www.challengingdepression.co.uk

Lundbeck

Cipralex®
escitalopram

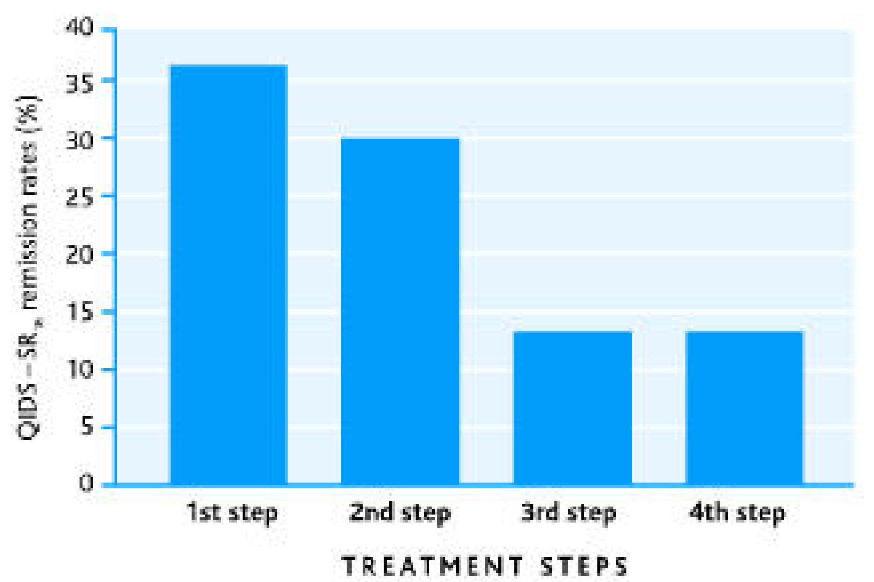

Figure 1. Acute remission rates by treatment step. Adapted from STAR*D, Rush et al.[3]

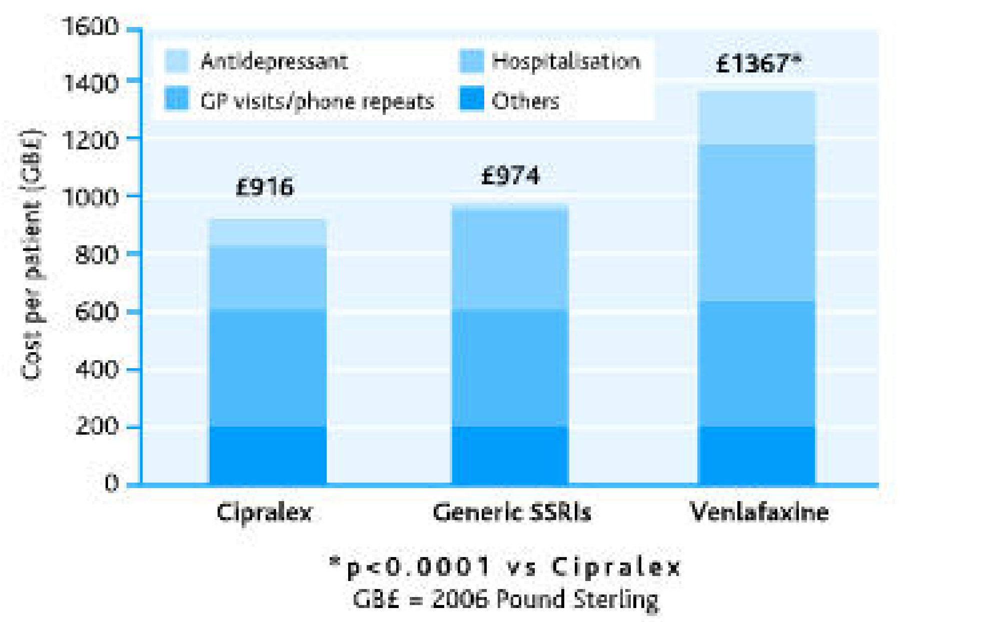

Figure 2. Total cost distribution per treatment group in severe depression for 12-month period following index date of study inclusion. Adapted from Wade et al, 2010[7]

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Abbreviated Prescribing Information.

Cipralex® (escitalopram) Tablets and Oral Drops, Solution
Prescribing information: Please refer to the full Summary of Product Characteristics before prescribing, particularly in relation to side effects, precautions and contra-indications. **Presentation:** Tablets containing 5, 10 or 20 mg of escitalopram (as the oxalate). Cipralex oral drops, solution containing 20 mg/ml escitalopram (as the oxalate), each drop contains 1 mg escitalopram. **Indications:** Treatment of major depressive episodes, panic disorder with or without agoraphobia, social anxiety disorder (social phobia), generalised anxiety disorder and obsessive-compulsive disorder. **Dosage:** Depression: 10 mg once daily. Dose may be increased to a maximum of 20 mg daily. Treatment for at least 6 months is required. Panic disorder: 5 mg for the first week increasing to 10 mg daily and, if needed, 20 mg daily. Maximum effectiveness is reached after about 3 months. Social anxiety disorder: Usual dose 10 mg once daily until symptom relief obtained (usually 2-4 weeks). Dose may be decreased to 5 mg or increased to a maximum of 20 mg daily. Treatment for 12 weeks is recommended. Treatment should be re-evaluated regularly. Generalised anxiety disorder: Initial dose 10 mg once daily. May be increased to a maximum of 20 mg daily. Obsessive-compulsive disorder: Initial dose 10 mg daily, increased to a maximum of 20 mg if required. Elderly (>65 years): Initial dosage is 5 mg once daily. Depending on individual patient response the dose may be increased up to 10 mg daily. Children and adolescents (<18 years): Not recommended. **Reduced hepatic function:** 5 mg daily for the first 2 weeks in mild-moderate impairment, increasing to 10 mg, if required. Use with caution and careful dose titration in severely impaired hepatic function. **Reduced renal function:** Use with caution in severely reduced renal function (CLCR 30ml/min). **Contra-indications:** Hypersensitivity to escitalopram or excipients. Use in combination with non-selective, irreversible monoamine oxidase inhibitors (MAOIs). Use in combination with reversible MAO-A (moclobemide) or linezolid. Use in patients with known QT interval prolongation or congenital long QT syndrome. Use together with medicinal products that are known to prolong the QT interval. **Fertility, pregnancy and lactation:** Do not use in pregnancy unless clearly necessary. Breastfeeding is not recommended. SSRI use in pregnancy, particularly in late pregnancy, may increase the risk of persistent pulmonary hypertension in the newborn (PPHN). **Precautions:** Possible risk in ability to drive a car or operate machinery. Alcoholic drinks not advised. Co-administration with serotonergic compounds not recommended. Insulin and/or oral hypoglycaemic dosage may require adjustment. Use with caution in patients at risk of hyponatraemia, with a history of mania/hypomania, undergoing ECT, with epilepsy (discontinue if seizures begin for the first time or increase in frequency), with bleeding disorders or taking medicines that will affect clotting of blood or platelet function. Escitalopram has been found to cause dose-dependent prolongation of the QT interval. Caution is advised in patients with coronary heart disease, significant bradycardia, recent myocardial infarction or uncompensated heart failure. Correct electrolyte disturbances such as hypokalaemia or hypomagnesaemia before treatment. Consider ECG review in patients with stable cardiac disease before treatment. Withdraw treatment and perform an ECG if signs of cardiac arrhythmia occur. Do not stop treatment abruptly. Closely supervise patients, especially those at high risk, for suicide-related behaviours during first few weeks of treatment, until improvement occurs. **Drug interactions:** MAOIs, MAO-A and MAO-B inhibitors. Potential interaction with serotonergic medicines (e.g. triptans), lithium, tryptophan, St John's wort, products which may lower the seizure threshold, omeprazole, esomeprazole, lansoprazole, fluvoxamine, ticlopidine and cimetidine. Caution in poor metabolisers of CYP2C19. Use caution with drugs metabolised by the enzymes CYP2D6 or CYP2C19. Co-administration with medicinal products that prolong the QT interval, such as Class IA and III antiarrhythmics, antipsychotics (e.g. phenothiazine derivatives, pimozide, haloperidol), tricyclic antidepressants, certain antimicrobial agents (e.g. sparfloxacin, moxifloxacin, erythromycin IV, pentamidine, anti-malarial treatment particularly halofantrine), certain antihistamines (astemizole, mizolastine) etc. is contraindicated. **Adverse events:** Adverse reactions are most frequent during the first or second week of treatment and include nausea, decreased or increased appetite, increased weight, anxiety, restlessness, abnormal dreams, decreased libido, anorgasmia in females, insomnia, somnolence, dizziness, paraesthesia, tremor, sinusitis, yawning, diarrhoea, constipation, vomiting, dry mouth, increased sweating, arthralgia, myalgia, ejaculation disorder, impotence, fatigue and pyrexia. Thrombocytopenia, anaphylactic reaction, hyponatraemia, anorexia, serotonin syndrome, convulsions, psychomotor restlessness/akathisia, mania, suicidal ideation, suicidal behaviour, QT prolongation, ventricular arrhythmia including torsade de pointes, gastrointestinal haemorrhages, hepatitis and angioedemas have also been reported. Abrupt cessation may produce discontinuation symptoms. Studies in patients ≥50 years of age, show an increased risk of bone fractures in patients receiving SSRIs and TCAs. ECG monitoring is advisable in overdose. Prescribers should consult the full Summary of Product Characteristics in relation to other side effects. **Legal category:** POM. Cipralex Tablets 5 mg (PL 13761/0006) 28 tablets £8.97; 10 mg (PL 13761/0009) 28 tablets £14.91; 20 mg (PL 13761/0011) 28 tablets £25.20. Cipralex 20 mg/ml oral drops (PL 13761/0028) 1 bottle x 15ml £20.16. **Further information available from:** Lundbeck Limited, Lundbeck House, Caldecotte Lake Business Park, Caldecotte, Milton Keynes, MK7 8LG. ® Cipralex is a Registered Trade Mark © 2012 Lundbeck Limited. **Date of last revision of PI** February 2012.

Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard
Adverse events should also be reported to Lundbeck Limited,
Medical Information, on 01908 638972.

Job Code: UK/ESC/1202/0350 **Date of preparation:** March 2012

Too busy dealing with the workforce crisis to get involved in a solution

Dr Nigel Watson says GPs are being shouldered off their local education and training boards – at a moment when engagement is crucial

The major challenges that currently face GPs are not CQC and revalidation – or even clinical commissioning. Rather the rising workload, and the increasing complexity of the cases we see every day, are what make our lives stressful.

Over the past two to three years, changing casework has led to overwhelming demands on GP time – and this is before GPs start working with their CCG to move work out of hospitals and provide more care in the community. Practices are facing falling profits and greater difficulty in recruiting new partners or salaried GPs. A significant number of GPs facing major pension changes have already decided retirement looks like an increasingly attractive option.

Few GPs are even aware there is a process in place that attempts to look at the needs of the NHS, in terms of doctor and nurse workforce, and to publish plans to train the estimated number of clinicians needed. The problem is, we seem to be too busy dealing with the crisis to engage with a possible solution.

Currently SHAs are responsible for commissioning the required number of training places in both hospital specialties and general practice. But from April 2013, the responsibility for workforce planning will fall to Health Education England (HEE). The local branches of HEE will be called local education and training boards (LETBs) and will be organised to represent local medical interest in training by grouping NHS providers to help HEE fulfil its functions – so all providers must be represented on an LETB.

Poor representation

GPs are not well represented on LETBs at the moment and there are two main reasons. First, when shadow boards were established it was unclear which organisations should be involved, especially for LMCs. In the past, LMCs haven't been involved with workforce planning as it fell to the deaneries, with national organisations such as the RCGP and the BMA providing guidance. Now funding for primary and secondary care workforces falls into the same pot and the deanery works for the LETB. Second, while LMCs hung back from joining the shadow boards, SHAs took the lead and wasted no time recruiting representatives for LETBs from the hospital trusts.

While my experience of LETBs has so far been good, I worry the system is vulnerable to tokenism. There is no current legislation to stimulate GP engagement in workforce planning, and if board members in one area decided to favour trusts over GPs there would be nothing to stop them doing so.

Where I work in Wessex, our LMC has established and maintained good relationships with other local NHS providers. So when the embryonic LETB was established, our group was approached and invited to become a member.

I turned up to the first meeting, which was dominated by the medical directors and chief executives of local hospital trusts, community providers and the mental health trust. I was the sole GP. The first question I was asked, by a hospital CEO whom I have known and respected for many years, was why I was there.

'As GPs, we provide 90% of all the contacts with patients,' I replied. 'So we are a major provider within the NHS despite receiving less than 8% of the budget.'

If general practice fails because of poor workforce planning, I added, the rest of the NHS will fail as well. The LMC represents all GPs and practices who work as providers – it is not to be confused with the local CCG.

Boards without GP representation also risk focusing on short-term staffing issues rather than a long-term strategy. Left unchecked, LETBs could also reduce, rather than increase, the number of funded places for training GPs.

GPs' key role

My LETB in Wessex will include two GP voting members out of a total of 16 – that is, about 13% of the board. There has been a guideline sent around the shadow boards that recommends around one board member in 10 should be a GP. HEE will publish a final copy of the document on its website later this month. To my mind, a goal of 15-20% representation seems a better aim.

The absence of GPs on an LETB either indicates that the organisation has failed to grasp the key role general practice has within the NHS, or – more concerning – demonstrates a deliberate attempt to keep general practice out of the decision-making process.

Dr Nigel Watson is a GP in Wessex, chief executive of Wessex LMCs and a GP adviser to the Centre for Workforce Intelligence

The views in this article are personal to Dr Watson and do not necessarily reflect the views of any organisation in which he has a role

A Scottish contract isn't the answer

A 'tartanised' contract won't solve GPs' problems, says Scottish GPC chair **Dr Alan McDevitt**

A battle of semantics is raging across Scotland's health service. Government officials touring the country want to know what health boards and local GPs would like from a 'more Scottish' GP contract. This has been interpreted by some as a precursor to a completely separate contract, but at present, this is far from the likely outcome.

With increasing divergence in the way primary care is delivered across the UK – largely as a result of the health and social care reforms in England – there are areas of the contract where it is now appropriate to discuss whether we can create more flexibility between different parts of the UK. The contact is already sufficiently flexible to accommodate some differences – for example, the global sum has always been divided among Scottish practices via a Scottish allocation formula, which was negotiated separately to reflect Scotland's unique geographical and population differences. Likewise, most enhanced services are negotiated and agreed separately in Scotland to reflect local priorities.

In addition to using the existing flexibilities, the Scottish Government has expressed interest in adapting the QOF to Scottish needs. It doesn't plan to change clinical indicators, but there is already some variation on the organisational indicators as a result of reforms in England. The Scottish Government agrees with us that there is no point reinventing the evidence base for clinical indicators that are the same for every GP and patient wherever they live and work, but we have also agreed to continue looking at the Scottish allocation formula to ensure it best meets the needs of Scotland.

Uncertainty and extra work

Talk of a 'Scottish contract' is largely a misunderstanding of terminology rather than an overt drive to separate us from our UK contractual agreements. There is a danger that, by touring the nation and asking health boards what they'd like to see done in general practice, the Scottish Government will raise expectations and create anxiety and uncertainty. The inevitable result is the recommendation that 'GPs are ideally placed' to do extra work. This risks passing even more underfunded and unresourced work onto an already stretched GP workforce, and everyone will be disappointed with the outcome. Any changes that the Scottish Government proposes as a result of this consultation will be negotiated and agreed with the Scottish GPC.

Just about every GP in the country is dealing with a level of workload that is neither good for patients nor for the wellbeing of the GP. We cannot deliver the Scottish Government's agenda of shifting the balance of care, anticipatory care, patient safety, improved access, reduced referrals and improved primary prevention with the current workforce. Each GP needs more time to do this and practice teams need to be supported and expanded.

In fact, this contractual debate is overshadowing the real challenges for Scottish general practice. As in the UK, the increasing demand for care of a growing population to be provided by primary care means much more must be invested in the workforce and GP premises.

What is important is that any proposals we develop with the Scottish Government must be clinically driven and evidence based. They should prioritise improving patient outcomes, not simply cost savings, and they must be achievable and deliverable by GPs.

I have no problem with the Scottish Government consulting with health boards to inform its primary care policy. However, they must be honest with themselves and those they speak to. This is not about a separate contract. This is about identifying priorities across the health service in Scotland and giving GPs the tools, resources and support to be part of the solution.

Dr Alan McDevitt is chair of the Scottish GPC and a GP in Clydebank

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Fostair® (beclometasone dipropionate and formoterol fumarate dihydrate pressurised inhalation solution). Please refer to Summary of Product Characteristics (SmPC) before prescribing. **Prescribing Information Presentations:** Pressurised inhalation solution containing 100 micrograms of beclometasone dipropionate and 6 micrograms of formoterol fumarate dihydrate per actuation. **Indications:** Regular treatment of asthma where use of a combination product (inhaled corticosteroid and long acting beta$_2$ agonist) is appropriate: patients not adequately controlled with inhaled corticosteroids and 'as needed' inhaled short acting beta$_2$ agonist; or patients already adequately controlled on both inhaled corticosteroids and long acting beta$_2$ agonists. Not appropriate for treatment of acute asthma attacks. **Dosage and Administration:** For inhalation use only. Fostair is not intended for the initial management of asthma. If an individual patient should require a combination of doses of the three drugs available in the combination inhaler, appropriate doses of beta$_2$ agonists and/or corticosteroids by individual inhalers should be prescribed. Beclometasone dipropionate in Fostair is characterised by an extra-fine particle size distribution which results in a more potent effect than formulations of beclometasone dipropionate with a non-extrafine particle size distribution (100 micrograms of beclometasone dipropionate extrafine in Fostair are equivalent to 250 micrograms of beclometasone dipropionate in a conventional formulation). Therefore the total daily dose of beclometasone dipropionate administered in Fostair should be lower than the total daily dose of beclometasone dipropionate administered in a non-extrafine beclometasone dipropionate formulation. Adults: 18 years and above: one or two inhalations twice daily, maximum four inhalations daily. 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Fostair should not be used as the first treatment for asthma, should not be initiated during an exacerbation, or during significantly worsening or acutely deteriorating asthma, and should not be stopped abruptly. If patients find the treatment ineffective medical attention must be sought. Paradoxical bronchospasm may occur with an immediate increase in wheezing and shortness of breath after dosing; treat immediately. Patients should take Fostair as prescribed even when asymptomatic. Systemic effects of inhaled corticosteroids may occur, particularly at high doses prescribed for long periods. These effects are much less likely to occur with inhaled than with oral corticosteroids. Possible systemic effects include Cushing's syndrome, Cushingoid features, adrenal suppression, decrease in bone mineral density, growth retardation in children and adolescents, cataract, glaucoma and more rarely a range of psychological or behavioural effects (particularly in children). 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L-dopa, L-tyrosine, oxytocin and alcohol can impair cardiac tolerance. Concomitant administration with MAOIs, including agents with similar properties such as furazolidone and procarbazine, may precipitate hypertensive reactions. Risk of arrhythmias in patients receiving anaesthesia with halogenated hydrocarbons. Theoretical potential for interaction in sensitive patients taking disulfiram or metronidazole. **Pregnancy and Lactation:** No relevant clinical data. Should only be used during pregnancy or lactation if the expected benefits outweigh the potential risks. **Undesirable effects:** Common: pharyngitis, headache, dysphonia. Uncommon: influenza, oral fungal infection, oropharyngeal and oesophageal candidiasis, vulvovaginal candidiasis, gastroenteritis, sinusitis, rhinitis, granulocytopenia, dermatitis allergic, hypokalaemia, hyperglycaemia, restlessness, tremor, dizziness, ocular hypertension, tachycardia, palpitations, hypotension, flushing, cough, productive cough, throat irritation, asthmatic crisis, diarrhoea, dry mouth, dyspepsia, dysphagia, burning sensation of the lips, nausea, dysgeusia, pruritus, rash, hyperhidrosis, muscle spasms, myalgia, CK-muscle protein increased, platelet count increased, free fatty acids increased, blood insulin increased, blood ketone body increased. Rare: agranulocytosis, angina pectoris, bronchospasm paradoxical, urticaria, angioedema, exanthema, blood pressure increased, blood pressure decreased, leukopenia, thrombocytopenia, hypersensitivity reactions, adrenal suppression, glaucoma, cataract, atrial fibrillation, dysphonia, exacerbation of asthma, growth retardation in children and adolescents, oedema peripheral, bone density decreased. Unknown: psychomotor hyperactivity, sleep disorders, anxiety, depression, aggression, behavioural changes (predominantly in children). **Legal Category:** POM **Packs and Prices:** Fostair 100/6 (PL08229/0156) £29.32. Each inhaler contains 120 actuations. [1] denotes Trademark. AeroChamber Plus™ is a trademark of Trudell Medical International. Full prescribing information is available from the **Marketing Authorisation Holder:** Chiesi Limited, Cherella Royal Business Park, Highfield, Chiselle, SN8 3RA. **Date of preparation:** February 2012.

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1. FOSTAIR. Summary of Product Characteristics. Chiesi Ltd. October 2011. 2. De Backer W, Devolder A, Poli G et al. Lung deposition of BDP/formoterol HFA pMDI in healthy volunteers, asthmatic and COPD patients. J Aerosol Med Pulm Drug Deliv 2010; 23(3): 137-145. **Date of preparation:** March 2012. FOS/0012/03/12.

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Date of preparation: April 2012
VES1214218

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Patient-held budgets are privatisation by the back door

From Dr Mary-Louise Irvine
Lewisham, south-east London
Member of BMA Council
via pulsetoday.co.uk

LETTER OF THE WEEK

Personal budgets: fundamental departure from NHS principles?

Dr Simon Fradd's opinion piece on patient-held budgets highlights the true agenda of the NHS reforms: the end of 'free at the point of use' ('Be brave, and hand the purse strings to patients', pulsetoday.co.uk/opinion).

Everyone has different healthcare needs: some will need tens of thousands of pounds' worth of care, others very little. How does one allocate patient-held budgets? Nobody has been able to explain what happens when your personal budget runs out yet.

Will it be like in the US when insurance companies stop paying out, regardless of what treatment you still require?

Dr Fradd simply says patients will 'clamour' for more money. Why should patients have to do that to get the care they need? That would be a fundamental departure from the principles of the NHS.

And let's talk about 'top-ups' and co-payments too. This is a way of allowing the more wealthy to pay for better care.

It is something the health insurance industry has been pushing for many years. It will also be a departure from the fundamental principle of the NHS, which is that people receive the care they need regardless of their ability to pay.

This 'patient choice' rhetoric is flimsy cover for naked privatisation. Dr Fradd's article demonstrates that those of us who fought the Health and Social Care Bill were quite right to warn about the damage to the NHS. He reported 'a terrible amount of opposition' to commissioning – in my opinion there was not nearly enough.

New budgets can change behaviour

From Dr Paul Stillman
Crawley, West Sussex
Member of the Self-Care Forum

Dr Simon Fradd believes we should welcome and support the introduction of patient-held budgets. I am amazed that pilot schemes are already under way, yet the profession seems slow to consider their impact. If widely adopted, personal health budgets would make the current arguments over commissioning both irrelevant and unimportant by comparison.

There are many huge decisions to be made. For example, will we all have the same budget?

That would probably be unworkable, but if we introduce variations then we raise colossal moral decisions about preferential budgeting to those whose lifestyle has contributed to their illness.

Tobacco, alcohol and obesity problems won't go away, but the cause and subsequent effects of all of our lifestyle decisions will be thrown into the sharpest focus.

Surely the ingrained behavioural patterns we have wrestled with for decades will change as people acquire more realistic views of themselves, the NHS and what it should be providing.

Of course there will be failures – not everyone can manage their domestic budget so why should this be any different?

Rescue systems will need to be provided, but I think the vast majority of people will be able to manage their own budgets and live within the boundaries set for them.

Don't run away from revalidation

From Dr David Church,
Machynlleth, Wales

I would like to counter Dr Mike Ashworth's opinion that revalidation is an insult to the professionalism of doctors ('Revalidation is still an insult', pulsetoday.co.uk/letters).

I feel we professionals should set an example to show that we are above reproach and not that we are above the law.

If I expect the staff of the railway company of which I am medical officer to pass a revalidation to continue working in safety-critical roles on a schedule starting every five years and increasing to annually – with medical examinations, fitness tests, vision testing, as well as rules tests – then I think they are more likely to co-operate with that if they see I am doing the same.

Conversely, while there are many doctors who practise with great skill and professionalism after the age of 80, there are some who need a gentle prod in their 50s and 60s to update in key areas, and even to consider dropping some responsibilities or retiring.

We could blame Shipman or those who reacted to the reports about him, but rather let's work on perfecting a process that will provide a solid foundation to base our professionalism in the future.

I accept revalidation is not perfect yet, but that means we should work to improve it, not run away from it.

A dumping place for extra work

From Dr Josef Kurlacose
Moneymore, Northern Ireland
via pulsetoday.co.uk

I was not surprised by your investigation revealing a fall in the proportion of GP compared with hospital trainees ('Workforce reform stalls as deaneries train hundreds of additional hospital doctors – but just eight more GPs' (pulsetoday.co.uk/news).

It is because we do not define safe working practice – for example, number of hours or the number of patients – that we GPs are seen as a cheap dumping place for extra work.

Managers will continue to load work on to primary care because there are no extra costs.

We will just work harder and harder to burnout, unless we define what are safe limits. We need health and safety for doctors as well as everyone else.

How will we handle GP shortage?

From Dr Mary Hawking
Dunstable, Bedfordshire
via pulsetoday.co.uk

Your investigation into GP trainee numbers focuses on the numbers of GPs who will be available in the future.

But in addition to moving work out of secondary care into primary care, GPs are to be made responsible for managing commissioning.

If the number of future GPs is restricted or reduced, what strategies do GPs have to manage the problem, when new GPs will be unavailable due to lack of supply?

Fifteen-minute appointments are the ideal

From Dr Simon Gilbert
Sutton, Surrey
via pulsetoday.co.uk

I agree with offering more planned reviews for patients with multiple long-term conditions ('Half-hour GP appointments "should be the norm", says RCGP', pulsetoday.co.uk/news).

My practice is already offering 15-minute consultations. But I'm not convinced about half-hour appointments.

The time limit in consultations helps focus patients and GPs on the important problems, as well as allowing the appropriate use of time for diagnosis and resolution of many problems.

Limiting the time also reduces the risk of over-investigation and over-management.

Flexible time slots are needed

From Dr Rosemary McRae
Rainford, Merseyside
via pulsetoday.co.uk

What's wrong with starting a consultation off in the 10 minutes booked, then asking the patient to come back for a double appointment to continue if it's required? Presumably we are not alone in doing this, but our routine appointment slots are still 10 minutes.

Offering half-hour appointments could result in a patient with a sore throat taking a half-hour appointment because that was the only one left, and the person who needs half-an-hour taking a 10-minute appointment when the half-hour ones had gone.

29

Supporting patients to achieve healthy, sustainable weight loss

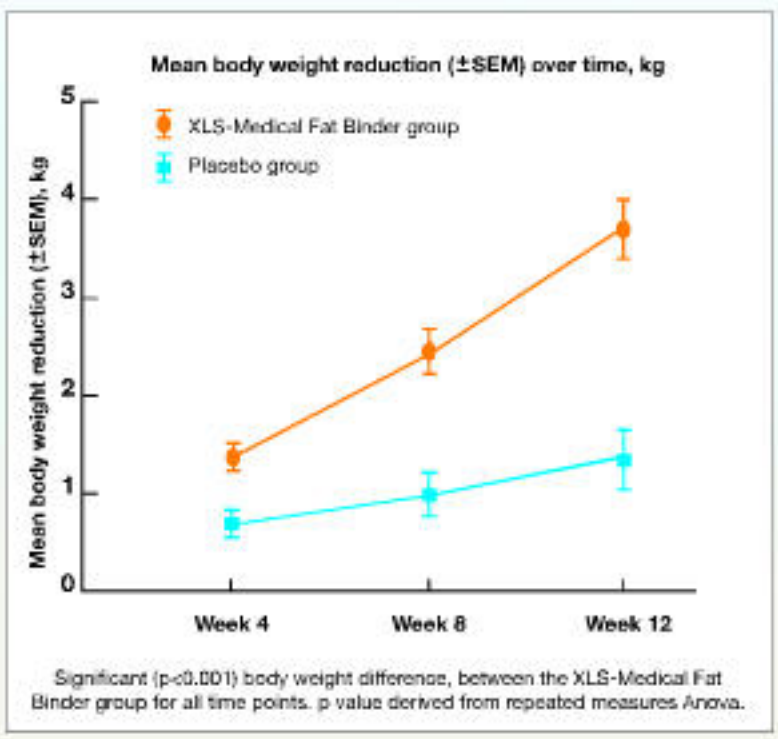
Obesity Journal publishes study that shows XLS-Medical can help dieters lose up to three times more weight than dieting alone when taken in conjunction with a healthy balanced diet

By 2015, government figures estimate that obesity will cost the economy £27 billion a year[1], with further increases predicted unless immediate action is taken. Healthcare professionals are being asked to support patients who want to lose weight. Engaging them in conversations about a healthy diet and lifestyle, as well as educating about the small changes which can make a real difference, will help them to follow a more realistic and sustainable weight loss plan.

Patients seeking additional weight loss support may wish to introduce an efficacious, clinically proven over the counter weight loss aid such as XLS-Medical Fat Binder to support their dieting efforts. XLS-Medical is not another fad plan or a miracle pill, but rather when taken alongside sensible eating and regular exercise, it has been clinically proven to help individuals lose up to three pounds for every one pound they lose on their own, while also being well tolerated.[2]

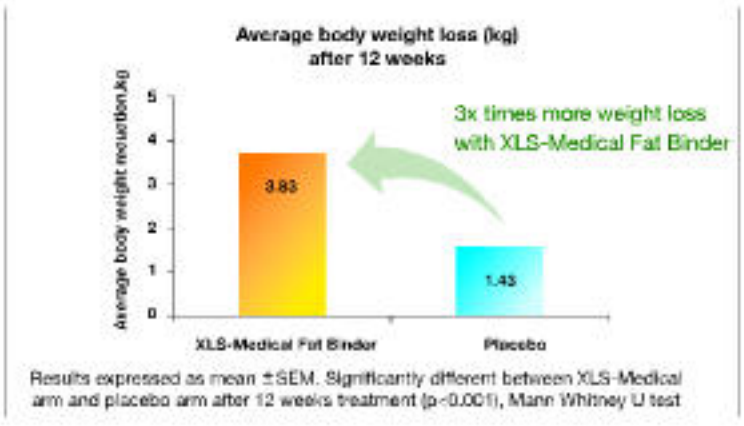
Clinically proven

The 12 week double blind, placebo controlled clinical trial entitled, "A natural fibre complex reduces body weight in the overweight and obese: A double-blind, randomised, placebo-controlled study" has been peer reviewed and published in the journal Obesity, the official journal of The Obesity Society. Involving overweight and obese adults, the study assessed the efficacy and safety of key ingredient Litramine IQP G-002AS in body weight reduction.



Significant (p<0.001) body weight difference, between the XLS-Medical Fat Binder group for all time points. p value derived from repeated measures Anova.

"The findings show that with the support of XLS-Medical, overweight and obese subjects can lose up to three times more than they could by dieting alone with no diet related treatment effects," comments Prof Barbara Grube, lead author of the study. "The outcomes of this clinical study are a positive step forward in helping people successfully manage their weight."



Results expressed as mean ±SEM. Significantly different between XLS-Medical arm and placebo arm after 12 weeks treatment (p<0.001), Mann Whitney U test

About XLS-Medical

Made with the fat binder Litramine® and essential fat-soluble vitamins, XLS-Medical has a well established safety profile. Unlike orlistat, XLS-Medical binds with fat from food and becomes a large fat-fibre complex. As the fat-fibre complex is too large to be absorbed in the small intestine, it is eventually excreted from the body normally.

Dieters are recommended to adopt a reduced calorie, lower fat diet in addition to regular exercise and to take 2 tablets 3 times a day after meals – with up to 6 tablets taken per day. Patients can seek additional advice from '123 hello me' the online weight loss support programme for XLS-Medical.

For more information please visit www.xlsmedical.com

Professor David Haslam, GP and Chair of the National Obesity Forum (NOF)

"The fact that most over the counter weight loss products do not have evidence supporting their efficacy, nor do they seek any, speaks volumes. The study of XLS-Medical now reported in the prestigious journal Obesity will be acknowledged by the medical community as it is a well designed and conducted double-blind randomised placebo-controlled trial, which looks at weight loss and improvement in body fat. It is a fairly small trial of only 12 weeks duration but longer term studies are in progress to further judge the product. The increased loss of weight with XLS-Medical is significant statistically, but also clinically – and the superior number of individuals managing to lose over 5% in weight particularly so, as this degree of weight loss translates strongly into health gains, and reductions in the risk of heart disease and diabetes. Furthermore the side effect profile is not problematic compared with other weight loss products. Larger and longer studies are eagerly awaited."

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1. Politics.co.uk. Comment: The true financial cost of obesity [online]. Available from: http://www.politics.co.uk/comment-analysis/2012/04/16/comment-the-true-financial-cost-of-obesity [Last accessed: 21 August 2012]
2. Grube B, Chong PW, Lau KZ et al. A natural fibre complex reduces body weight in the overweight and obese: a double-blind, randomised, placebo-controlled study. Obesity Journal 2012; doi:10.1038/oby.2012.165 [epub ahead of print 25 June 2012]

PULSE VIEWS LETTERS

We want to hear your views

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Write to Pulse, Briefing Media, 3rd Floor, Mermaid House, 2 Puddle Dock, London EC4V 3DB. Let us know where your practice is situated. Feedback may be edited

Good doctors can juggle patients

From Dr David Stokoe
Birkenhead, Merseyside
via pulsetoday.co.uk

I worry that any GP should feel that unless the 'norm' is 30-minute appointments, they are not able to 'do the job properly'.

Clearly some consultations are long but most of us in the real world cope by according the patient the time he or she requires and catching up with a couple of quick sick notes or sore throats. If the quick appointments don't materialise we run late. That's life – or at least, it is outside the cosy world of academia.

Thirteen's the magic number

From Dr David Bush
Wolverhampton
via pulsetoday.co.uk

I work to approximately 13-minute appointments and by doing that I can stick to time and keep stress down.

I think this also allows me to 'do the job properly' – certainly my referral rates are relatively low and patient satisfaction scores relatively high.

I will undertake approximately 30 patient contacts in a day (six or seven hours) plus the unavoidable paperwork that makes up a 10-hour day.

I feel I will be able to sustain this up to a reasonable retirement age, and continue to be civil to patients along the way but I am not prepared to compromise by reducing consultation times.

The downside, of course, is that patient access is getting more difficult each year.

Patients come more frequently and that has not been catered for, other than by developing the practice nurse and HCA roles.

What I really need in order to provide a gold standard service is another full-time GP in the practice, but there is no money available for this.

Free up time for complex patients

From Dr James Goodman
Stourport-on-Severn, Worcestershire
via pulsetoday.co.uk

Within our practice we are trying to develop alternatives to appointments in the hope that this will free up valuable GP time to spend with the complex patients.

It is an exciting challenge but only time will tell whether or not we are successful.

There are a number of patients who undoubtedly benefit from a thorough 30-minute consultation with an expert GP.

This, in turn, would in the majority of cases result not only in improved patient care and outcomes, as well as patient satisfaction but also reduce healthcare costs in the long run.

It's time for us all to go locum

From Dr Sunil Kumar Bhalla
Birmingham
via pulsetoday.co.uk

Once again the Government is clawing back the so-called funding it gave out in the new contract ('Government U-turn excludes GPs from DDRB pay review', pulsetoday.co.uk/news).

It continues to change QOF, making it more difficult to earn money. The BMA needs to take a stronger line on this but I suspect it will not do much.

Over 28 years as a GP I have learned that there is nothing much you can do about this sort of clawback.

It would be best for all of us to become locums – work for two hours in the morning and evening and enjoy the rest of our time – leaving the Government to deal with the rest.

It would mean little loss in income, but a reduction in stress levels. All the other work we do would then have to be properly funded by the authorities.

'NHS brand' needs to sort itself out first

From Dr Mark McCarthey
Liskeard, Cornwall
via pulsetoday.co.uk

Local hospitals should sort themselves out before subjecting others to their 'management skills' ('Government resuscitates plan to sell NHS brand abroad, says RCGP', pulsetoday.co.uk/news).

There is a fat chance of making any profit from this.

If they mismanage patients they could even be sued for damages and make a massive loss.

And if they do make a profit, we can guess where the money will go.

Chances of 'British patients get better services at their local hospital'? Zero to the power of one million. What a distraction!

For the record

The editorial in the 22 August issue of Pulse referred to a small rise in GP trainee numbers in England. In fact, as reported in the front-page story in the same issue, there was a small fall. The disparity resulted from additional data coming in as we were going to press. Pulse's priority is accuracy. However, in the busy process of preparing a weekly publication, mistakes can occur. To draw our attention to an error, email letters@pulsetoday.co.uk

PULSE 50 GPs WITH INFLUENCE

Pulse asked a panel of 50 leading GPs to help us compile our fourth annual list of GPs who are considered most influential on the profession, the NHS and Government policy

In this issue

Key

- ▲ Up compared with last year
- ▼ Down compared with last year
- ◀▶ Same position as last year
- N New entry this year
- C Commissioning GP
- U Up-and-coming GPs

More online

pulsetoday.co.uk/top50

Top commissioning GPs

Top up-and-coming GPs

Top five on camera
Watch interviews with our top five most influential GPs as they discuss their year and what the future holds for the profession.

Read last year's top 50

Gerada, woman of action

Dr Gerada won Pulse's 'headline-hogging' award last year for going beyond the call of duty in keeping GPs in the news, but there was one in particular that caught thousands of GPs' attention. 'Gerada injured in bike accident' was one of the most viewed articles on PulseToday last year, with many subsequently following her recovery on Twitter. The incident brought nationwide attention to the dangerous spot for cyclists on Blackfriars Bridge in London – which has since been redesigned.

Having made her recovery, Dr Gerada then went on to join BMA Council member Dr Clive Peedell for the final stage of his 'Bevan's run' from Cardiff to London, to demonstrate against the Government's health reforms – although this time on foot, accompanied by her dog Lucy.

1 Dr Clare Gerada ◀▶

For the second year running, RCGP chair Dr Clare Gerada tops Pulse's Top 50 list of the UK's most influential GPs. She speaks to deputy editor Nigel Praities about her whirlwind year leading the profession...

For a woman who's had an 'extraordinarily difficult' time of it lately, Dr Gerada sits surprisingly easily in her chair. But when she tries to summarise the last 12 months, there's a definite heaviness in her voice.

'It has been an extraordinary year,' she says. 'It has plumbed the depths and also reached the heights.

'I have learned a phenomenal amount, but I would not want to repeat the year I've just had.'

But then the clouds lift, and the RCGP chair is talking about 'moving forward' again – a testament to the seemingly limitless energy that has become her trademark.

We meet at her GP practice in Vauxhall, south London, amid a tangled new-build bankside development. She is ensconced in a back room on the phone to a journalist when I arrive, simultaneously tapping at a laptop in front of her.

As the figurehead of a fraught, impassioned but ultimately unsuccessful campaign to scrap the health bill, Dr Gerada has rarely been out of the media spotlight this year.

I have been told off for not criticising GPs enough, but that isn't my job

She makes no apologies for her combative, high-visibility approach, arguing it was crucial she explained how she believed the NHS reforms would affect patient care.

'It was really important that the RCGP highlighted the issues around the Health and Social Care Bill, now the Act,' she says. 'It is really important to stick up for general practice and continuously tell the public how fantastic our profession is.'

But she admits she has learned to be more careful around the media, citing the letter she wrote to the Prime Minister in March in which she claimed the time had come 'to restate our similarities rather than continuously focus on our differences'.

'We were trying desperately at the eleventh hour to find a third way through, and that was splashed across the media as a U-turn,' she laments. 'It certainly wasn't a U-turn. But yes, I am careful now. I know a lot more about what might be picked up.'

In February, Dr Gerada revealed she had often been told to 'settle down' and stop 'staremongering' over the health bill, and she has also been accused by some of being too uncritical of GPs.

'I have been told off for not criticising GPs enough, but I say that isn't my job,' she says. 'Until we start looking at the causes of variability – not just in patients, but below that – I am not going to be criticising.

'Of course there is unacceptable practice among some of my profession, as there is in every profession. But as chair of the RCGP, I need to understand variability and not criticise my own colleagues.'

After the pitched battles over the health act, Dr Gerada has found some common ground with the Department of Health over the current workforce crisis in general practice. After first reading 'every single strategy and vision document I can get my hands on', she is busy formulating a 10-year master plan for the profession.

'The challenge for the GP of the future is quite significant – they will be looking after more complex patients,' she says.

'So we are putting together an action plan that will start at medical school and persist right beyond, with more GPs spending longer with their patients and communities.'

At the heart of this is a call for 10,000 more GPs over the next 10 years, something the DH has taken on board by pledging a 20% increase in training places.

Dr Gerada has also already won a sizable victory in persuading education bodies to back the extension of GP training to four years – the plan is now awaiting formal sign-off from Medical Education England and financial approval from the Treasury.

But she is not resting on her laurels, and for the remainder of her period as chair – her terms ends in November 2013 – she will be working to 'increase our numbers, increase the time we can spend with patients and give the evidence to the public about how important general practice is, and how important it is to develop the workforce'.

'What I really want to do is leave a legacy for general practice,' she says.

Best moment Successfully making the case for extending GP training to four years.

Worst moment Her letter to David Cameron that sparked accusations of an RCGP U-turn over the health bill.

Read our full list of up-and-coming GPs online
▶ pulsetoday.co.uk/top50

2 Professor Steve Field ▲2

Professor Steve Field has become something of a Marmite figure, gaining praise and disapprobation in equal measure since his appointment as chair of the NHS Future Forum in the spring of last year.

His rise in the influence rankings reflects his willingness to take on the task of leading the Government's listening exercise on its controversial health bill – a role described as a 'poisoned chalice' by one of our panel.

The former RCGP chair has launched stinging attacks on the quality of general practice in some areas, and caused controversy with his claim that GPs' resistance to the abolition of practice boundaries was 'complete bollocks'. But he will mostly be remembered this year for making the case for the Government's health reforms – and for his claim that Prime Minister David Cameron 'would make a great GP'.

His impact on the NHS reforms will be felt for decades to come, with the listening exercise resulting in a duty on Monitor to encourage integration rather than

competition, nurses and consultants gaining a bigger role in clinical commissioning and the retention of any qualified provider. Professor Field was subsequently handed responsibility for updating the NHS Constitution, saying it needed 'sharper teeth'. In June, he added his voice to those calling for GP trainees to receive mental health education as part of the curriculum. He has also recently been appointed deputy national medical director at the NHS Commissioning Board.

One member of our panel felt Professor Field's work has been more visible than genuinely influential, but another felt he had been treated 'unfairly' and deserved credit for keeping the debate over inclusion and health inequalities 'at the forefront'. His work on the Department of Health's National Inclusion Board is testament to his origins – he is from a deprived area of the Black Country – and he continues to work as a GP in Birmingham.

Professor Field admits the past year has been difficult, but says: 'My influence on policy is there for people to see when they look for it. But I did find it frustrating sometimes, being behind the scenes.'

Best moment NHS Future Forum calls for radical changes to make NHS more integrated.
Worst moment U-turn over support for practice boundaries.

How we created the top 50

This is the fourth year running Pulse has published a list of the most influential figures in general practice – and once again we turned to the profession to help us compile the list.

We invited a panel of 50 leading GPs, including members of the RCGP and GPC, prominent academics and senior Government advisers to nominate who they thought has had the most influence, for better or worse, over the past 12 months, and who is likely to play a key role going into 2013.

Then for the first time, Pulse's editorial team also got involved, drawing on our experienced team of editors and reporters to help finalise a list that we hope reflects the true breadth and depth of the profession.

Read longer versions of all the GP profiles at pulsetoday.co.uk/top50.

3 Dr Laurence Buckman ▼1

Given his reputation as the pugnacious front of the profession, GPC chair Dr Laurence Buckman might have been expected to relish the pitched battles and skirmishes of a momentous year.

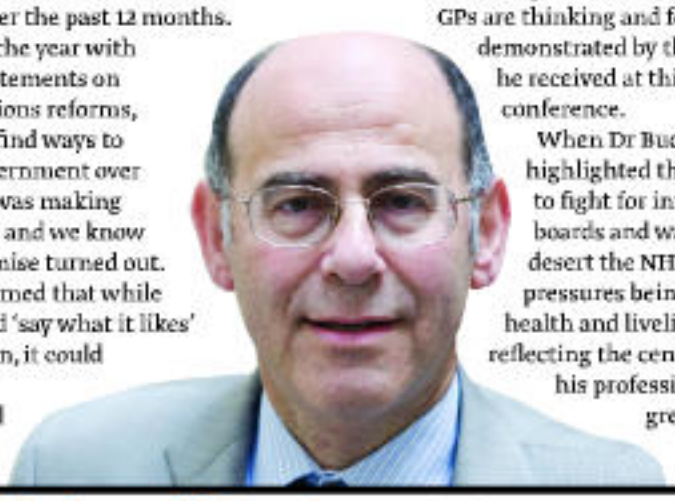
But while RCGP chair Dr Clare Gerada became the face of the fight against the health bill and BMA chair Dr Hamish Meldrum led the troops up the hill on pensions (but left it to successor Dr Mark Porter to bring them down again), Dr Buckman has looked somewhat lost in the maelstrom over the past 12 months.

He started the year with combative statements on the NHS pensions reforms, promising to find ways to 'hurt' the Government over an issue that was making GPs 'furious' – and we know how that promise turned out.

He also claimed that while the GMC could 'say what it likes' on revalidation, it could not go ahead without a deal on funding for remediation. Now new BMA chair Dr Mark Porter admits revalidation is 'not going to be perfect from the start' and the profession may have to proceed with key issues raised by the BMA still unresolved.

But never underestimate Dr Buckman's considerable influence. As one of our panel said, his 'no-nonsense clarity and sharp wit' are why the GP from Finchley, north London, is held in such esteem among the grassroots of the profession.

He has a deep understanding of what GPs are thinking and feeling, as demonstrated by the reception he received at this year's LMCs conference.



When Dr Buckman highlighted the need for GPs to fight for influence on CCG boards and warned they may desert the NHS due to the pressures being placed on their health and livelihoods, he was reflecting the central concerns of his profession at a time of great flux.

Dr Buckman has been up against an intransigent Government, but has won some significant victories over the past year.

He was instrumental in watering down the potentially catastrophic plans for abolishing GP practice boundaries, and instead managed to get the Department of Health to agree to a much-delayed pilot – potentially kicking the idea into the long grass.

He can also take credit for forcing ministers to allow some CCGs to put the brakes on the rollout of NHS 111 – although only eight of them took up this opportunity.

Dr Buckman himself says it is 'the same big things' that have formed the focus of his negotiations this year: expenses, workload, premises, recruitment and revalidation.

A man of his word – he was the first GPC member to confirm his practice would be taking industrial action over pensions – we can expect business as usual from the GPC chair over the next year.

Best moment Securing talks on new funding for GP premises.
Worst moment Agreeing to include new quality and productivity indicators in the QOF.

4 Dr Richard Vautrey ▲2

The past year has been a strong one for Leeds GP and GPC deputy chair Dr Richard Vautrey, a man described by members of our panel as 'the bright spark' of the GPC and 'a canny politician who brings a bit of plain Yorkshire speaking to debates'.

Those attributes have enabled Dr Vautrey to articulate the concerns of GPs clearly and become an authoritative voice of the profession.

He was one of few members of BMA Council who was unafraid to speak to the media on the pensions dispute (although he struggled to convince his own practice to take industrial action) and he memorably described the mooted quality-premium payment as something that would 'lead to GPs being regularly on the front page of the *Daily Mail*'.

He has also become one of the most recognisable GPC faces on the social networking site Twitter, using it to give his views on the day's headlines.

Dr Vautrey is a great advocate of the importance of protecting GPs from work that is not their responsibility, leading on new guidance to avoid GPs being expected to mop up secondary care tasks. He highlights the fallout from the Health and Social Care Act and the pensions dispute as the issues that have dominated the last year, adding: 'I think this year and the next will shape the future for general practice as well as the wider NHS.'

His main focus in the coming year will be trying to squeeze a better deal for practices out of the contract negotiations with the Government: 'The main concerns will be GP workload and rising expenses. There is a belief that this is untenable and we will be doing our level best to ensure no more work flows in from secondary care to primary care without increased resources.'

Commissioning and regulation of GPs via revalidation and CQC registration are also key issues that will rise to the top of the agenda, and he predicts: 'We will find out whether CCGs really will be clinically led. It will be this year that starts to determine that.'

It's clear he is not about to tire. He describes it as 'a great privilege' to represent the profession and says he will continue in his role as deputy chair as long as the GPC has faith in him.

Best moment Railing against the implications of paying GPs a quality premium.
Worst moment Failing to persuade his practice partners to take industrial action over pensions.

MORE ONLINE
Watch full interviews with all our top five GPs
pulsetoday.co.uk/top50

5 Dr Chaand Nagpaul ◀▶

The GPC negotiator and Harrow GP has graduated from rising star to a genuine contender to be the next chair of the GPC.

As the lead negotiator on commissioning, his profile has soared as he has been at the forefront of difficult discussions with the Government over the implementation of the Health and Social Care Act.

Widely hailed for his thoughtful and articulate approach, his measured yet authoritative presence has led to some wags hinting that a career in television is on the cards – suggestions that are laughed off by the man himself. He says explaining how the commissioning changes would impact on the working lives of GPs was one of the biggest challenges he faced this year.

Dr Chaand Nagpaul has not been shy in criticising the Government's health reforms. He reserves particular ire for the creeping privatisation of the NHS, claiming one of his biggest goals is mitigating the damaging effect of commercialisation. He has highlighted the dangers of outsourcing commissioning support and has also spoken out against moves by CCGs to performance manage practices.

In addition to his commissioning role, Dr Nagpaul leads for the GPC on negotiations over IT and enhanced services, meaning his in-tray is always full.

He says: 'I have enjoyed representing the concerns of grassroots GPs. Highlighting this to ministers is what counts.'

Best moment Receiving a rapturous ovation at the LMCs conference after claiming the Department of Health's refusal to publish the risk register of its NHS reforms was 'the height of hypocrisy'.
Worst moment Being 'Daily Mailed' during coverage of the day of industrial action – the paper printed a picture of his home and criticised him for 'driving a Jaguar with a personalised number plate'.

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

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PULSE TOP 50 GPs

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6 Dr Charles Alessi ▲14 C

Dr Charles Alessi's role as one of the most prominent GP cheerleaders for the Health and Social Care Act has seen his profile rocket over a year during which he took on the role of interim chair of the new NHS Clinical Commissioners group and became chair of the National Association of Primary Care (NAPC).

A charismatic yet divisive character, Dr Alessi is sometimes viewed by Government critics as an apologist for Andrew Lansley and has, at times, been forced to act as a shield for the policies of the unpopular health secretary.

But Dr Alessi is steadfast in his belief that

People forget what we do is difficult and carries a level of risk

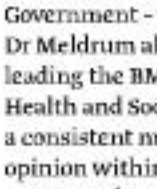
clinically led commissioning is the only way forward. He was nominated by our panel for his 'passion to see GPs forging ahead with entrepreneurial spirit to benefit patients', as well as for having the 'ear of the politicians'.

He says he took on his two new roles for NHS Clinical Commissioners and the NAPC 'in the eye of the storm' and insists GPs will emerge fighting from what he describes as a tough year for general practice: 'GPs have been through a difficult time and have been attacked quite a lot. What we do is difficult and it carries a level of risk. That is something some people tend to forget'.

Dr Alessi, who retired from his London practice in February, is now concentrating on his role in spearheading GP commissioning.

'It's about getting away from the old notions and managing the population more sensibly and in more of a joint way,' he explains. 'I think we are in a really good place to build on general practice and play a leading role in managing patients' health.'

7 Professor Mike Pringle ▲10



The one thing Professor Mike Pringle – who will take over the presidency of the RCGP in November after heading off competition for the prestigious post in recent elections – does not lack is experience. Affectionately described by one panel member as 'a good, solid RCGP chap', Professor Pringle was chair of the college between 1999 and 2001, and, until recently, the RCGP medical lead for revalidation. He has proved vital in guiding the college and the profession through the lead-up to revalidation and, despite his non-confrontational manner, he has been firm in insisting that GPs must accept the inevitable process.

A former guest editor of Pulse, Professor Pringle recently retired from his practice on the Nottinghamshire-Lincolnshire border, where he worked for more than 30 years. He remains professor of general practice at the University of Nottingham and was awarded a CBE for services to medicine last year.

Our panel described him as a 'solid educationalist' with 'deep roots' in the RCGP. One commented: 'I think he will become very influential very quickly. He is astute, experienced, trusted and wise.'

8 Dr Hamish Meldrum ▼5

Slipping down the rankings this year is Dr Hamish Meldrum, the former chair of the BMA who relinquished his position to consultant Dr Mark Porter in June. The last 12 months of Dr Meldrum's chairmanship were unquestionably the most challenging, as his feted diplomacy and mediation skills were tested to the limit by the fight on two fronts: the NHS pensions reforms and the Health and Social Care Bill.

His reluctant co-ordination of doctors' first industrial action in 37 years was a defining moment. Although the backlash from patients was minimal, he was forced to counter negative headlines in the national press, and ultimately the BMA – not the Government – was forced into a climb-down. Dr Meldrum also faced the tough task of leading the BMA's campaign against the Health and Social Care Bill and trying to forge a consistent message from the disparate opinion within the association.

He was heavily criticised by some dissenters on BMA Council for failing to fight harder against the legislation.

A low point came last autumn, when the BMA's London regional annual general meeting censured Dr Meldrum for failing to promote members' views and campaign for the withdrawal of the bill.

He ended his five-year chairmanship on a characteristically temperate note, urging doctors at this year's annual representative meeting that 'nobody should be rushing to repeat or escalate' the day of action over pensions reforms. Dr Meldrum retired from his practice in Bridlington, East Yorkshire, in March 2011.

9 Dr Mike Dixon ▼2 C

Hailed as the 'most skilled political operator in GP-land' by one of our panel, Dr Michael Dixon remains one of UK general practice's most prominent figures. Known for having 'the ear of policy makers' when it comes to commissioning, the NHS Alliance chair has supported the Government's plans to establish CCGs but has not been afraid to challenge ministers – as well as other GPs – on issues he believes need tackling.

He has repeatedly urged the Government to hold its nerve and throw its 'full weight' behind GP commissioning, but also raised concerns about CCGs becoming too 'centrally driven' and 'bureaucratic'.

But as an eternal optimist, he believes GPs are now well placed to lead the changes.

'I think there could be an enhanced role for GPs, not only in looking after patients but in looking after the whole of our population,' says Dr Dixon, who will retain a strong voice in his new role as interim president of NHS Clinical Commissioners.

Dr Dixon is also a well-known advocate of complementary medicine and is chair of the College of Medicine, the unofficial successor to the defunct Prince's Foundation for Integrated Health, of which he was medical director.

Up-and-coming GPs

There are many new entries in the top 50 this year, with a number of young, fresh faces showing their influence on the profession. From GP trainee representatives at the BMA and the RCGP Dr Krishna Kasaraneni and Dr Stuart Sutton, just starting their careers, to a possible future GPC negotiator Dr Charlotte Jones, we also have some new faces leading the commissioning challenge, such as Dr Sam Barrell and Dr Penny Newman, who are at the coalface of the new NHS.

10 Dr Nigel Watson ▲6 C

Dr Nigel Watson is chief executive of Wessex LMCs and chair of the GPC's commissioning and service development subcommittee.

Described by one of our panel members as 'generating solutions behind the scenes to all kinds of difficult issues', the New Forest GP has played a central role in developing GPC policy on the Government's health reforms.

Our panel also highlighted Dr Watson's key role in liaising with Department of Health policy makers on behalf of the GPC, praising him as 'well respected by civil servants'.

Dr Watson, who has been a GP for 25 years, says he relishes the opportunities that come with change and uncertainty: 'I think there are loads of opportunities for GPs to influence the way the agenda is going. I still think general practice is a wonderful profession.'

11 Dr Colin Hunter ▲21

Dr Colin Hunter has gained prominence this year both as RCGP treasurer and as the man presiding over the clinical domain of the QOF. Described by one of our panel as the 'canny power behind the throne' at the RCGP, he has led on the development of the college's new headquarters in London and helped keep it on an even keel financially. With his QOF hat on, he labours over the wording of indicators and scrutinises the results from pilots. As chair of the independent NICE advisory committee that oversees the QOF, he faces pressure from the Government and patient groups for a QOF that incentivises GPs for outcomes rather than processes.

With the GPC making clear it will be pushing to retain the QOF status quo this year, the Aberdeen GP admits he faces a difficult balancing act: 'The challenge will be to keep the QOF relevant for GPs and to present good information to negotiators.'

12 Dr Fay Wilson ▲1 N

New entrant Dr Fay Wilson is an 'honest, passionate advocate of general practice and all that is good about it', according to our panel.

The Birmingham GP, a director of out-of-hours provider BADGER and former chair of the LMCs Conference, describes herself as an old-fashioned feminist. She has bemoaned the loss of the only female GPC negotiator and has done her bit for female representation on the BMA after putting her hat in the ring to become the next BMA deputy chair.

Dr Wilson has defended the BMA leadership in the past over its handling of the NHS pensions dispute, arguing: 'What do you do with a Government that says: "We aren't talking to you – clear off"?'

In the year to come, Dr Wilson predicts CCG implementation will bring about a 'huge amount of navel gazing' for the profession and is critical of the misconstrued role of the CCG as a performance manager of GPs.

13 Professor Helen Lester ▲4

Professor Helen Lester holds great sway over GPs' daily working lives as a result of her role as clinical lead in the development of the QOF.

She combines the task of overseeing pilots of potential new QOF indicators with her post as professor of primary care at Birmingham University – and she's also a jobbing GP in the city: 'With the QOF, I sometimes think we focus too much on overall indicators. I'd like more regular changes to the QOF so it becomes a routine part of everyday workload.'

As one of our panel commented, Professor Lester is also a 'wonderful researcher who has driven the knowledge base of our profession for decades'. Professor Lester herself says her priority is to develop clinical tools that GPs will actually want to use – such as the algorithm she developed with Diabetes UK this year, which reminds GPs when to introduce metformin. She is also chair of the clinical innovation and research centre at the RCGP, where her research focuses on cancer, diabetes and mental health.

14 Dr Johnny Marshall ◀▶ C

Former NAPC chair Dr Johnny Marshall, a GP in Wendover, Buckinghamshire, has kept his profile high with his role as a leading GP supporter of the Government's commissioning agenda.

His stance on the NHS reforms has not always proved popular with the rank and file, but his determination has earned him respect, with one panel member describing him as a 'leading-edge thinker' in primary care.

Dr Marshall has continued to bang the drum for clinical commissioning in his new role as interim partnership development director at NHS Clinical Commissioners. He is also an advisory member of the NHS Commissioning Board's future design group.

He says he has been encouraged in the past year to see GPs 'stepping up to the plate' to lead the establishment of CCGs, and adds: 'A significant number of GPs are putting their hands up and getting involved.'

But he insists most of the hard work is yet to come: 'It's a critical period of time.'

15 Dr Michelle Drage ▼6

A vocal leader for the UK's largest LMC since 2002, Dr Michelle Drage is described by one of our panel as the 'best horizon scanner around on future threats and opportunities'.

As chief executive of Londonwide LMCs, this year Dr Drage has defended practices in the capital on big issues including revalidation, pensions and the Government's plans to open up local

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- Advice on managing diabetes with renal impairment
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- DH proposals for a single diabetes QOF indicator, worth £5,000
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References
1 http://www.pulsetoday.co.uk/newsarticle-content/-/article_display_list/14266606/gps-asked-to-mass-screen-all-patients-aged-40-years-or-older-for-diabetes
2 Preventing type 2 diabetes: risk identification and interventions for individuals at high risk. Issued: July 2012. NICE public health guidance 38. guidance.nice.org.uk/ph38.
3 European Society of Cardiology Congress abstract no. 385 and The Lancet, published online 29 August 2010

...fortunately for them there's

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enhanced services to private providers. But her influence extends far beyond the capital, with our panel saying she runs the 'most influential GP representative organisation' and another adding that 'her appetite and enthusiasm for medical politics is undiminished – her eye is never off the ball'.

Drawing on her experience as a GPC negotiator, Dr Drage was instrumental in ensuring London GPs did not sign up to inappropriate CCG constitutions. Dr Drage says her challenges in the year ahead will be easing fears over reductions in practice income and tackling the paucity of partnership opportunities in London.

16 Professor David Haslam ▲6

It has been an interesting year for former RCGP chair Professor David Haslam.

He has been president of the BMA during a period when the association has been fighting fiercely on behalf of GPs – while at the same time filling the much more contentious role of clinical adviser to the Care Quality Commission as it implements its controversial GP practice registration scheme.

But Professor Haslam insists he has been representing GPs in his role on the CQC: 'I have gone out of my way to make sure the registration process is as logical as possible. It is vital we do it in the most respectful way to general practice, and the last thing we want is to have opportunities lost.'

He describes his period as president of the BMA, which came to an end in June, as 'enlightening' and says he is confident the association can walk the 'tightrope' in representing GPs, despite widespread criticism of its handling of the pensions dispute.

Professor Haslam also spent part of the year contributing to the RCGP's independent Commission on Generalism.

This year he retired from his practice of 35 years at the Ramsey Health centre in Huntingdon, Cambridgeshire.

17 Dr Howard Freeman C N

It was Dr Howard Freeman's role as a commissioning pioneer that caught the eye of our panel. The part-time Wandsworth GP splits his remaining time between high-profile roles as associate medical director for primary care for NHS London and joint medical director for NHS South West London. He is also an interim chair of Merton CCG. Much of his time in the past year has been spent establishing and chairing the London Clinical Commissioning Council. Dr Freeman is also a key architect behind a controversial scorecard measuring the performance of GP practices in London.

He says the past year has been one of the most challenging since he got involved in medical politics 20 years ago: "This is the humpty-dumpty change. The NHS has fallen off the wall and is in so many pieces we might never get it back together again.'

Despite this downbeat analysis, Dr Freeman is adamant that the clinician's role in reforming the NHS remains more important than ever.

18 Dr Barry Lewis N

Dr Barry Lewis's influential role as one of the central architects of the successful bid to extend GP training sees him join our list as a new entrant.

He was a GP in Rochdale, Lancashire, for 33 years before retiring this year. But as director of North Western Deanery and chair of the Committee of GP Education Directors (COGPED), he has his hands full working with the RCGP on the practicalities of implementing four-year GP training. COGPED's plan for fourth-year registrars to be drafted in to plug service gaps and fill out-of-hours rotas have proved controversial, prompting the GPC to say it would create a 'sub-grade' of GP – but Dr Lewis insists the benefits of extended training will be 'enormous'. But there remain hoops to jump through, not least in gaining final approval for the plans from Medical Education England and the devolved nations.

Dr Lewis enjoys his job and delights in the part he plays in training doctors for what he calls the 'hardest job in medicine': 'My highlight this year, as always, is watching trainees mature into qualified GPs.'

19 Dr Iona Heath ▼9

Dr Iona Heath may be stepping down from her role as president of the RCGP in November, but our panel say she will remain an inspirational role model for the profession.

One described Dr Heath as 'amazing', adding: 'Whenever she talks, she spellbinds her audience and always has the facts and knowledge to back up what she says.'

Another said: 'She is one of my heroines. If I look at all of the GPs who have been most inspirational, she is on that list.'

Dr Heath was a GP in Kentish Town, north London, from 1975 until 2010 when she retired from practice and took up the largely ceremonial position of RCGP president.

She is internationally renowned for her writing on the ethics and core values of general practice. Dr Heath gave the prestigious Royal College of Physicians' Harveian Oration last October, highlighting the importance of the doctor-patient relationship and warning of the danger of categorising patients without taking account of their personal experience.

20 Dr Dean Marshall N

After standing down from a six-year spell as chair of the Scottish GPC, Dr Dean Marshall was elected back onto the GPC in controversial fashion, taking the place of the only female negotiator. The result was testament to his no-nonsense negotiating style on behalf of GPs in Scotland, where he says his proudest achievement was leading on a *Way Ahead* document for the Scottish NHS. He says the document will be used by the Scottish Government to inform its NHS reforms – and he hopes to facilitate the same level of engagement with the Department of Health in his work for the GPC.

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Top commissioning GPs

With GPs poised to take on full commissioning responsibility from next April, it is perhaps inevitable that the NHS reforms cast a long shadow over our list, with at least 10 nominated GPs having a prominent commissioning role.

These include medico-political leaders such as NAPC chair Dr Charles Alessi, NHS Alliance chair Dr Michael Dixon and GPC commissioning lead Dr Chaand Nagpaul, and also CCG leaders carving out a new role locally, such as Dr Howard Freeman, Dr Sam Barrell and Dr Sam Everington.

Significantly, though, our list also includes several GPs nominated principally because of their criticism of the NHS reforms – with figures such as Dr Kailash Chand and Dr Louise Irvine having led opposition at the BMA over the past 12 months.

38 PULSETOP 50 GPs

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He joins the negotiating committee at what he calls a 'time of crisis' for UK GPs.

Dr Marshall's negotiating remit currently covers appraisal and revalidation, while he also supports fellow negotiators on pensions and other key issues, such as the implementation of England's NHS reforms.

'I worry that if it goes wrong, GPs will be picking up the pieces,' he says.

21 Dr Beth McCarron-Nash ▼3

There was widespread surprise when Dr Beth McCarron-Nash, the sole woman on the GPC negotiating team, recently lost her negotiator's post to Dr Dean Marshall in a mid-term election.

Despite this setback, Dr McCarron-Nash has had a busy year. She has lobbied against unpalatable aspects of the Health and Social Care Act and is particularly proud of her role in achieving what she describes as a 'fair deal' for GPs in this year's contract negotiations.

The Cornwall sessional GP has led the GPC's negotiations on education, training and the workforce, including the plans to extend GP training to four years.

She has also campaigned hard against an increase in pensions contributions, which, as the youngest GPC negotiator, would have hit her and her peers particularly hard.

She is now determined to tackle what she calls a 'two-tier' system that divides GP partners from salaried and sessional GPs by encouraging more practices to take on new partners.

22 Dr Alan McDevitt

The highlight of Dr Alan McDevitt's year came in August, when he officially took on his new role as chair of the Scottish GPC.

The Clydebank GP has his work cut out for him, leading Scotland's 5,000 GPs: 'I look forward to representing Scotland at UK negotiations – which I expect will be quite different to our talks with the Scottish Government.'

He identifies GP premises as a key issue that needs to be addressed: 'If GPs are to care for their patients and develop services, we need to deal with the serious problems with GP premises. Investment is vital.'

23 Dr Margaret McCartney ▲27

Dr Margaret McCartney has leapt up the charts this year following the release of her debut book, *The Patient Paradox*. Our panel praised the book as 'a major tome' and said the Glasgow GP's writing was both patient-centred and evidence-based. In her own blogs and her regular columns for Pulse, Dr McCartney targets the areas of general practice and public health where the evidence base is lacking. From flu vaccinations to vitamin D supplements, her eye for detail and straight-talking style have earned her much respect – and a large Twitter following. Dr McCartney is currently writing her second book, which is due out next year.

24 Professor Bill Irish

As chair of the GP National Recruitment Office, Professor Bill Irish issued a stark warning over an impending jobs crisis in general practice this year. He claimed doctors simply don't want to be GPs anymore and said deaneries were reducing the number of GP places on offer because of the difficulty of filling them with high-quality applicants.

The Department of Health subsequently announced a 20% rise in GP training places – but Professor Irish remains sceptical that the target will be met: 'I am not particularly optimistic.'

Although pessimistic about GP workforce numbers, Professor Irish says the 'tacit approval' of four-year GP training from Medical Education England was a highlight. In the coming year, he is planning a programme to actively recruit GP trainees for isolated and deprived areas of the UK and to try and keep up with the massive changes set to engulf deaneries over the next few months.

25 Dr James Kingsland ▼14

Despite his lower public profile over the past year, the Wirral GP remains an influential figure behind the scenes of general practice. In his role as a special adviser on commissioning to the Department of Health, he travels the length and breadth of the country spreading the commissioning gospel to clinicians.

Criticised in some quarters for taking a Government role while still president of the NAPC, he has retained the ability to challenge the status quo in primary care and is widely admired for his unswerving focus on improving standards in general practice.

This year, Dr Kingsland opened a new practice in purpose-built premises, complete with an ultrasound scanner, pharmacy and a range of social services, pioneering what he described as the '21st century of primary care'.

He also spoke out against the BMA's day of action on pensions, saying he supported neither the principle nor the practice of industrial action.

Top five tweeters

One of the year's developments has been the increasing use of Twitter by GPs. Many have ventured onto the social media site to keep up to date, fight back against negative media headlines about the profession and network with each other.

Here are some of the best accounts to follow from our Top 50:

- **Dr Clare Gerada @clarercgp**
- **Dr Jonny Tomlinson @mellojonny**
- **Dr Mary Church @zetadoc**
- **Dr Kailash Chand @kailashchandOBE**
- **Dr Margaret McCartney @mgtmccartney**

31 Dr Sam Barrell C U

Devon GP Dr Sam Barrell has risen to prominence this year as one of the new breed of clinical leaders spearheading the transformation of the health service.

Until recently, Dr Barrell, who practices at the Compass House surgery in Brixham, was chair of Baywide CCG, but she is now the clinical accountable officer for the newly formed South Devon and Torbay CCG.

One of our panel members described her as 'beginning to get the ear of central policy makers', while another said she was 'nationally influential, but most importantly

Our panel said she is 'beginning to get the ear of policy makers'

influences locally for better care for patients'.

Dr Barrell cites relationship building as a big challenge in her part of Devon, but has gone to great lengths to try and impress the need to lead upon her peers. With over 50 GPs in her CCG now actively engaged with commissioning, she believes the local profession is beginning to get on board with service redesign. The CCG already has new or improved services for diabetes, cardiology, end-of-life care, obesity, alcohol and urology in place.

Dr Barrell has also used her network as a tutor at the Peninsula Medical School to attract good-quality backfill from newly qualified GPs.

She says: 'We have also worked hard on GP engagement and have a truly dedicated network of some 50 GPs locally who are involved in lots of aspects of commissioning and service redesign. As a clinical leader, I know this can only be done through the willing co-operation of our member practices.'

26 Professor Amanda Howe ▲4

'Wise and gets things done – her influence behind the scenes is immense,' is how one Pulse panel member describes Professor Amanda Howe.

A GP in Norwich, professor of primary care at the University of East Anglia and honorary secretary at the RCGP, Professor Howe has been instrumental in developing the college's plans for the future and recently authored its report into generalism. She recently prompted debate when urging GPs to consider half-hour appointments as routine for patients with complex health conditions. Professor Howe is a strong voice for women in medicine and has campaigned for more flexibility in the profession to accommodate women's careers. She is also involved in research on commissioning and funding.

27 Professor Tony Avery

As the lead author of two of the most important studies into GP prescribing in recent years, Nottingham GP Professor Tony Avery's profile has soared in a year in which he was marked as 'becoming more influential' by our panel.

His GMC-funded paper into prescribing errors in general practice found one in 10 scripts had errors, and the research is already leading to changes in the clinical decision support tools offered by GP systems providers.

Future work includes developing a patient safety toolkit for use in GP practices and, along with the University of Manchester, he will be setting up a patient safety translational research centre that will evaluate safety systems in general practices.

'I'd enjoy being able to do research that makes a difference,' he says.

28 Dr David Bailey

This year will be Dr David Bailey's last as chair of GPC Wales – though he hopes to continue as a GPC negotiator if re-elected. As deputy chair and the senior GP on the BMA pensions committee, the Caerphilly GP has lobbied hard against the Government's plans to raise GPs' retirement age and increase pension contributions. Alongside this, he has remained dogged in defending Welsh GPs and one panel member described him as both 'hugely influential' and 'well respected by the Welsh Government'.

Dr Bailey was also the GPC's lead negotiator in talks over a £10.7m reimbursement owed to dispensing practices across England and Wales for underpayments in 2010/11 and 2011/12.

29 Dr Peter Swinyard ▲20

Veteran GP Dr Peter Swinyard continues to champion the cause of small practices in his role as chair of the Family Doctor Association. But the Swindon GP's views are more nuanced than some of his grassroots peers. Dr Swinyard has been quick to flag up the potential dangers of revalidation, warning it could force single-handed GPs to retire. Over the next 12 months, he hopes to support family doctors by helping GPs adapt to the new Care Quality Commission requirements and changes to the QOF.

30 Dr Paul Charlson ▲17

A Government loyalist, the chair of Conservative Health is known to have the ear of health secretary Andrew Lansley. Despite the backlash the Government faced from the profession over the Health and Social Care Act, Dr Charlson says he is heartened to see GPs embracing their new commissioning role despite any reservations they might have had.

But the East Yorkshire sessional GP is under no illusions about the scale of the task facing CCGs: 'Trying to make significant changes when budgets are so tight is not going to be easy.'

32 Dr Kailash Chand ▼5

Dr Kailash Chand worked for 25 years as a GP in Ashton-under-Lyne, Lancashire, before becoming chair of NHS Tameside and Glossop in 2009. He has become well known for his dogged campaigning against the Government's health reforms, and this year won both plaudits and headlines for forcing a House of Commons debate after his Drop the Bill petition attracted more than 170,000 signatories. The debate did not stop the NHS reforms, but it gave him plenty of support as he rejoined BMA Council. He

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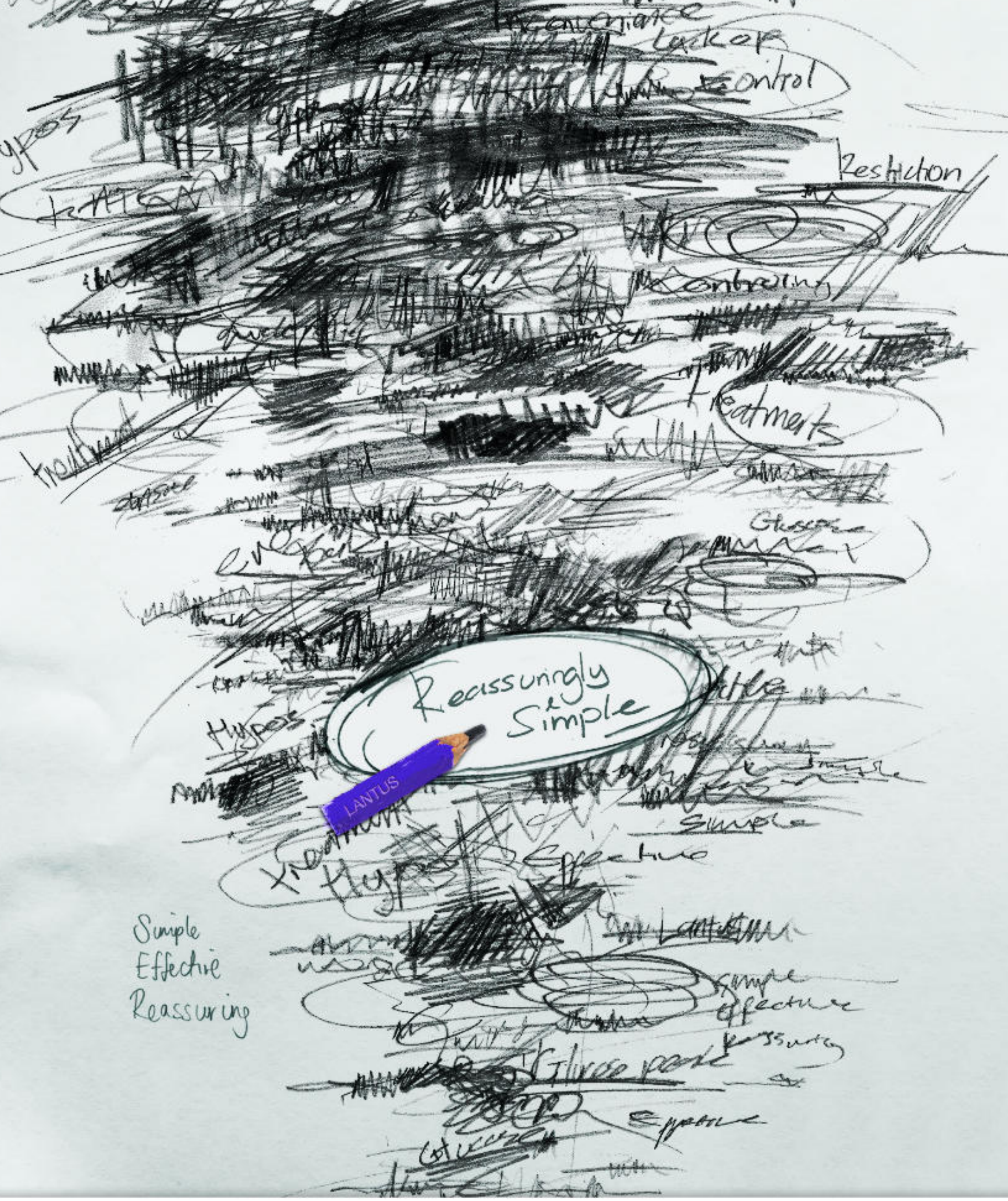

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40 PULSE TOP 50 GPs

Top five on camera

Watch interviews with our top five most influential GPs as they discuss their year and what the future holds for the profession.


Dr Clare Gerada


Dr Laurence Buckman


Professor Steve Field


Dr Chaand Nagpaul


Dr Richard Vautrey

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Who else was nominated

Dr Darin Selger
Professor Graham Watt
Dr Clare Taylor
Dr Pauline Brimblecombe
Dr Mark Sandford-Wood
Dr Duncan Walling
Dr Anthony Brzezicki
Dr Steve Kell
Dr Simon Poole
Professor Christian Mallen
Dr Amy Small
Dr Nikki Kanani
Dr Ben Brown
Dr Chris Williams
Dr David Paynton
Dr Elliott Singer
Dr Faizan Ahmed
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Dr Steve Mowle
Dr Sara Khan
Dr Aqil Chaudary
Dr Rebecca Rosen
Dr David Hegarty
Dr Howard Jones
Dr Hugh Reeve
Dr Jason Broch
Dr John Hussey
Dr Nicola Jones
Dr Stephen Richards

33 Dr Peter Holden

Along with Dr Laurence Buckman, GPC veteran Dr Peter Holden is the last remaining member of the negotiating team that secured the new GMS contract in 2004. Dr Holden took a lead role this year in negotiating with the Government over the controversial introduction of the new NHS 111 service for urgent care. A 'card-carrying Tory', the Derbyshire GP has nevertheless issued a series of withering put-downs to the Government, not least when he said: 'Resignation's too good for Lansley, Cameron should sack him.'

34 Dr Charlotte Jones

Nominated for 'combining imagination and hard work', Dr Charlotte Jones took a real leap a year ago when the Swansea GP was elected deputy chair of GPC Wales. She is described by our panel as an 'experienced and very effective communicator' and a 'very clear thinker with the potential of becoming a very high-level GP negotiator'.

She is currently a member of the training and workforce committee of the GPC, a GP trainer and appraiser, and has been a manager of out-of-hours services since 2004. She is also a member of Morgannwg LMC.

35 Dr Nigel Sparrow

Hailed as an 'unsung hero' by our panel, Professor Nigel Sparrow is chair of the professional development board at the RCGP. A GP in Nottingham, Professor Sparrow has also played a key role in moving the college's quality scheme for practice accreditation to align with Care Quality Commission registration, a move intended to ease the regulatory burden for GPs.

36 Dr Krishna Kasaraneni

Newcastle United fan Dr Krishna Kasaraneni is rivalling Geordie wonderkid Andy Carroll in the meteoric-rise stakes, having only decided to go into general practice two years ago. Described by one of our panel members as having 'his finger on the pulse of trainees', the current chair of the GPC trainees committee only decided it was time for a career change after three years in surgical training. Now a GP trainee in Sheffield, Dr Kasaraneni has had his hands full this year by ensuring the views of trainees were heard in the discussions on extending GP training to four years.

37 Professor Malcolm Lewis

A member of GMC Council and a GP in Swansea, Professor Malcolm Lewis is described by our panel as a figure with a 'huge influence' on the direction of appraisal and revalidation. He was largely an unknown figure to grassroots GPs until he stepped into the bear pit at this year's LMCs conference. But he ruffled some feathers with his comments that disagreements over remediation 'shouldn't be a delaying factor' for revalidation.

38 Dr Louise Irvine

As a prominent member of the Drop the Bill campaign, Dr Louise Irvine, a GP from Lewisham in south-east London, took her protest to the streets, joining a demonstration on Westminster Bridge and then calling for a boycott of commissioning. This April, she also won a seat on BMA Council.

39 Dr Stuart Sutton

He may not be a familiar name to many, but Dr Stuart Sutton is a young GP to watch. Currently a GP registrar in Newham, east London, he has been chair of the RCGP's associates in training committee since November 2011 and co-chair of GLADD (Gay and Lesbian Association of Doctors and Dentists) since 2009.

Our panel predicted he will 'go places' – and he certainly has had a productive year, helping the RCGP successfully present its case for extended GP training.

40 Sir John Oldham ▼16

The Department of Health's lead on QIPP, Sir John Oldham has been hugely influential over the past few years as the DH's top dog on primary care efficiency.

Sir John has said he will step down 'towards the end of the year' from this role and had hoped to become RCGP president, although he was beaten in the election by Professor Mike Pringle. Still a practising GP in Glossop, he is also a vocal proponent of self-care, which he believes needs to be pushed further up the DH agenda.

41 Dr Kamlesh Khunti ▼1

Professor Kamlesh Khunti, a GP in Leicester, has long been an authoritative voice for primary care on a number of national diabetes programmes and policies. A professor of primary care diabetes and vascular medicine at the University of Leicester, this year he chaired the NICE programme development group overseeing the development of new guidelines that urge GPs to screen all patients aged 40 or older for diabetes.

42 Dr Tom Black

An affable Derry GP, Dr Tom Black became chair of GPC Northern Ireland last year and immediately made a splash by calling on GPs in the province to take on more commissioning roles.

Dr Black's main task this year was taking part in the implementation of the Northern Ireland review of health and social care, and he says he has been lobbying hard to ensure changes are 'properly planned, managed and resourced'.

43 Dr Sam Everington ▼8

The pioneering GP, who runs the feted Bromley-by-Bow Health Centre in east London, is a man with many hats. The current chair of NHS Tower Hamlets CCG, he is a member of both BMA and GMC Councils and the former deputy chair of the BMA. On top of this, he has advised both Labour and Conservative governments on general practice.

Read the full profiles of all our top 50 GPs online
▶ **pulsetoday.co.uk/top50**

49 Dr Jonny Tomlinson N U

Dr Jonny Tomlinson may still be a relative unknown to many in the profession, but for any GP who has dipped their toe into the world of social networking, his 'mellojonny' moniker will be very familiar.

After RCGP chair Dr Clare Gerada, Dr Tomlinson is one of the most prominent – and prolific – GPs on Twitter, with more than 3,000 followers and counting, and he has used that platform and his *A better NHS* blog to campaign vigorously against the Government's NHS reforms and health-service cuts.

The conversations you can have on Twitter are very powerful

Described by our panel as 'kind and thoughtful' and someone who 'writes well and makes me feel good about general practice', he is a partner at a practice in Hackney, east London, and a GP trainer.

Dr Tomlinson began blogging in 2009 and now it's not uncommon to find him in the pub with leading health policy brains such as King's Fund chief economist John Appleby and editor of *Health Policy Insight* Andy Cowper. He was one of the GPs who publicly criticised the BMA's plans for industrial action over pensions, and also wrote movingly in Pulse about his experience in the centre of the riots in London last summer.

He is a persuasive evangelist for the way Twitter has created a stronger sense of community among GPs: 'In terms of the conversations you can have with interesting people, it's incredibly powerful – I don't have any political ambitions, but if you want to talk about your profession you can't help but stand up and be a representative.'

48 Dr Martin Roland ▼36

Professor Martin Roland is a respected and outspoken academic who continues to have an impact on primary care policy. A GP in Cambridge, he helped draw up the new GMS contract in 2004, worked on the expert panel that decided clinical QOF indicators before the job was handed to NICE and has been involved in developing the GP Patient Survey since its start.

50 Dr Kambiz Boomla ▼19

Nominated by a number of GPs from the capital on our panel, Dr Kambiz Boomla, a GP in Tower Hamlets, east London, is well known for being a politically active left-winger – and this year has been no exception. Dr Boomla has just gone part-time at his practice in Limehouse and has recently stepped down as chair of East London LMC. He hopes his extra time will help him raise support for events such as the 'anti-austerity' march in October.

44 Dr Mary Church N

A GP in Glasgow, Dr Mary Church was chair of the LMCs Conference this year. She is also one of a number of GPs to have taken to Twitter like a fish to water. From GP training to the way the national anthem was played at the London Olympics, Dr Church is never afraid to be controversial and displays a cool scepticism that befits her role as a 'an elder stateswoman' of the profession – as she was described by one member of our panel.

45 Dr Tony Copperfield N

Pulse's star columnist, regular blogger and professional cynic, Dr Copperfield is the only fictional doctor to make our Top 50 GPs list.

A published author and regular contributor to national newspapers, the Essex GP made our list of top medical blogs this year – which was described by one of our panel members as 'so true to life I feel like I could have written them'.

46 Dr Robert Varnam C N

Dr Robert Varnam is a GP in inner-city Manchester and head of policy at – and co-founder of – the RCGP Centre for Commissioning.

He is also known for his work as a member of the primary care team at the NHS Institute for Innovation and Improvement, and was a member of the Government's NHS Future Forum that conducted the listening exercise on the health bill.

Over the next few months he will be leading a programme working with GP practices in the Midlands to improve medication safety.

47 Dr Penny Newman N U

Dr Penny Newman, a GP in Ipswich, was described as an 'amazing GP' by our panel, in particular for her *Realising Potential* report that has inspired a new NHS leadership programme for female doctors and that aims to increase the number of women at 'board level or equivalent' by 10% by 2017.

Top 20 non-GPs

Our panel of 50 GPs nominated the non-GPs they thought were the most influential on the NHS and general practice. Here are their choices

1 Sir David Nicholson ▲1

The next 12 months will be crucial in deciding whether the restructured NHS is a success, so it's lucky the man on whom the whole thing rests has broad shoulders.

Sir David has been chief executive of the NHS since 2006 and is a respected hand on the tiller of the health service, and will head up the organisation that all GP practices in the country will contract with.

As chief executive of the NHS Commissioning Board, he will be in charge of implementing the radical redesign of the NHS, which will see PCTs and SHAs abolished and CCGs take their place. It's a huge challenge, but he is also tasked with making £20bn worth of efficiency savings under the eponymous 'Nicholson challenge' at the same time. This savings drive will now extend beyond 2015, and he recently warned the NHS needed substantial 'service change' to succeed.

As our panel said his interpretation of the Government's legislation will be 'make or break' for the future of the NHS. One panel member said: 'His interpretation of central policy into local implementation will have significant impact, even if it wasn't what the policy makers envisaged.'

His interpretation of central policy will have impact

In his keynote speech to the NHS Confederation in June, he was bullish, insisting politicans make the case for change to the public, and was candid about the possible need for hospital closures.

He also seems to be a man who listens. Faced with a Pulse investigation showing the majority of CCGs had yet to recruit a consultant to their board, he said he was 'very open' to relaxing the legal stipulation that they must come from outside the area.

Having said that, his time leading the board has already had its share of controversy – with new guidance suggesting that GP LESs should only be commissioned without using any qualified provider if they are of 'limited value' or where GPs are the 'only capable providers'.

So far he has avoided any overt criticism of GPs – unlike the chair of the board Professor Malcolm Grant – but he will be the man ultimately responsible for performance managing practices. So GPs will be expecting a lot more from him over the next year.

2 Andrew Lansley ▼1

Time will judge whether he becomes the man who destroyed the NHS or saved it, though there is no disputing that Andrew Lansley's fingerprints will remain all over the health service for a long time. But arguably, the health secretary's biggest achievement has been keeping his job, despite insistent calls that he should be sacked.

Mr Lansley was elected as MP for South Cambridgeshire in May 1997 and served as shadow minister for health for seven years before being appointed health secretary after the general election in 2010. He is no rookie, but has been criticised for being too much of a technician and unable to explain the rationale for his reforms clearly enough.

The BMA's 'no confidence' vote in the health secretary – held at its annual representative meeting in June – was carried by 159 votes to 124, despite BMA chair Dr Hamish Meldrum calling on the conference to reject the motion, pleading: 'I've got to negotiate with him, and it's awkward to say "here's your P45 – let's talk."'

In nominating Mr Lansley, one panel member said he was probably the most influential non-GP on the NHS 'for all the wrong reasons', while another said he has 'survived a turbulent year' although the full extent of his reforms 'perhaps did not'.

He has certainly made history by becoming the first health secretary for decades to drive doctors to take industrial action over his planned changes to their pensions. His intransigence on this is probably motivated by not wanting to upset the Treasury, but it comes at an awkward time if he wants GPs to start delivering on his reforms in the next year. Others said he has managed to do what many other BMA leaders wished they could and 'created unity' in the profession, although he might not have welcomed the manner in which it was achieved.

3 Dr Mark Porter

Barely weeks into his new role as chair of BMA Council, Dr Mark Porter had to make what could be the defining decision of his tenure. Having succeeded Dr Hamish Meldrum in June, Dr Porter had to turn to his colleagues and somehow justify the decision to abandon industrial action over pensions – although he didn't pretend it was the decision he liked. Consultant anaesthetist Dr Porter's first few months as BMA chair have been tough to say the least, but our panel said his 'incredible intellect' would stand him in good stead.

4 Niall Dickson ▲2

As chief executive of the GMC, this year Niall Dickson will be responsible for bringing in the biggest shake-up in the regulation of doctors in more than 150 years.

The GMC declared itself ready for revalidation in July, although whether the NHS itself will be ready is open for debate.

Mr Dickson says there is 'genuine engagement' on the ground with revalidation, but admits there is some work still to do.

5 Dame Barbara Hakin ▼2

A former GP, Dame Barbara Hakin's key role in implementing the Government's reforms as national director of commissioning development at the NHS Commissioning Board is focusing on authorisation of CCGs. This year, she oversaw the development of the final list of 212 CCGs to be authorised. A skilled operator, Dame Barbara will be an experienced pair of hands for NHS Commissioning Board chair Sir David Nicholson to rely on.

6 Ben Dyson ▲4

Ben Dyson, a senior civil servant and champion of patients with learning disabilities, was recently announced as the director in charge of primary care and commissioning guidance at the NHS Commissioning Board.

7 Professor Sir Bruce Keogh

Sir Bruce Keogh has been medical director of the NHS since 2007 and this year spearheaded the Department of Health's IT revolution, launching a revamped NHS Choices.

8 Mike Farrar

The NHS Confederation chief executive recently said the NHS was 'a supertanker heading for an iceberg', because of 'chronic failure' to address the need for service reconfigurations.

9 David Cameron ▼1

The Prime Minister has staked his reputation on the success of the Health and Social Care Act and will continue to exert a huge influence over the direction of healthcare policy.

10 Paul Dacre ▼1

The editor of the *Daily Mail* remains the profession's pantomime villain, after continuing to devote many column inches in his paper to bashing GPs over pay.

11 Stephen Dorrell

As chair of the House of Commons health committee, the former Tory health secretary has been a nagging thorn in the side of health secretary Andrew Lansley, popping up at regular intervals to cast doubt on his grand vision for the NHS.

12 Professor Malcolm Grant

A former provost of University College London and a trained lawyer, Professor Grant made something of a Basil Fawlty-esque entrance into his new post as chair of the NHS Commissioning Board when he admitted to GPs he was not a 'patient of the NHS'.

13 Nicola Sturgeon ▲1

Deputy first minister of Scotland and cabinet secretary for health, Ms Sturgeon has sparked rumours of a break-up of the UK-wide GP contract with her calls for its 'tartanisation' in Scotland.

14 George Osborne ▼2

The man who has delivered more GP nightmares than Wes Craven this year, the Chancellor of the Exchequer has enraged even card-carrying Tory GPs with his reforms to the NHS Pension Scheme.

15 Professor Chris Ham ▼11

As chief executive of the King's Fund, Professor Ham is an influential voice in the debate over the future of the NHS. At the head of one of the UK's most influential health policy think tanks, he has argued that redesigning the NHS is the only way it can survive.

16 David Behan

Recently appointed chief executive of the Care Quality Commission, Mr Behan faces a tough task to convince both GPs and the public that the regulator will be fit for purpose.

17 Andy Burnham

Labour's shadow health secretary wasted no time in taking the coalition Government to task and generating negative headlines, with his grasp of data on burgeoning waiting lists and rationing of NHS care.

18 Jim Easton

As the DH's national director of improvement and efficiency, Jim Easton has his work cut out trying to kick the NHS finances into shape. As one member of our panel says: 'He will be a key person in transforming the NHS.'

19 Dr Jennifer Dixon

Described as a 'fantastic role model' by one of our panel, the director of the Nuffield Trust trained in paediatrics before her career in policy analysis and is one of the foremost academic experts in UK health policy.

20 Professor Allyson Pollock

The professor of public health research and policy at Queen Mary, University of London, is a well-known critic of the private finance initiative and private sector involvement generally in the health service.

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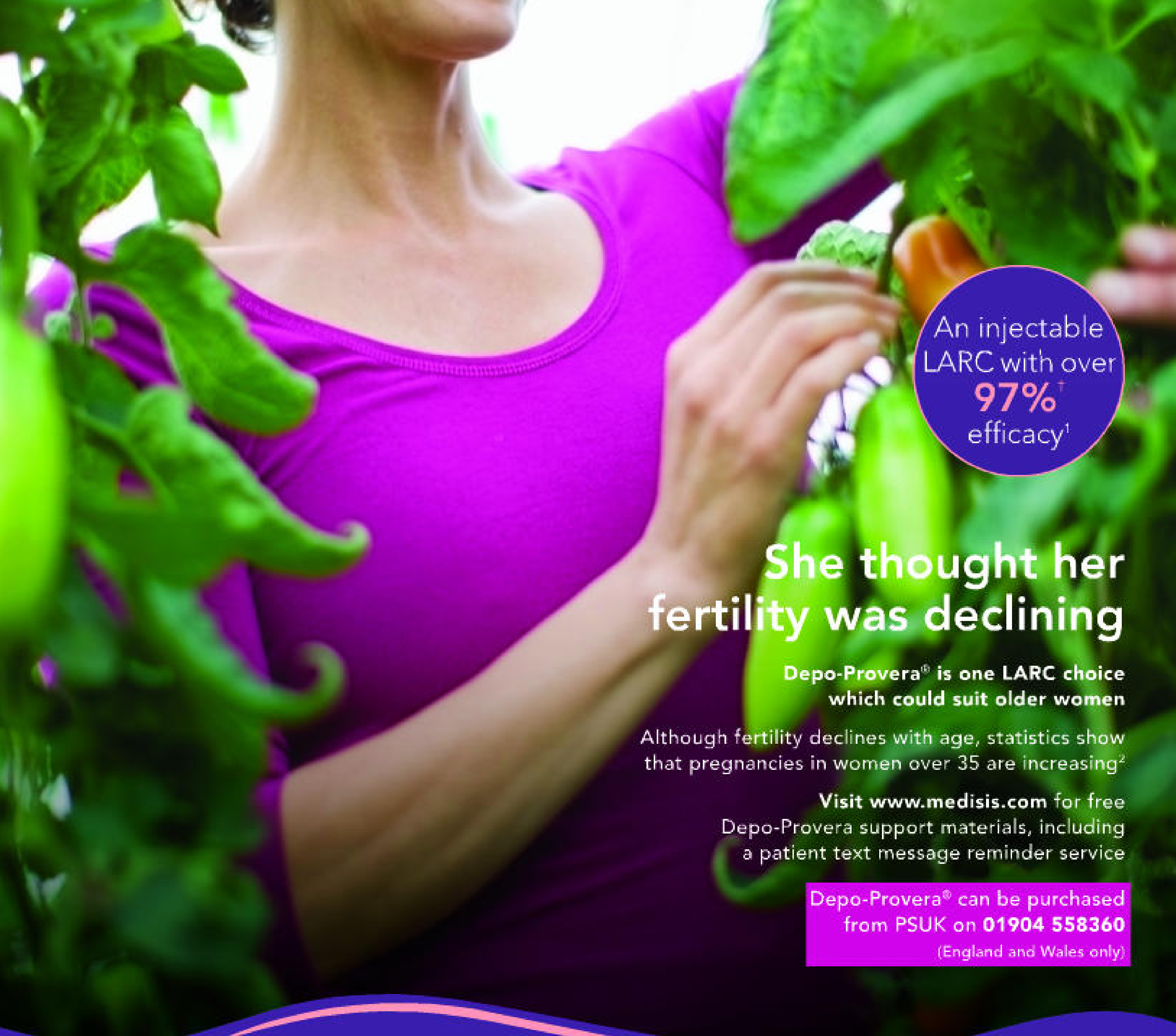
Read full profiles of all our top 20 non-GPs, as well as our Top 50 GPs, at pulsetoday.co.uk/top50



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Please refer to the SmPC before prescribing Depo-Provera 150 mg/ml. **Presentation:** 1 ml Disposable syringe, containing 150 mg medroxyprogesterone acetate in a Sterile suspension for injection. **Indication:** Long-term contraceptive agent, in women who have been counselled concerning the likelihood of menstrual disturbance, potential delay in return to full fertility and risks of bone mineral density losses. Short-term contraception for the following (i) for partners of men undergoing vasectomy, until the vasectomy becomes effective, (ii) in women who are being immunised against rubella (iii) in women awaiting sterilisation. May only be used in adolescents after other methods of contraception were considered to be unsuitable. **Dosage:** *First Injection:* 150mg intramuscular injection during the first 5 days of a normal menstrual cycle. *Post Partum:* Within 5 days post partum (if not breast-feeding). Women in puerperium can experience prolonged and heavy bleeding, therefore caution is required, and women should be advised accordingly. If the puerperal woman will breast-feed, the initial injection should be no sooner than 6 weeks post partum. *Further doses:* These should be given at 12 week intervals, however as long as the injection is given no later than 5 days after the 12 week interval, no additional contraceptive measures are required. For partners of men undergoing vasectomy, a second injection 12 weeks after the first may be necessary in a small proportion of patients where the partner's sperm count has not fallen to zero. If the dose repeat interval is greater than 89 days (12 weeks and 5 days) for any reason, then pregnancy should be excluded before the next injection is given and the patient should use additional contraceptive measures (e.g. barrier) for fourteen days after this subsequent injection. Elderly: Not appropriate. Children: Depo-Provera is not indicated before menarche. Data in adolescent females (12-18 years) is available, *Refer to the Summary of Product Characteristics* for further information. Other than concerns about loss of BMD, the safety and effectiveness of Depo-Provera is expected to be the same for adolescents after menarche and adult females. Depo-Provera may be poorly metabolised in patients with severe liver insufficiency. No dosage adjustment is required for renal insufficiency. **Administration:** By deep intramuscular injection. The sterile aqueous suspension should be vigorously shaken just before use to ensure the dose being given represents a uniform suspension. **Contraindications:** Known sensitivity to medroxyprogesterone acetate or any of its ingredients. Pregnancy. Known or suspected hormone-dependent malignancy of breast or genital organs. Patients with presence or a history of severe hepatic liver disease whose liver function has not returned to normal. Patients with abnormal uterine bleeding, whether administered alone or in combination with oestrogen until a definite diagnosis has been established and the possibility of genital tract malignancy eliminated. **Special Warnings and Precautions:** Use of Depo-Provera reduces serum oestrogen levels and is associated with significant loss of BMD due to the known effect of oestrogen deficiency on the bone remodelling system. Bone loss is greater with increasing duration of use, however BMD appears to increase after Depo-Provera is discontinued and ovarian oestrogen production increases. In adolescents and women with significant lifestyle and/or medical risk factors for osteoporosis, other methods of contraception should be considered before using Depo-Provera. Results from a study support the conclusion that the higher observed incidence of fractures among DMPA users was principally a result of factors other than exposure to DMPA. DMPA injection can be used for 2 years as birth control method or endometrial treatment if other birth control methods or endometrial treatments are inadequate. BMD should be evaluated when a female needs to continue use of DMPA injection long-term. In adolescent females, interpretation of BMD results should take into account patient age and skeletal maturity. The administration of Depo-Provera usually causes disruption of the normal menstrual cycle. Bleeding patterns can include amenorrhoea. Women should be counselled that there is a potential for delay in return to full fertility following use of the method, regardless of the duration of use. Long-term case-controlled surveillance of Depo-Provera users found no overall increased risk of ovarian, liver, or cervical cancer and a prolonged, protective effect of reducing the risk of endometrial cancer in the population of users. *Refer to the Summary of Product Characteristics* for further information. There is a tendency for women to gain weight while on Depo-Provera therapy. Reports of anaphylactic responses (anaphylactic reactions, anaphylactic shock, anaphylactoid reactions) have been received. Should the patient experience pulmonary embolism, cerebrovascular disease or retinal thrombosis while receiving Depo-Provera, the drug should not be re-administered. Patients with a history of endogenous depression should be carefully monitored. Some patients may complain of premenstrual type depression while on Depo-Provera therapy. As with any intramuscular injection, especially if not administered correctly, there is a risk of abscess formation at the site of injection, which may require medical and/or surgical intervention. Patients with a history of the following conditions should be carefully monitored: endogenous depression (including premenstrual-type depression), migraine or unusually severe headaches, acute visual disturbances of any kind, pathological changes in liver function or hormone levels. Diabetic patients should be carefully monitored while receiving DMPA; increases and decreases in total cholesterol, triglycerides and low-density lipoprotein (LDL) cholesterol have been observed. DMPA have been associated with a 15-20% reduction in serum high density lipoprotein (HDL) cholesterol levels. Potential for an increased risk of coronary disease should be considered prior to use. Doctors should carefully consider the use of DMPA in patients with recent trophoblastic disease before levels of human chorionic gonadotrophin have returned to normal. Pathologists should be informed of the patient's use of Depo-Provera if endometrial or endocervical tissue is submitted for examination. Results of certain laboratory tests may be affected. *Refer to the Summary of Product Characteristics* for further information. **Drug Interactions:** Aminoglutethimide administered concomitantly may significantly depress bioavailability. The possibility of interaction (including oral antibiotics) should be borne in mind in patients receiving concomitant treatment with other drugs. **Pregnancy and Lactation:** Check for pregnancy before initial injection, and also if administration of subsequent injection is delayed beyond 89 days (12 weeks and 5 days). **Side-effects:** The following adverse events were commonly reported (by more than 5% of subjects): menstrual irregularities (bleeding and/or amenorrhoea), weight changes, headache, nervousness, abdominal pain or discomfort, dizziness, asthenia (weakness or fatigue). Further adverse events reported (by 1% to 5% of subjects) include: decreased libido or anorgasmia, backache, leg cramps, depression, nausea, insomnia, leucorrhoea, acne, vaginitis, pelvic pain, breast pain, no hair growth or alopecia, bloating, rash, oedema, hot flushes. *Refer to the Summary of Product Characteristics* for more detailed information on side-effects. **Package Quantities and Basic NHS Cost:** Single Prefilled Syringe pack £6.01. **Legal Category:** POM. **Marketing Authorisation Number and Holder:** PL 00057/0665, Pfizer Limited, Ramsgate Road, Sandwich, CT13 9NJ, UK. **Last Updated:** January 2012. Further information is available on request from: Medical Information at Pfizer Limited, Walton Oaks, Dorking Road, Tadworth, Surrey, KT20 7NS, UK. Tel: +44 (0) 1304 616161. **Ref: DP 8_0**

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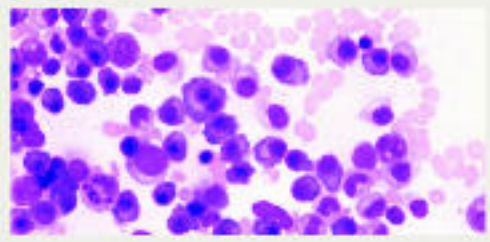

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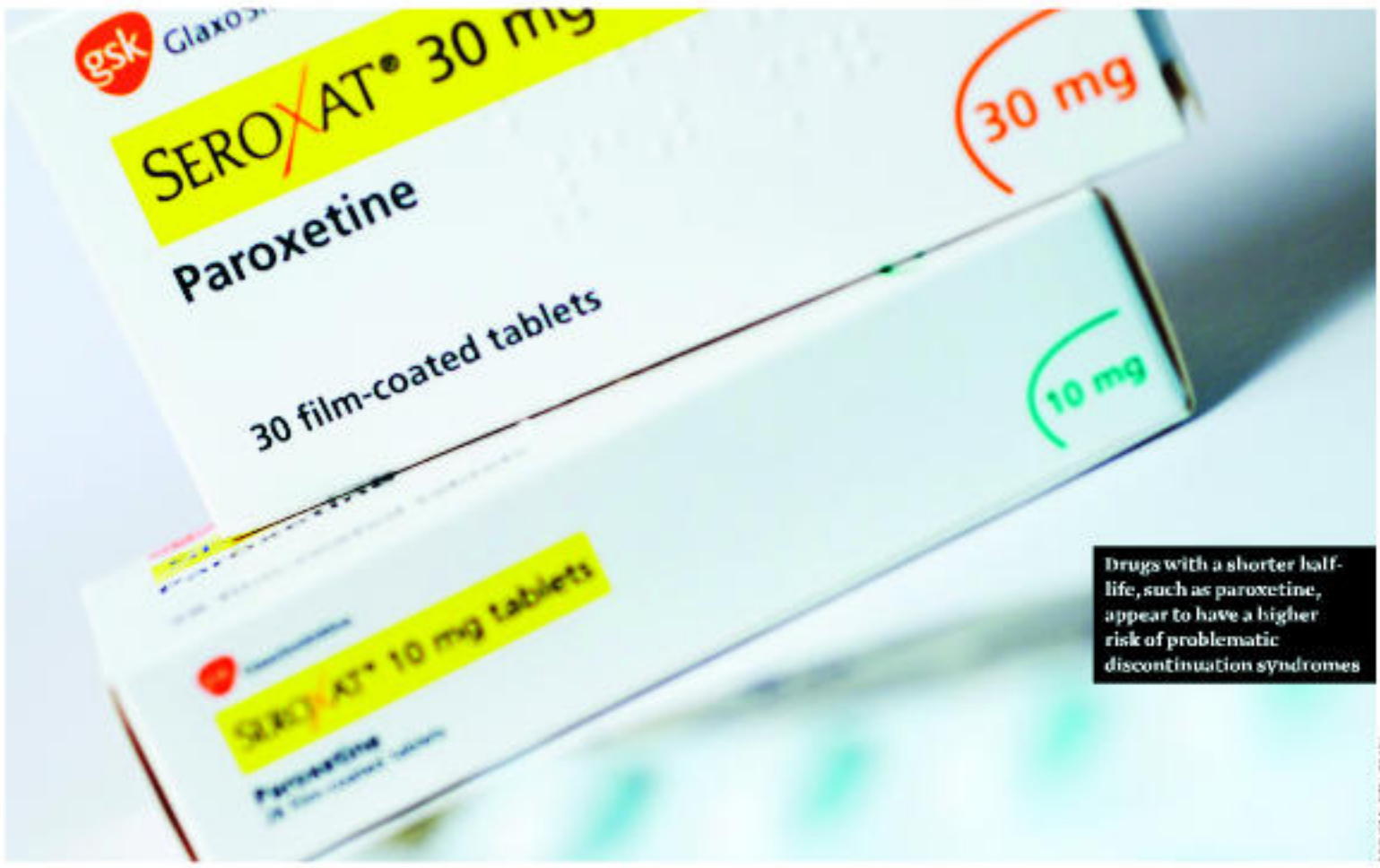
Consultant psychiatrist Professor Anthony Cleare and colleagues answer questions from GP Dr Pam Brown on managing depression, including the role of exercise, changing drugs and pregnancy



Drugs with a shorter half-life, such as paroxetine, appear to have a higher risk of problematic discontinuation syndromes

KEY QUESTIONS

Depression

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1 What is the evidence that exercise improves mild depression or has a role alongside drug treatment, and what type, duration and intensity of exercise is needed?

A randomised controlled trial recently found that adults with depression receive no additional benefit from 'facilitated physical activity' as an adjunctive treatment for depression. Unfortunately the media widely reported this as 'exercise does not work for depression', but this is too simplistic and probably inaccurate.

In this study, 'facilitated physical activity' was face-to-face and telephone sessions encouraging physical activity rather than an actual physical activity programme. And since most patients were also having other interventions for depression, the trial tells us little about the efficacy of exercise compared with no treatment.

For many patients with mild depression, exercise may be a more acceptable form of treatment than medication or psychotherapy.

A Cochrane review carried out earlier this year showed that exercise for depression was superior to no treatment. The social aspect of exercise may also be important.

Further research is required to determine the optimum type, intensity and duration of exercise needed for a clinical effect. In the meantime, for motivated patients, it is probably wise to recommend exercise known to be beneficial for cardiovascular health – aerobic, at least 40 minutes' duration, at least three times per week.

A group or social context, and an activity the patient enjoys, may also help.

2 How soon should we consider changing antidepressant because of lack of effect, and how can we safely transition between drugs?

Traditional teaching tells us there is a two- to three-week delay before antidepressants start working and the full clinical effect is not apparent until six to eight weeks, or even later in the elderly.

But recent meta-analyses have shown improvement actually occurs within one to two weeks. And patients who show little or no effect by four weeks are unlikely to do so by eight.

So if there is no improvement after four weeks, consider dose escalation (if appropriate) or switching. If there is improvement then you can expect further improvement by eight weeks of treatment.

In a recent study, patients were treated with escitalopram and non-responders were switched to duloxetine at either four weeks or eight weeks. Although time to full remission of symptoms was not different, remission rates were higher with the early switch strategy. All depressive episodes should be treated to remission to allow full functional recovery and to reduce the risk of relapse in the longer term.

Stopping any antidepressant may cause discontinuation symptoms, so it is advisable to taper doses. For most antidepressants, it is safe to cross-taper cautiously from one

antidepressant to another – there is no set speed to this and it is best judged by patient tolerability, but typically can be done over four weeks.

Exceptions include monoamine oxidase inhibitors (MAOIs), where there needs to be a drug-free period of one to two weeks when swapping to or from most other antidepressants, and fluoxetine, which needs a five- to six-week washout before starting a MAOI and a four- to seven-day washout before starting a tricyclic antidepressant.

Switching from an SSRI to duloxetine can be done abruptly. You can find further guidance on switching between classes in the *Maudsley Prescribing Guidelines*.[1]

3 High-dose citalopram has been associated with prolongation of the QT-interval in a small number of patients. What is the evidence for improved efficacy of this and other SSRIs at high doses – for example, in obsessive compulsive disorder?

A recent meta-analysis of SSRI efficacy in OCD showed better response rate and symptom scores with higher doses, but high doses were also associated with more dropouts because of side-effects.[2]

Individual dosing studies have found response rates are higher for 60mg of citalopram (65% response) compared with 40mg and 20mg doses.

Patients on escitalopram who don't respond to 20mg may respond to a high-dose regimen – up to 50mg/day – rather than continuing on 20mg/day.

In contrast, in depression, clinical improvement is not significantly greater in high-dose groups and side-effects are more likely.[3] So higher-dose medication in depression should be reserved for treatment-resistant patients.

4 Often patients choose to stop antidepressants suddenly. Is the pattern of discontinuation symptoms the same for tricyclics and SSRIs? What is the optimal regimen to prevent these symptoms?

Many patients skip a few doses of antidepressants and others stop their medication abruptly. In this context, all antidepressants can cause discontinuation syndromes. Symptom severity depends largely on the half-life of the drug rather than the class.

Drugs with a shorter half-life, such as paroxetine and venlafaxine, appear to have a higher risk of problematic discontinuation syndromes than longer half-life drugs, such as fluoxetine. Common symptoms are shown in the table (right).

Many symptoms are common to all drugs, but some are class specific, such as shock-like sensations and irritability for SSRIs.

Tell patients about the likelihood of discontinuation symptoms at the time of prescription, as many are distressed by the abrupt onset of symptoms and fear it to be a relapse. Patients at particular risk of discontinuation symptoms include those who are:

- taking short-acting drugs
- irregularly compliant
- taking medication for eight weeks or longer
- also using other centrally-acting medication such as antihypertensives or antihistamines
- young.

Symptoms typically start within five days of stopping medication or after missed doses, and are usually mild and self-limiting, although can be prolonged. To avoid or minimise symptoms, discontinue over at least a four-week period – the shorter the half-life the slower the taper. Take particular care at the end of the taper period, when the symptoms are most likely to occur. If patients experience more prolonged reactions and have difficulty discontinuing shorter half-life antidepressants, try switching to a longer half-life medication.

Occasionally patients choose to stop more abruptly and have more severe symptoms for a shorter period rather than experiencing several months of symptoms during a slow taper.

5 We have been advised to switch all patients on dosulepin to antidepressants that are safer in overdose. What is the relative safety of SSRIs and lofepramine, and which is the safest in overdose?

SSRIs have the lowest risk of toxicity in overdose of all antidepressants and there is little to choose in terms of the fatal toxicity index (deaths per million prescriptions) between individual SSRIs and lofepramine.

There is evidence that QTc prolongation is more common with citalopram, but little to suggest that this is more dangerous acutely, since QTc prolongation can occur with all SSRIs in overdose.

Of the newer drugs, mirtazapine has a similar fatal toxicity index, whereas venlafaxine is intermediate between SSRIs and older tricyclics.[4]

6 Taking both NSAIDs and SSRIs can increase the risk of upper gastrointestinal bleeding. How great is this increased risk when taking both drugs and how much can it be modified by use of PPIs? Does it vary with age?

SSRIs are responsible for an additional three episodes of bleeding in every 1,000 patient years of treatment over normal background incidence. Co-prescription of low-dose aspirin at least doubles the risk of GI bleed compared with an SSRI alone, and co-prescription with an NSAID quadruples the risk.

The risk of bleeding is also increased in those taking steroids and anticoagulant medications such as warfarin, and in those with peptic ulcer disease. Advanced age is an additional important risk factor for bleeding in the context of SSRI use.

PPIs decrease the risk of GI bleeds with SSRIs alone or in combination with NSAIDs, although not quite to control levels. NICE recommends that SSRIs should not be offered as first line to those taking NSAIDs or anticoagulants, and if SSRIs are required they should be given with a PPI.

7 Which is the safest antidepressant to use in pregnancy and breastfeeding? What's the optimal period after stopping therapy before conception? If the woman is already six to eight weeks pregnant, is there still benefit in changing or stopping drugs at this stage?

Decisions around pharmacotherapy during pregnancy and the postnatal period are complex and based on individual risk-benefit assessments, so consider referral to a perinatal psychiatry service for specialist advice.

It is important to advise patients that there is uncertainty about the risks of antidepressants. The background risk of foetal malformation in any pregnant woman is 2-4%.

Paroxetine is associated with cardiac malformations beyond the background rate and is contraindicated in pregnancy. But most of the associations between antidepressants and congenital abnormalities are not robust or have not been replicated.

Also remember that untreated depression itself may be associated with poor outcomes such as pre-term delivery and low birthweight.

Tricyclics have traditionally been the drug of choice in the puerperium. NICE recommends imipramine and nortriptyline, as they are secreted at low levels in breast milk. But there are disadvantages – tricyclics are more likely to be fatal in overdose and are generally less well tolerated than SSRIs.

A recent paper argues that SSRIs, with the exception of paroxetine, may be as safe as tricyclics.[5] Sertraline is secreted at low levels in the breast milk and so is the SSRI of choice if the woman wishes to breastfeed.

There is no established optimal drug-free period before conception, but drugs should not be withdrawn suddenly. Some antidepressants such as paroxetine and venlafaxine may need to be withdrawn over a period of a few months to avoid discontinuation effects.

All antidepressants are associated with neonatal withdrawal effects. These are usually mild and self-limiting, except in paroxetine and venlafaxine – so these should be swapped in pregnancy.

Antidepressants may also be associated with pre-term delivery and low birth weight. The use of SSRIs after 20 weeks' gestation may be associated with persistent pulmonary hypertension.

So a pregnant woman in remission may wish to stop antidepressants after the first trimester when the main risk period for congenital abnormality has passed, but consider her past psychiatric history, risk of relapse and the potential consequences of relapse for the pregnancy and neonate as well as the woman herself.

8 Depression in adolescents seems to be becoming more common. Does this age group respond to cognitive behavioural therapy? If antidepressants are needed, which is most appropriate? Should we always refer?

Diagnoses of depression appear to be increasing in most age groups, though arguments remain about why. For adolescent depression, NICE recommends a stepped-care approach. Uncomplicated mild depression without risk factors – comorbidity, family psychiatric history, suicidal ideation or neglect – can remain within primary care, but more severe depression or the presence of risk factors requires a referral to child and adolescent mental health services (CAMHS).

Mild depression can be managed initially by watchful waiting, followed by supportive therapy, group CBT or guided self-help. Mild depression persisting more than two to three months, or non-responsive to the initial interventions, also warrants a CAMHS referral. CBT and other psychological interventions such as interpersonal psychotherapy or brief family therapy are effective in adolescent depression. NICE recommends that antidepressants should only be used in moderate to severe depression, and only in conjunction with psychological therapy, with careful monitoring for adverse events.

A GP would not be expected to instigate antidepressant treatment in adolescents, because these patients need assessment and diagnosis by a child psychiatrist first.

Self-injurious and suicidal behaviour, often in conjunction with agitation or akathisia, affects around 2-3% of adolescents and young adults – although there is no convincing evidence that the suicide rate itself is increased by antidepressant use.

Fluoxetine remains the only antidepressant licensed for use in adolescent depression. As always, the risks and benefits need to be considered on an individual basis.

Common discontinuation symptoms[1]

Antidepressant class (drugs commonly associated with discontinuation)	Common symptoms
MAOI (all, especially tranylcypromine)	Agitation, ataxia, movement disorders, insomnia, sleepiness, vivid dreams, slow or rapid speech, cognitive impairment
TCA (amitriptyline, imipramine)	Flu-like symptoms, insomnia, excessive dreaming
SSRI (especially paroxetine) SNRI (especially venlafaxine) Buproprion	Flu-like symptoms Shock-like sensations, dizziness, vivid dreams, irritability, crying spells
Mirtazapine	Anxiety, insomnia, nausea

Adapted from *Maudsley Prescribing Guidelines*[1]

Professor Anthony Cleare is a consultant psychiatrist, **Dr Lena Rane** and **Dr Pratima Singh** are specialty trainees in psychiatry and **Dr Gregory Shields** is a core trainee in psychiatry at the National Affective and Emotional Disorders Service at the South London and Maudsley NHS Foundation Trust. Professor Cleare is also chair of psychopharmacology and affective disorders at the Institute of Psychiatry, King's College London

Dr Pam Brown is a GP in Swansea

The National Affective and Emotional Disorders Service at the Maudsley and the Bethlem Royal Hospitals, London, provides specialist outpatient and inpatient treatment for those with complex or treatment-resistant affective disorders and for depressed healthcare professionals. Referrals can be accepted from GPs and secondary mental healthcare nationally.

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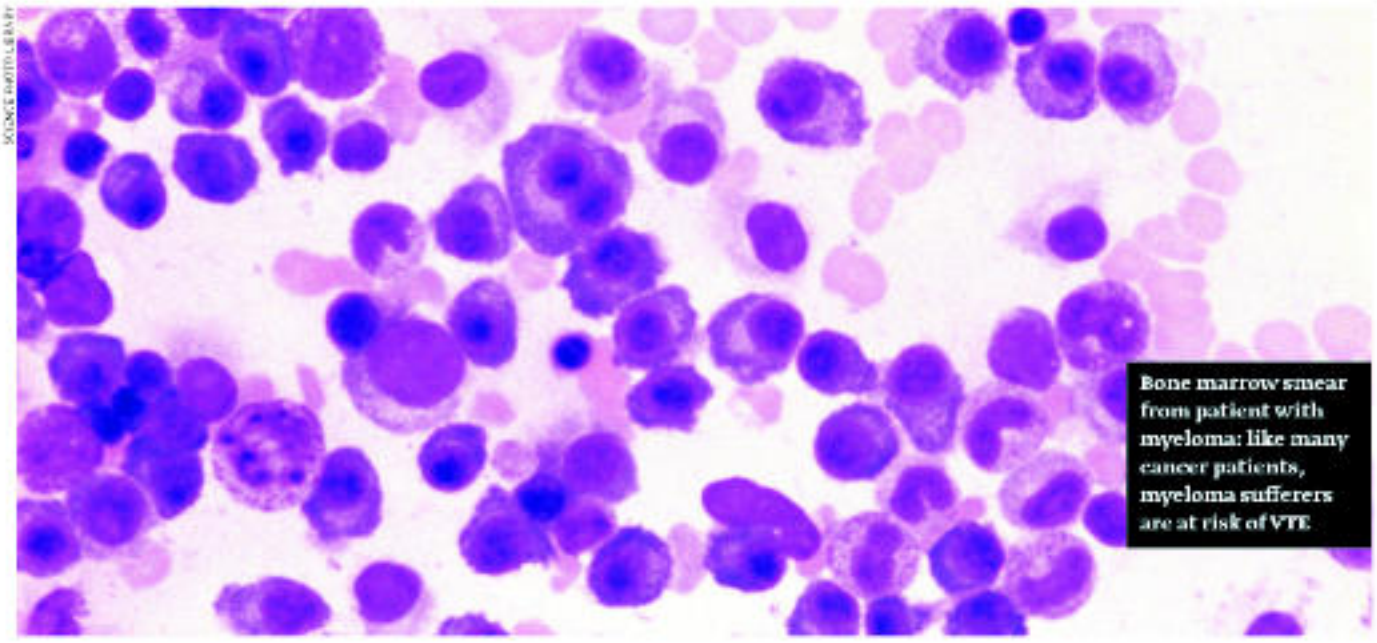

SCIENCE PHOTO LIBRARY

Bone marrow smear from patient with myeloma: like many cancer patients, myeloma sufferers are at risk of VTE

TEN TOP TIPS

Myeloma

Haematologist Professor Graham Jackson gives his top advice on diagnosing myeloma

1 **Consider myeloma in bone pain, infection or anaemia.**
Consider myeloma in patients with persistent bone pain – such as non-improving back or rib pain, or osteoporosis – recurrent or persistent infection, renal impairment or unexplained anaemia. The majority of new cases tend to occur in those over 60 years of age, although 10-15% of cases develop in those aged under 45. Myeloma is a common haematological cancer. Early diagnosis is important as myeloma can have debilitating complications that affect the bones, kidneys and immune system, causing a dramatic impact on quality of life.

2 **Test both urine and serum.**
Myeloma is characterised by the secretion of a monoclonal immunoglobin (paraprotein), which is detectable by serum protein electrophoresis in most cases. But 20% of patients produce Bence Jones protein or free light chains in the absence of paraprotein. These are excreted and readily detected in urine. Send a urine sample to the laboratory, as dipstick testing for protein is unreliable for Bence Jones protein.

3 **Be aware of monoclonal gammopathy of undetermined significance.**
Monoclonal gammopathy of undetermined significance (MGUS) may be identified in 1-3% of the population over 65 and does not need urgent referral. However, a small proportion of patients may develop myeloma, so patients with MGUS should be monitored every three to six months by their haematologist. Patients with MGUS have paraprotein in the serum, but no other clinical features of myeloma.

4 **Avoid NSAIDs.**
Active pain management is important, as bone complications can severely affect quality of life. Use non-opioids or opioids, but avoid NSAIDs as they can exacerbate existing renal damage caused by cast nephropathy.

5 **Promote patient mobility.**
Keeping mobile and maintaining a level of physical activity minimises muscle weakness, helps protect bones and improves overall health. Physiotherapy can be helpful. Contact Macmillan nurses and local services for additional support.

6 **Encourage fluid intake to help prevent kidney damage.**
Renal impairment is found in up to 20% of patients at diagnosis. Encourage patients to drink at least 3l of fluid a day and avoid nephrotoxic drugs. Hypercalcaemia requires urgent admission.

7 **Treat infection aggressively.**
Myeloma patients are immunosuppressed. Minor infections should be treated with oral antibiotics and patients should receive flu and pneumonia vaccination.

8 **Be vigilant for psychological problems.**
Depression and anxiety can be common in both patients and their families. This should be actively managed and monitored.

9 **Remember thromboembolism.**
Like many cancer patients, myeloma patients are at risk of venous thromboembolism (VTE) and treatments increase this risk. If patients develop a swollen leg, pleuritic chest pain, haemoptysis or sudden breathlessness, VTE should be suspected.

10 **Be aware of the side-effects of bisphosphonates.**
Myeloma patients benefit from long-term bisphosphonate therapy. A rare side-effect is osteonecrosis of the jaw, so patients need to maintain good dental hygiene at all times.

Professor Graham Jackson is a consultant haematologist at Newcastle Hospitals trust and professor of clinical haematology at Newcastle University

Myeloma UK offers a range of educational resources for healthcare professionals. To assist GPs in the diagnosis of myeloma, Myeloma UK has developed the Myeloma Diagnosis Pathway, which outlines to GPs the signs and symptoms of myeloma and the investigations to carry out if myeloma is suspected. Download it at myeloma.org.uk/diagnosis-pathway

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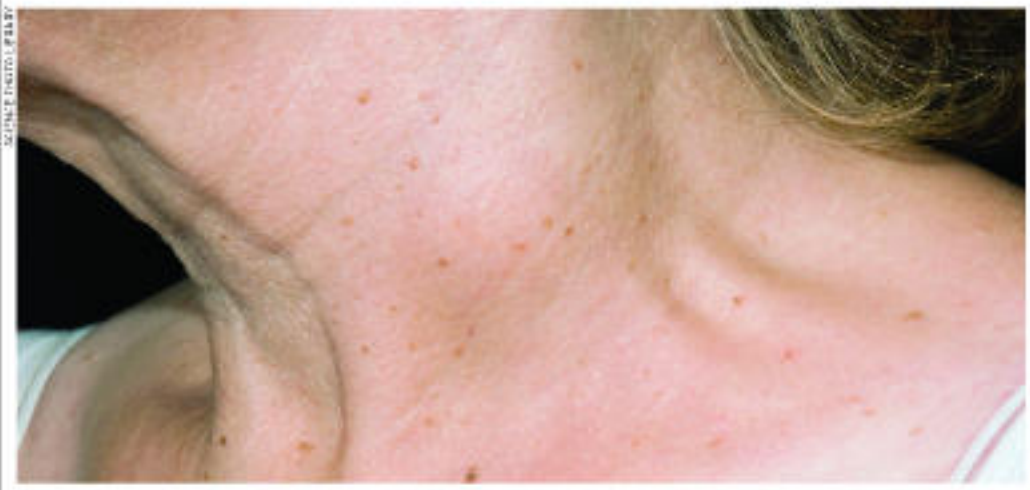

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ENT CLINIC

Laryngeal cancer

ENT GPSI Dr Raj Singh on the second most common head and neck cancer

CASE

This 69-year-old woman presented with a sore throat, hoarseness and a painless mass on the left side of her neck. The sore throat had been present for about three months and she had already been prescribed two courses of antibiotics. She had only noticed the swelling two months ago, but it had grown since.

She also mentions that she has had increasing difficulty and some pain swallowing, and has been eating less and less solid food.

She is being treated for hypertension and COPD, and the practice nurse who last saw her in the COPD clinic says she is noticeably thinner.

The patient smoked around 20 cigarettes a day until she was diagnosed with COPD nine years ago, and now smokes four or five a day.

Examination finds a 2cm firm, mobile and non-tender mass with no overlying erythema or induration. The oral cavity and oropharynx are normal. She is referred urgently and laryngoscopy reveals an ulcerated, necrotic mass on the laryngeal surface of the epiglottis that extends to the false vocal folds. The true vocal folds appear normal.

Histology shows a squamous cell carcinoma and a partial laryngectomy is carried out.

The problem

- Cancer of the larynx is the second most common head and neck cancer after cancer of the oral cavity.[1]
- It is much more common in males, with a male:female ratio of almost 5:1.
- It is rarely seen in those people younger than 40 years of age, but incidence rises steeply thereafter - with 73% of cases occurring in people over the age of 60.[1]
- Most laryngeal cancers originate in the glottis. Supraglottic cancers are less common, and subglottic tumours the most rare.
- Smoking is the most important risk factor. Death from laryngeal cancer is 20 times more likely for the heaviest smokers than for non-smokers.
- Heavy alcohol consumption - particularly spirits - is also significant. The two risk factors of smoking and drinking combined appear to act synergistically.
- Poor dentition is also a risk factor.

Features

- The symptoms of laryngeal cancer depend on the size and location of the tumour.
- Chronic hoarseness is the most common early symptom, but any of the following can be seen alone or in combination: a neck lump, sore throat, dysphagia, pain, ear ache or persistent cough.[1]
- Patients may also complain of breathlessness, weight loss or haemoptysis.

Diagnosis

- A full head and neck examination should be carried out, including inspection and palpation of the oral cavity and oropharynx - to rule out second primary tumours or other lesions - and an assessment of dentition.
- Palpation of the neck - looking for lymphadenopathy - is essential and an evaluation of the cranial nerves should also be carried out.
- Urgently refer any patient with hoarseness persisting for more than three weeks for a chest X-ray to exclude lung cancer - particularly smokers older than 50 years of age and heavy drinkers.[4]
- No other investigation is recommended in primary care.
- A normal chest X-ray should prompt the patient to be referred urgently to a head and neck cancer team.
- Flexible laryngoscopy allows the whole larynx to be examined and allows accurate staging of any tumour.
- Other investigations include fine-needle aspiration and CT, MRI or PET scans.

Management

- Total and partial laryngectomy are the main surgical procedures.
- Where possible, the goal of treatment is to remove the tumour and prevent recurrence while maintaining laryngeal function.
- Chemoradiation with preservation of the larynx has shown survival rates similar to total laryngectomy plus radiation therapy.[5]
- Outcome depends on the initial staging and is relatively good in early disease, with over 90% achieving five-year survival rates.[1]

Dr Raj Singh is a ENT GPSI in Manchester

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Top 5 modules

GP Dr Melanie Wynne-Jones, a member of the Pulse Learning user panel - chooses her top 5 recent modules.

Dr Melanie Wynne-Jones is a GP trainer in Stockport, Cheshire

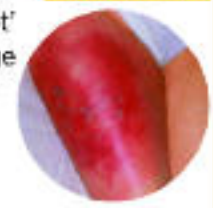
Hot topics in learning disability 1.5 CPD hours

I found this a really useful module. It includes a helpful précis of the RCGP recommendations on providing health checks for people with learning disability and a section on creating a template for the checks - based on the learning disability DES. Although we already provide much of this care in my practice, I still picked up lots of tips about Fragile X syndrome and the need for an echo in adults with Down's syndrome.

Key questions on polycystic ovary syndrome 1.5 CPD hours

Several of my female patients with facial hair have asked about PCOS recently and I found this module offered a really practical, structured approach to diagnosing the condition. I shall keep it to hand in my consulting room. The module also clarified the range of treatments for me, and the need to treat amenorrhoiec patients because of the risk of endometrial hyperplasia and cancer- something I wasn't previously aware of.

Hot topics in venous thromboembolism 1.5 CPD hours



This certainly is a 'hot' topic - given the large numbers of patients we see with painful swollen calves, and the pressure on us to avoid unnecessary admissions. This module uses the recent NICE guidance to provide clear, practical, decision-making steps for suspected DVT and PE. It uses primary care case histories to explain the use of Wells scores, D-dimer testing, scans and the use of heparin and other anticoagulants.

Managing chronic fatigue in primary care: a video module. 1 CPD hour

I liked the format of this module - a video with slides - as well as the content. For us in primary care, medically unexplained symptoms and chronic fatigue are both very common and challenging. This module provided effective strategies and the evidence behind them. I particularly liked advice on proactive counselling after severe infections such as glandular fever, as it can reduce chronic fatigue morbidity six months later.

Key questions on COPD 1.5 CPD hours

This module does a great job of using common COPD scenarios from everyday general practice to cover specific parameters and the must-do points. All this is backed up by reference to the NICE guidelines, and includes oxygen prescribing, pulmonary rehabilitation and cor pulmonale. The discussion about recent concerns over anti-muscarinic drugs and the list of do's and don'ts for end-stage palliative care was particularly helpful.

The information: trochanteric bursitis 0.5 CPD hours

Treating trochanteric bursitis can be rewarding especially if it can be done without the need for referral. I've tended to rely on localised tenderness in diagnosing the condition, so the list of differential diagnoses was useful, and I was pleased to learn about more specific discriminating tests. I didn't realise that it's possible to repeat steroid injections up to three times, so this module will change my clinical practice.

New this month on Pulse Learning

The information

These new modules are concise, case-based lowdowns on the evidence behind common presentations using PUNS and DENs

The information: the painful shoulder 0.5 CPD hours

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> **A simple, practical guide for the GP on managing everyday shoulder problems**
>
> Dr Kate Barnes

The information: shingles 0.5 CPD hours

Trigger factors, treatment options and modalities, the risk of transmission and how to spot ocular herpes zoster early.

> **Useful clinical points made in a concise presentation**
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THE INFORMATION

Hyperhidrosis

Launching the section of our series focusing on dermatology, Mr Ian Loftus, consultant vascular surgeon, looks at hyperhidrosis using PUNs and DENs

THE PATIENT'S UNMET NEEDS (PUNs)

A 25-year-old man presents complaining of excessive sweating. He's suffered the symptom for years, but is finding it increasingly troublesome – he has problems gripping a pen because of it and is embarrassed about shaking hands with colleagues at work. He has no relevant past medical history, but says his sweating is making him increasingly anxious. Having checked out his symptom on the internet, he has discovered that some people are helped by botox injections or surgery and asks whether these might be options for him.

THE DOCTOR'S EDUCATIONAL NEEDS (DENs)

How common is hyperhidrosis and what are the various types?

Hyperhidrosis is sweating in excess of that required for normal thermoregulation. A US study demonstrated that the prevalence is 2.9% of the population aged over 12 years[1] and a third of these patients say the sweating is intolerable and interferes with normal life.

Primary hyperhidrosis is poorly understood, but is likely to be related to over-activity of the sympathetic nerves. It is often focal, affecting the hands, axillae and feet. Secondary hyperhidrosis can be focal or generalised and is related to a variety of conditions including metabolic, endocrine and neurological disorders. But secondary hyperhidrosis is very unusual – there is rarely an underlying cause.

Are there any investigations the GP should consider? Does this depend on the type of hyperhidrosis?

As in this case, most patients with hyperhidrosis are young and otherwise healthy. Rarely, secondary hyperhidrosis is associated with systemic disorders such as hyperthyroidism, but extensive investigation is unnecessary. A general history and examination will suffice for most patients.

What general advice and specific treatment can the GP offer? How much does anxiety contribute to the problem, and are formal anti-anxiety treatments such as cognitive behavioural therapy effective?

You can offer patients some general advice on wearing loose clothing and avoiding any triggers that they can identify. Non-surgical treatments include the use of topical aluminium chloride – which can be bought over the counter – and oral anticholinergic drugs such as oxybutynin, an unlicensed medication. Anticholinergics, though, will only work in around two-thirds of cases and have side-effects – especially dry mouth – that some patients find intolerable.

Anxiety and stress can compound hyperhidrosis, which in turn exacerbates the anxiety, particularly in social situations.

Iontophoresis offers temporary relief rather than a permanent solution

Key points

Cause

- Primary hyperhidrosis is poorly understood, but is likely to be related to over-activity of the sympathetic nerves.
- Anxiety is a common trigger.

Epidemiology

- Studies have shown a prevalence of 2.9%.
- Secondary hyperhidrosis is relatively unusual, but can be associated with a variety of systemic conditions.

Management

- Conservative measures are appropriate in most individuals, which include:
  - topical aluminium chloride
  - avoidance of triggers
  - wearing loose clothing.
- Iontophoresis and intradermal botulinum toxin injections offer temporary solutions for patients with severe sweating of the extremities and axillae respectively.
- Surgery can offer a permanent solution for severe sweating of the hands and axillae. The major side-effect is compensatory sweating elsewhere on the body, which is severe in 1-2% of cases. Careful patient selection and counselling are essential prior to surgery.

Almost half of affected patients report emotional triggers for their symptoms and the association is probably even more common than reported.[2]

You can consider drug treatments for anxiety, but this should be done on an individual basis. Therapy to alleviate anxiety and stress can also be useful for a small proportion of patients – only refer if it is clear that anxiety is a trigger for the hyperhidrosis, or is making it worse.

What treatment can a dermatologist offer, and when is it appropriate for the GP to make a referral?

Some dermatologists offer iontophoresis for excessive sweating of the hands and feet. This employs an electrical current in water and provides temporary relief rather than a permanent solution – it requires multiple treatments and the results are variable. But iontophoresis is one of the few treatments available for severe sweating of the feet, so patients with intolerable sweating in this area of the body should be referred.

Dermatologists may also recommend intradermal botulinum toxin injections at the site of sweating. This treatment is usually only indicated for axillary hyperhidrosis because it requires multiple injections, which are often too painful for the hands and feet. Botulinum toxin injections are usually successful, but improvement only lasts a few months and the treatment needs to be repeated at regular intervals. It is safe, well tolerated and associated with high levels of patient satisfaction.[3]

GPs should refer a patient if the condition is having a severe effect on their life – this varies considerably between individual patients depending on what they do for a job and their hobbies. Duration of symptoms is not generally relevant to a referral, since many patients will have suffered in silence for years.

When should the GP consider asking for a surgical opinion? What treatments might the surgeon offer and what are the potential complications of these?

The decision about when to refer for a surgical opinion depends very much on the site and severity of hyperhidrosis.

For patients with hyperhidrosis of the hands and axillae, surgery is a permanent solution, while botulinum toxin injection is temporary. GPs will need to have a discussion about this with the patient – some patients would never consider surgery, while others just want a solution and are happy to have an operation.

Some surgeons – usually vascular surgeons with a special interest in hyperhidrosis – offer endoscopic thoracic sympathectomy as a permanent solution for excessive sweating of the hands, axilla and occasionally the face.[4] This involves the use of endoscopic techniques to access the thoracic cavity, followed by identification and complete division of the sympathetic nerves responsible for sweating of the upper limb. The procedure is somewhat controversial, but with an experienced surgeon it can offer a dramatic and permanent resolution of symptoms.

Evidence demonstrates a significant improvement in well over 90% of cases of hand sweating and in around 90% of cases of sweating in the axillae, but lower success rates for facial sweating. There is a small but defined risk of recurrence over a period of years. But the main side-effect is compensatory sweating elsewhere on the body – this is quite common, affecting over 50% of patients, but it is not usually severe.

Other rare complications include pneumothorax and Horner's syndrome. Patients should be counselled carefully before embarking on any surgery.

Mr Ian Loftus is a consultant vascular surgeon with a special interest in the treatment of hyperhidrosis at St George's Healthcare NHS Trust, London, and reader in vascular science at St George's University of London

This article was produced in collaboration with the Royal College of Surgeons – a professional body that sets the highest possible standards for surgical practice and training, leading to the delivery of safe and high-quality patient care. The Royal College of Surgeons has expertise, authority and independence, allowing it to act in the best interests of patients and in support of those providing their care. Go to rcseng.ac.uk for more information.

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POST-OP PROBLEMS

Cardiovascular surgery

Mr Simon Kendall, cardiothoracic surgeon, and SpRs **Miss Clare Burdett** and **Dr Ben Davison** advise on how to manage complications after cardiovascular surgery

Coronary heart disease has a UK prevalence of 2.7 million, and over 400,000 patients require hospital admission each year.[1]

More than 230,000 cardiac catheterisations are performed annually. As a result, 90,000 patients undergo percutaneous coronary intervention (PCI)[2] and over 22,000 have coronary artery bypass graft surgery (CABG), with a further 3,500 having a combined CABG and valve procedure.[3]

PCI is usually a day-case procedure, while CABG requires an average of five to seven days in hospital.

The short hospital stay allows early mobilisation and return to normality for the patient, but means that complications are often encountered first by the GP.

Most cardiology or cardiothoracic departments will have a direct point of contact for advice or emergency referrals.

Percutaneous coronary intervention

The risk of a major complication after PCI – death, MI or stroke – is around 1%.

Most complications are related to the procedure itself and occur soon after, so the incidence of post-discharge problems is low.

Immediate and early

Vascular complications

Vascular complications are the most common and usually occur within 12 hours of the procedure.

Incidence depends on the vascular access route – around 1% if the femoral artery is used and less than 0.5% with a radial approach. In the UK, more than 50% of PCIs are transradial.[4]

- *Bruising* is common and does not require any intervention.
- *Haematomas* occasionally develop post-discharge. A femoral haematoma can present as a tender mass around the arterial puncture site. Apply direct pressure over the femoral artery above the puncture site and arrange emergency admission. Motor or sensory deficits from femoral or lateral cutaneous nerve compression because of a groin haematoma are rare and usually resolve within a few weeks – but seek expert advice if this occurs after discharge. Forearm haematoma can occur after radial artery cannulation, but this is usually immediately apparent. Again, initial management is with compression, commonly with a blood pressure cuff inflated to just below diastolic pressure.
- *Retroperitoneal haematoma* may occur if the femoral artery is punctured above the inguinal ligament. This is a rare but serious complication requiring immediate admission. It presents with cardiovascular collapse and ipsilateral flank pain.
- *Pseudo aneurysm* is rare and is usually distinguished from haematoma by the presence of a pulsatile mass and arterial bruit over the puncture site. Most pseudo aneurysms occur within three days of surgery. Arrange urgent admission as there is a risk of expansion and rupture.

Contrast reactions

- *Anaphylactoid reactions* to contrast agents are rare and usually occur during the procedure, but the reaction may be delayed. This usually presents as an urticarial rash and is commonly attributed to an adverse reaction to clopidogrel. It is important not to stop dual antiplatelet therapy – see stent thrombosis below. Treat with antihistamines. Inform the cardiologist, as pre-medication with steroids and an antihistamine will be required for subsequent interventions.
- *Contrast-induced nephropathy* is rare. The main risk factors are diabetes and CKD. Pre-hydration and limiting the volume of contrast used minimises the risk. Transient elevations in serum creatinine occur in about 5% of patients, peaking at one to two days and returning to normal within seven days. At-risk patients should have been identified by the cardiology team pre-discharge and plans for monitoring given to the GP. If renal failure occurs, arrange urgent admission.

Radiation reactions

- *Radiation-induced skin injury* is very rare. Patients usually present with erythema, similar to sunburn, which develops within hours of the procedure. Flamazine cream can be applied and it is important to inform the cardiologist. More serious skin injury will need specialist referral.

Stent complications

- *Acute stent thrombosis* is uncommon, but can occur early or late. It usually occurs if dual antiplatelet therapy is prematurely interrupted and is associated with significant morbidity and mortality. Symptoms are those of acute MI and ST elevation is often present. Emergency admission is required.

Late

Stent complications

- *In-stent restenosis* usually occurs three to six months after PCI when bare metal stents are used, and after six to nine months with drug-eluting stents. Early recurrence of angina is suggestive of in-stent restenosis. Management includes additional anti-anginals and referral to cardiology or a rapid-access chest pain clinic.

Coronary artery bypass graft surgery

The overall risk of death is 1.7% after CABG,[3] but can be more accurately calculated for the individual using the EuroSCORE risk evaluation tool. Go to pulsetoday.co.uk/tools-and-resources to access this.

Immediate and early

Cardiac complications

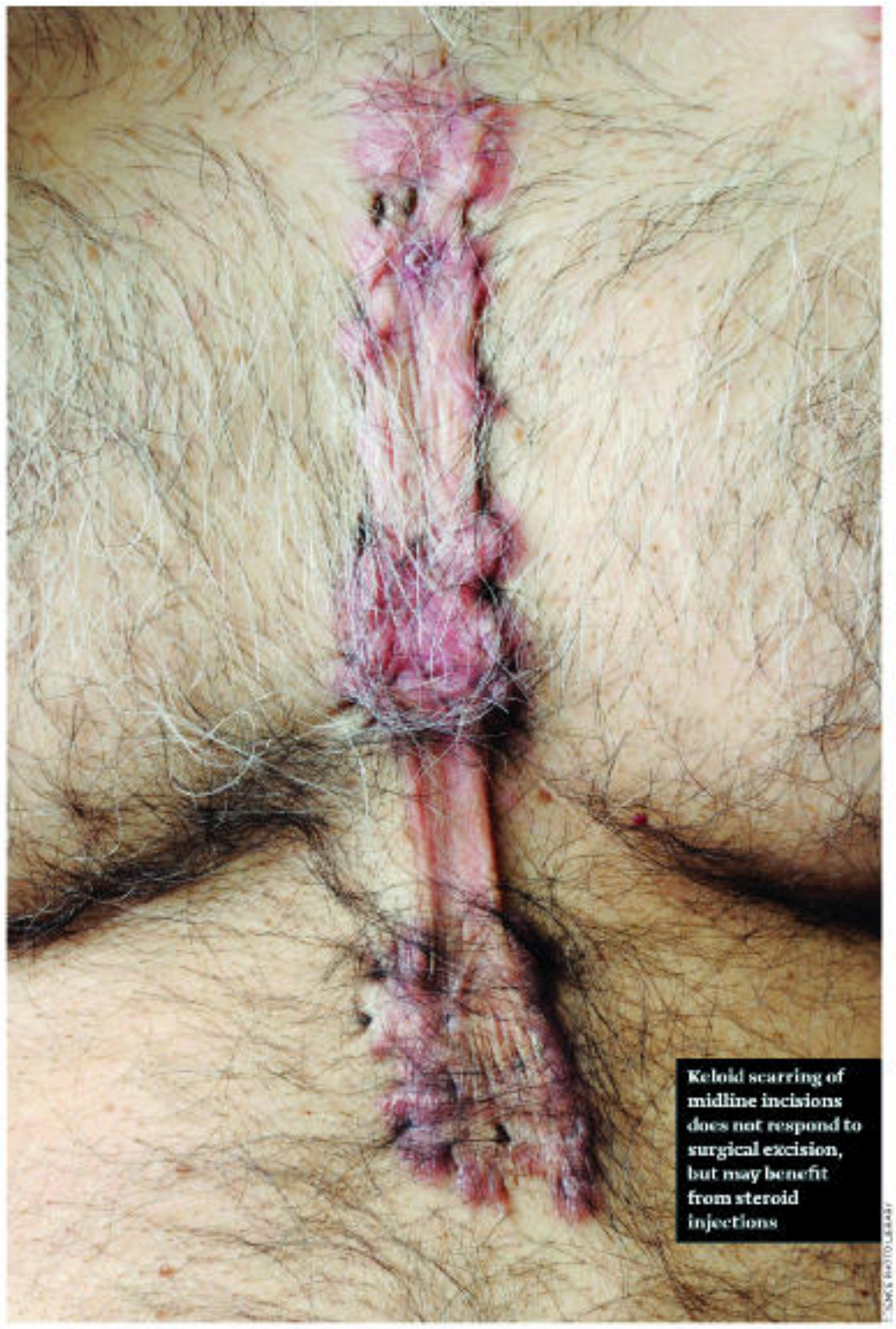
- *Bleeding (with or without tamponade)* usually occurs before the patient has been woken up. It requires blood products and a possible return to theatre. Patients may be sent home on ferrous sulphate and GPs may be required to recheck the haemoglobin.
- *Arrhythmias* are common and most settle quickly. New-onset atrial fibrillation occurs in around one in five patients and can be treated with normalisation of electrolytes, DC cardioversion and anti-arrhythmics. Most patients are in sinus rhythm at discharge. Those discharged in atrial fibrillation will usually stay on medication until clinic review. If atrial fibrillation is first diagnosed in the community, start a ß-blocker or amiodarone (plus warfarin) and wait for clinic review. If the patient remains symptomatic, discuss with cardiology as early DC cardioversion may be warranted.

Respiratory complications

- *Chest infection* is common and the risk is exacerbated by sternal pain, which can result in poor respiratory effort and cough. Early mobilisation reduces the risk. If the patient presents in primary care, use antibiotics and pain relief.
- *Pulmonary embolism* occurs in less than 0.5% of cases,[4] and you should seek expert advice. Recent surgery will contraindicate thrombolysis.
- *Slow respiratory wean* presents rarely. Some patients – particularly those with pre-existing respiratory disease – require a prolonged stay in the intensive treatment unit for respiratory support and often tracheostomy. The patient will be decannulated by discharge, but may present with problems like tracheal stenosis.

Cerebral complications

- *Confusion* has many causes, but is usually resolved by discharge. Patients with underlying dementia may have a transient or permanent worsening of symptoms following surgery and the use of cardiopulmonary bypass.
- *Stroke* rate is 1-2% overall,[4] but this is



Keloid scarring of midline incisions does not respond to surgical excision, but may benefit from steroid injections

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Classification

In cardiovascular surgery, complications can be considered to be immediate (prior to discharge from hospital), early (within 72 hours) or late (after 72 hours)

complications

elevated in high-risk groups such as those with peripheral vascular disease. Patients are usually diagnosed while an inpatient, but may require GP help with residual disability.

Renal complications

- *Acute kidney injury* is relatively common, especially in patients with a history of CKD. Some 3.6% of patients require short-term dialysis following surgery.[2] In most patients, renal failure is transient and U&Es will be improving or have returned to normal by discharge. GPs may be asked to monitor U&Es and also restart medications such as ACE inhibitors when appropriate. Worsening renal function in the community should be referred.

Gastrointestinal complications

- *GI bleeds* are relatively common post-op. Many CABG patients will have started or increased their doses of aspirin and possibly clopidogrel after the operation, which increases the risk. Where possible, persevere with or re-commence aspirin as it is beneficial for preventing graft thrombosis.

Late

Cardiothoracic complications

- *Musculoskeletal pain* is often centrally

located, but may radiate around the back and between the scapula due to the forces exerted on the rib cage by the sternal retractor. Treat with simple analgesia.

- *Chest wall hyperparaesthesia* is a result of mammary artery harvest and so is usually limited to the left side. Initial numbness changes to heightened sensitivity and tingling – often aggravated by seat belts and clothes. This usually settles within three months, but rarely it can be persistent.
- *Dressler's syndrome* affects 5% of patients. It can present from one week to several months after surgery. Chest pain is 'sore' rather than dull. Patients may also present with lethargy, raised inflammatory markers and arthralgia. Listen for a pericardial rub. ST segments are elevated (concave) in all leads. Treatment is initially with NSAIDs followed by oral steroids. Pericardial effusions are common post-operatively – treat with diuretics. Some 5% enlarge and can cause compromise or slow tamponade, presenting with low blood pressure and poor urine output. If you're concerned, order an urgent echocardiogram and refer to a cardiologist.
- *Angina* peaks at three months.[4] It may be due to graft failure or thrombosis, suboptimal revascularisation or 'coronary steal', where a large early branch of the internal mammary artery diverts blood away from the left anterior descending artery to the chest wall. Graft failure risk can be reduced by lifestyle changes and compliance with medication. More than 80% of patients are angina free at five years, and 60% at 10 years.[5] If angina returns, refer to cardiology as stenting or a repeat CABG may be possible.
- *Pleural effusion* develops in up to 40% of patients. Respiratory examination will show reduced breath sounds and dullness to percussion. This is more common on the left than the right side. If you're concerned, organise a chest X-ray. Large effusions – greater than a third of the lung field – can be drained for symptomatic relief. Increasing diuretics is usually adequate for treating smaller effusions.
- *Heart failure* may present with bilateral ankle swelling, sacral oedema and raised jugular venous pressure. Uptitrate diuretics initially, but refer if treatment is not effective.

Wound complications

- *Bulge at the top of the wound* is common and is the result of suturing. It generally remodels and flattens over time.
- *Instability and sterile dehiscence* will present with 'clicking' when the patient turns their head – place your hands either side of the sternum and ask the patient to turn their head from side to side and cough to confirm. Monitor initially and advise the patient to avoid strenuous activity or lifting and to support the sternum if coughing. Refer for non-urgent assessment if it fails to improve.
- *Infection* can be deep or superficial. If it is just skin erythema or breakdown, give antibiotics. If there is discharge of pus or instability – which occurs in 1–4% of patients[6] – refer back for assessment.
- *Keloid scarring* of midline incisions does not respond to surgical excision, but may benefit from steroid injections.
- *Protrusion of sternal wires* under the skin may cause irritation or pain. Re-refer if problematic as they can be removed.

Conduit site – saphenous vein or radial artery complications

- *Haematomas* are generally self-limiting and patients can be reassured.
- *Infection* can be treated with antibiotics and dressings. Re-refer if it becomes unmanageable.
- *Unilateral limb swelling* resolves over time. Deep vein thrombosis is rare, but if you are concerned – especially if there is calf tenderness – it should be investigated.

Neural complications

- *Nerve injury* to the brachial plexus can be caused indirectly by sternal retraction. It presents with muscle weakness and paraesthesia in C8-T1 territory. Occasionally, ulnar nerve injury is caused by pressure at the elbow from arm positioning during surgery. Persistent symptoms may require neurology referral and are usually treated with physiotherapy.
- *Altered sensation* may occur because of damage to small nerve branches during conduit harvest. It sometimes resolves, but if not most patients adapt.

Mr Simon Kendall is a cardiothoracic surgeon, Miss Clare Burdett is a cardiothoracic SpR and Dr Ben Davison is a cardiology SpR at South Tees Hospitals NHS Foundation Trust

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Top tips to optimise elderly care

Dr David Lyon talks through ways to improve the quality of care for elderly patients and reduce costs, such as avoiding admissions through better pre-hospital support

OLDER PEOPLE ARE A GROUP that are likely to require a lot of care in the broadest sense. They often have multiple long-term conditions as well as social care needs.[1,2] They account for a large proportion of acute admissions and referrals, and have more complex care needs than most younger patients.[3]

Care for older people is often disjointed and uncoordinated, but GPs see older people a great deal and have access to a lot of information about them and so have a unique opportunity to improve their care.[4]

GPs are 'gatekeeping' less and less, and are taking on more of a 'navigator' role in the NHS as patients are offered more and more complex options.

Elderly patients with multiple health and social needs are a particular challenge. Practices are ideally situated to ensure these patients receive timely, more appropriate care. The quality and productivity (QP) indicators within the QOF have been introduced to drive improvements in outpatient referrals and reduce acute admissions to hospital. The elderly will benefit from both, but especially in acute admissions.

A practice that manages its older population proactively will be better able to deliver on the QP indicators and these are suggestions on how that can be done.

1 Ensure continuity of care

Older people with multiple health problems are one of the patient groups most likely to benefit from continuity of care.[5] Practices that deploy their doctors and nurses to care for particular patients long term are more likely to reduce acute admissions, according to research published last year.[6] The registered list works beautifully for older patients: they are seen more than most,

56

attend more check-ups for long-term conditions and can be given the flu jab at the same time. GPs who know their patients are best placed to intervene proactively, respond promptly when things go wrong and judge which patients are at the highest risk of an acute admission. Risk stratification tools are in vogue at the moment, but evidence that their use leads to reduced admissions is unclear.

2 Beware of polypharmacy

The elderly are particularly vulnerable to side-effects from medications as their kidneys and other organs age, yet attract an increasing number of drug treatments as new comobidities develop.[7]

GPs are required to carry out annual medication reviews of all their patients on repeat medication as part of the QOF – almost any treatment can be reduced or stopped, but painkillers, psychotropics and antihypertensives are the obvious ones. Elderly patients on multiple medications would benefit and money would be saved.[8]

3 Create individual care plans

A personalised care plan (PCP) is less to do with the medical inputs, important as they are, and more to do with social and psychological support and wellbeing. Looking at patients as rounded human beings and working with social care and the voluntary sector can identify seemingly small interventions that make a big impact on people's lives – AgeUK's befriending service is one such example. The first step in developing a PCP is to talk to patients and their carers about what they feel is important.[9]

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4 Integrate and co-ordinate care

A PCP, when it has been written, will have several elements – including health, social care and voluntary sector input. The plan will work best if all these agencies are brought together, so practices able to find time to meet with community matrons, district nurses, social workers and volunteers to discuss and organise care for people with complex needs will find these patients experience a smoother service and suffer fewer crises.[10] The local health and wellbeing board will be a good forum to help implement integrated care. The evidence that such integration benefits individuals is strong – but little evidence it produces cost savings.

5 Engage with carers

Even if a practice manages to deliver all of the above really well, the key person in a patient's life remains their carer, usually a spouse or another relative who may have health problems of their own.

Good care and support for this person will protect both the carer and the patient who relies on that person's good health. Ask patients who their carers are – a QOF health check is a good time to do this.

The RCGP has initiated a programme to encourage practices to identify carers and offer support, which may be a useful resource if you don't have much experience in this area.[11] Don't forget to get carers' contact details, as they can prove essential if you struggle to get through to the patient directly.

6 Reduce admissions from care homes

Care homes play a crucial role in geriatric medicine. If there is a need, care home residents ought to have access to the same care as anybody else, regardless of the fact they effectively have live-in staff.[12] There appears to be an excess of admissions from some care homes – GPs and commissioners can spot this and help arrange support to tackle the problem. Remember, however, that people admitted to a care home are generally in the last three years of their lives, so this might be a good time to discuss advanced care planning with the patient and their relatives.

7 Provide pre-admission care

Intermediate care provides a more cost-effective arrangement than hospital admission, especially when it takes place in or closer to patients' homes and involves a multidisciplinary, multi-agency team. General practice input should help ensure the 'step up' from community to intermediate care works well and creates the improved outcomes that make it worth the money. It can reduce admissions successfully and can be a cost-effective alternative.[13]

Dr David Lyon is a GP in Runcorn, Cheshire and co-developer of the Early Admission Risk Likelihood Index tool

MORE ONLINE
Go to pulsetoday.co.uk/practice-business for three more tips on elderly care

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PRACTICE FINANCE DIARY: SEPTEMBER

GP pensions – NHS or private?

THIS MONTH, THE BMA is due to take part in fresh talks with the Department of Health on pensions.

The meetings will focus on contribution increases and retirement age as a review into the safety of NHS workers retiring at 68 begins. With rival unions unlikely to agree to a more equable application of pension contribution increases across the NHS, the BMA has a battle on its hands.

Talking to my GP clients over the past 12 months, it is clear they're all thinking about their pensions an awful lot more than ever before. Precisely which aspect of their pension arrangements is worrying them largely depends on their age.

Many will be considering the pros and cons of a private pension scheme in the months ahead.

Bob Senior
is the head of medical services at RSM Tenon and chair of the Association of Independent Specialist Medical Accountants

Increasing retirement age

For GPs who were within 10 years of their normal retirement age (usually 60) on 1 April this year, the present proposals suggest that they will continue with the 1995 NHS Pension Scheme and their retirement age will not be changed.

GPs aged between 46 years, seven months, and 50 years on 1 April 2012 will be affected by the change in retirement age under the new NHS Pensions Scheme, but not immediately on its introduction in 2015.

For everyone else, the new scheme will be linked to the state pension age and, for GPs born after April 1978, this will mean a retirement age of 68. Most of the GPs I talk to are pretty cynical and expect it to move beyond 68 before they retire.

A lot to lose

Nobody is happy with the proposed changes, but those with the biggest axe to grind are GPs who had hoped to retire – albeit on a reduced pension – in their mid- to late 50s.

The reason for their disquiet is the abatement rules applying to the scheme, which discount the pension for GPs taking early retirement by approximately 5% a year. This means that a GP with a retirement age of 68 taking their pension at 58 could face an almost 50% reduction in the value of their pension. Many of these GPs may consider moving into a private pension scheme in 2015, a prospect that may attract younger GPs too.

A 68-year-old GP taking their pension at 58 could face a reduction of up to 50% in their pension value

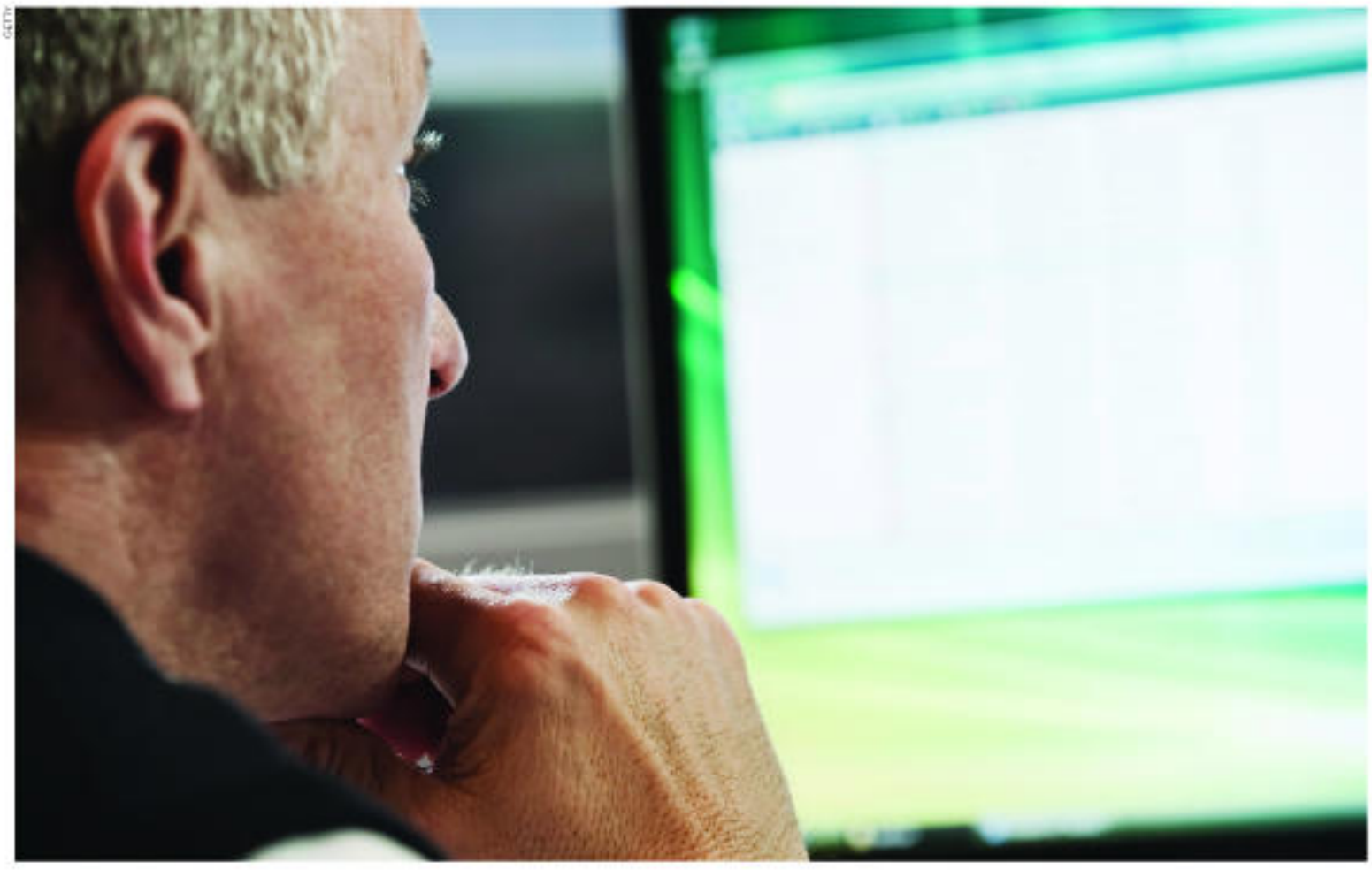
While the new NHS Pension Scheme will undoubtedly offer better returns than a private pension, there is more flexibility with the latter. You can pay in as much as you can afford (within limits) rather than being forced to pay up to 28.5% of your NHS income in contributions. A private pension scheme also allows retirement without penalty from age 55 – there are no abatement rules to erode the value of the pension.

Contributions will rise

No GP likes the prospect of having to pay more into their pension, but it appears to be mainly older GPs who are upset about the proposed hike in contributions. Having to pay a fair contribution is not in dispute – but why are senior members of other public-sector pension schemes not paying anything like the same level of contributions as GPs?

Some independent financial advisers have calculated that, to fund an equivalent private pension, a GP would need to contribute around 41% of their NHS income. But the affordability of the NHS Pension Scheme remains in doubt and the problem will only get worse.

Medical students starting their courses this autumn could graduate in five year's time with up to £90,000 of student debt. By then, it is highly likely that mortgage rates will have gone up. Will these doctors be able to afford 28.5% pension contributions? Something will have to give, and many young GPs will opt for a lower-value private pension in return for lower, more flexible contributions. With top earners likely to desert the NHS Pension Scheme, could the viability of the scheme be in doubt?



Four ways to make prescribing data work for you

Kym Lowder lists the key steps to making the most of information about how medicines are managed in your CCG

LAST YEAR, THE KING'S FUND identified improved medicines management as one of 10 high-impact issues in achieving better patient outcomes and efficient use of resources.[1]

Its report noted that prescribing costs 'are rising at a relentless rate – about 7% in real terms – and account for 12% of the NHS budget'. Around 7% of hospital admissions have been attributed to adverse drug reactions and evidence shows up to two-thirds were preventable.[2]

Below are four tips for using data to help improve the quality and efficiency of prescribing for member practices of your CCG.

1 Start with good data

In general, employing an analyst full time at central support-services level is the most cost-effective way of getting good data although some larger CCGs might employ an analyst directly. Variation in prescribing or the use of an expensive drug sometimes is sometimes justified. For example, prescribing costs in a practice serving a high number of care homes are obviously going to be higher than those for a practice with a high proportion of students.

2 Agree reasonable performance measures

When benchmarking, consider both comparisons with regional and national data. The NHS Business Services Authority publishes monthly prescription statistics that can be accessed by PCTs, CCGs and individual practices.

National comparator data is also available on the QIPP section of the National Prescribing Centre website.

Software prescribing support systems such as Scriptswitch and Eclipse can be tailored to support specific care pathways or the prescribing priorities of a CCG.

3 Look for both over- and under-prescribing

NSAIDS are a good example here, as there is a threefold variation in NSAID prescribing rates between PCTs in England. Are outliers in the high use of NSAIDS – particularly diclofenac and COX2 inhibitors when alternatives are preferable – also found in other prescribing areas?

When looking for instances of under-prescribing, start by comparing prevalence and prescribing to find practices with poor levels of diagnosis in particular disease areas.

4 Include medicines optimisation in all pathway redesign

A simple example of this would be that, when moving a dermatology service from secondary care to the community, your CCG implements safeguards to ensure community-based health professionals such as pharmacists are aware of the MHRA guidance around women prescribed isotretinoin.

The use of high-cost new drugs in primary care might lead to reduced hospital admissions – for example, if newer anticoagulants prove more clinically effective than older ones.

Kym Lowder is a pharmacist in Kent and a Primary Care Commissioning associate

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MORE ONLINE
For an extended version of this article, including two more tips on using prescribing data in your practice, visit
pulsetoday.co.uk/commissioning

How will the Commissioning Outcomes Framework affect commissioners?

The NHS Commissioning Board's commitment to developing a national Commissioning Outcomes Framework (COF) became more of a reality earlier this month, when NICE released its first set of 44 outcome indicators.

The board is now close to deciding which indicators to select for its final COF for CCGs in 2013/14.

There are four main ways the COF will affect CCGs.

First, CCGs need a clear, overarching outcomes framework. At present, the first set of COF indicators have been released without a finalised framework within which to operate. In order to know the scope in which the indicators operate, CCGs will need to understand the expectations placed on them.

For example, if a CCG sees its current delivery against the COF indicators is in the 75th percentile against peer CCGs with similar needs and characteristics, what progress will it need to make? And will the degree of progress be the same when compared to a CCG peer in the 20th percentile?

Second, CCGs need a COF that brings some balance between national and local priorities, as it will form a critical element of the NHS Commissioning Board's relationship to CCGs.

The COF should, in the long term, enable CCGs to focus on clinical areas where their current level of 'performance' against peer CCGs is weaker.

Every GP practice needs to have encouragement to achieve the COF, and CCGs where member practices don't engage with those targets will be less likely to achieve them.

Third, CCGs also need to have a clear commitment to outcomes over process measures. The health service and CCGs are very used to a target-driven culture, and in the future we need to avoid the worst excesses of what a focus on process-driven targets did.

For CCGs the board's selection of indicators for the COF will be critical on two levels – they must be well spread across disease areas to work well locally and they must be economic enough to avoid burdening CCGs with additional data collection.

Both these factors would avoid a 'scattergun' approach to the use of clinical and managerial resources. Measuring success through outcomes will only be successful if CCGs work effectively in partnerships with the local authority, health and wellbeing boards and the Commissioning Board.

Finally, the COF should be supported by an incentive scheme, currently known as the quality premium.

There is considerable work still to do to clarify how closely the premium will be aligned with the COF indicators and how other incentives across the NHS system – such as CQUIN and the QOF – could be aligned locally.

The duty of CCGs is to commission the best possible healthcare for their population, so if savings are created in one area then the groups will have the power to reinvest them in effective providers.

However, achieving good results in one disease 'domain', such as diabetes, might be linked to commissioning for other domains such as heart disease, so practice leads shouldn't expect to see direct funding gains based on their own commissioning decisions.

There is an urgent need to define the overarching framework for COF to prevent the indicators becoming a set of isolated measures.

Dr Charles Alessi is a GP in London, interim chair of the NHS Clinical Commissioners and chair of the NAPC

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Nottingham – SSAFA Southglade Health Centre

Providing all essential, additional and enhanced services 5 days a week, 8 – 6.30, with extended opening hours in the future.

As a caring and patient focused practitioner you must have excellent communication and interpersonal skills and welcome the challenge of implementing change within a NHS setting. Experience of SystmOne would be useful but training can easily be provided.

For more information about SSAFA Care CIC please visit www.ssafacare.org.uk and for background information on our parent charity go to www.ssafa.org.uk

For an introductory chat, please contact Suzanne Uprichard, General Manager, UK Primary Care, on 07818 564554 or to apply, please forward a CV to Suzanne.u@ssafa.org.uk

SSAFA (the employer) is an Equal Opportunities Employer and is committed to using the Criminal Records Bureau Disclosure Service.

Registered Charity Numbers 210760 (England and Wales), SC038066 (Scotland) Established 1885.

SSAFA Care

www.ssafacare.org.uk

Claremont Medical Practice Scarborough

We are a GP Practice in the centre of Scarborough that has recently lost two partners due to retirement and are looking for GPs to work with us from October 2012 but will wait for the right candidate.

We are looking for 2 WTEs (job shares welcome and part time considered) to take on a salaried role with a view to assuming an innovative Partnership and Clinical Lead role within the Practice within 12 months or by mutual agreement. A desire to become involved in Medical Student and Registrar Training will be an advantage.
One post will be replacing a Partner with a special interest in MSK and additional expertise in this area would be desirable for one of the positions.

All salaried posts are covered by the standard BMA contract with its emphasis on personal development and education. We think you will find the salary competitive and the working conditions and Scarborough area make being here a worthwhile life choice.

There is in addition an opportunity to supplement income with sessions for either the out of hours service or local walk-in centre.

For more information please e-mail:
Dr David Ames at david.ames@nhs.net.
Or 07798925563
Dr Fiona Beardsley at
Fiona.beardsley@gp-b82056.nhs.uk

Applications by CV and covering letter to: Christine Titley, Claremont Medical Practice, 56-60 Castle Road, Scarborough, North Yorkshire, YO11 1XE

Closing date for applications: Friday, 21st September 2012, but recognising that we are in the holiday season we will extend this if required.

GP PARTNERSHIP

Due to the retirement of the Senior Partner, a vacancy has arisen at Greenside Surgery, Greasbrough, Rotherham South Yorkshire for a new full time partner, commencing on 1st January 2012. This is a long established 2 partner, PMS, training practice. The practice employs 2 Salaried Doctors and 2 Practice Nurses. The list size is 5,350.

The practice is looking for a GP who aims for high standards of care with an interest in all aspects of practice, including training, and who wishes to improve the already high levels of achievement that the practice attains. The surgery offers a wide range of services, with a number of attached staff located in purpose built premises, owned by the partners, on a single site.

The successful applicant would have a 6 month of mutual assessment before taking up the partnership.

Informal enquiries are welcome.
Contact Dr Chris Myers by e-mail:
Christopher.myers@gp-c87020.nhs.uk
or telephone 01709 560887.

To apply for the post send a CV with covering letter and 2 references to
Dr Chris Myers FRCGP Greenside Surgery
Greasbrough Rotherham
South Yorkshire S61 4PT.

Closing Date 28th September 2012

GP PARTNERSHIP VACANCY

Claygate, Surrey

An established suburban village practice. The local area has excellent schools and amenities and good access to main airports and London

- List size 3000
- Three GP partners, two salaried GPs
- Over 20 years experience of training GPRs
- Fully computerised (Synergy)
- PMS
- Modern purpose built premises
- 2 practice nurses, 1 HCA and phlebotomist
- Active in local CCG
- Longstanding patient participation group

We are seeking a highly motivated doctor to fill a practice vacancy of 6-8 sessions. There is opportunity for the individual to develop clinical and managerial skills and to play a full part in the further development of the practice.

Applications with C.V. and covering letter to:
Ms. Leana Ait-Younes, Practice Manager, Capelfield Surgery, Elm Road, Claygate KT10 0EH.
Email: aleana@nhs.net.
www.capelfieldsurgery.co.uk
Closing Date: 5:00pm Friday 5th October 2012

Grove Surgery

Full-time Partner or Salaried GP (8 sessions)

Start date: Mid-January 2013

We are looking for a GP to join our friendly, hard-working team. The Practice is located in the ancient town of Thetford, surrounded by countryside yet 20 mins from Bury St Edmunds and equidistant from Cambridge and Norwich. We are interested in a highly motivated, hardworking candidate who recognises the benefits of enthusiasm, teamwork and the ability to see the lighter side of life. **A happy working environment is as important as a successful one.**

- GMS practice with superb in-site pharmacy
- 13,000 patients
- 8 GPs
- Weekly in-house CPD
- Research and teaching practice (Cambridge Graduate Scheme)
- Full clinical QOF points achieved in 2011/12
- Systmone
- Optional local OOH

Please contact Sue Morgan, Practice Manager, for further information or to arrange an informal visit on 01842 851080.
e-mail: susan.morgan6@nhs.net, or e-mail: Dr Paul Gray: psl.gray@nhs.net
www.grovesurgerythetford.co.uk

Closing date: 23rd September 2012

Mid Cheshire Hospitals NHS

NHS Foundation Trust

Shropdoc

Central Cheshire Urgent & Primary Care Centre

The Urgent Care Centre at Leighton Hospital, Crewe, is recruiting sessional GPs to provide enhanced Primary Care to walk-in and GP referral patients. We are operational from 08.00 – 18.30 weekdays but extended hours are planned to include evenings.

The GP and primary care Nurse Practitioner team deliver immediate care to walk-in and ambulance patients along with clinical pathways in partnership with Acute Trust staff. Current pathways include the Community DVT and IV@Home (antibiotics for cellulitis) services. There is a very active project list and we are seeking GPs with an interest in urgent Primary Care who wish to have both a clinical and developmental role in the service. These pathways are needed to support the CCG urgent care strategy – providing care closer to home and avoiding admission.

The GP workforce is provided and managed by Shropdoc and terms & conditions are competitive.

If you are interested in this post and would like to learn more about what is involved in the first instance, please contact Dr Russell Muirhead or Dr Simon Chapple for further information.

russellmuirhead@doctors.org.uk Phone – 01743 454900

simon_chapple@doctors.org.uk Phone - 01270 273807

DOCTORS/GPS REQUIRED

NHS
Partners4Health

Frustrated by the QOF treadmill?
Enjoy working with the acutely ill?
Passionate about delivering excellent, patient centred care?

Based in the historic city of Chester, Partners4Health is recruiting additional GPs to support our existing team of doctors, Advanced Nurse Practitioners and healthcare assistants to deliver urgent care in

- Hospital at Home, an innovative service that treats patients in their own home who would normally need to be admitted to hospital
- General Practice where you will be part of the practice team and have the opportunity to maintain your GP skills

Partners4Health is an NHS body and successful applicants will benefit from excellent terms and conditions including the NHS pension scheme. Salary range £76,000-£82,500 per annum for a 37.5 hour week including protected development time.

Candidates must have completed their GP training and have a minimum of 12 months further experience in Primary Care.

Closing date for applications 28 September 2012

For further information contact Dr John Hodgson, Medical Director 01244 385387 or johnhodgson1@nhs.net
For a job pack contact Anne Briffa, office manager on 01244 385388 or a.briffa@nhs.net

Half time partner (4 Sessions over 2 days)

plus

Maternity Locum (6 months) from Feb 2013 (3 full days)

We are looking to recruit an enthusiastic and committed half time partner to join our busy but friendly patient centred training practice. Plus a 6 months maternity locum from Feb to July 2013.

- List (growing) 5,247
- 3 partners (female)
- High QOF achievement
- INPS Vision remote medical system
- 5 weeks annual leave plus up 2 days study leave
- The ability to work up for partner cover would be advantageous
- Excellent support staff
- Very keen and committed training practice
- Salaried with a view to partnership considered

Informal enquiries and visits are welcome.
Please send your written application plus CV by email to: - steve.howard2@nhs.net
Dr Hutchings and Partners, Rosemead Surgery,
8A Ray Park Avenue, Maidenhead, Berks SL6 8DS.
Tel 01628 639724

Partnership in Surbiton

Brunswick Surgery, Oakhill Health Centre

An opportunity to replace an outgoing partner in a GMS practice committed to the values of traditional family medicine. Good work/life balance. Moving to new purpose-built shared premises in 6 months.

- 6/7 sessions
- Excellent QOF achievement
- INPS Vision (Accredited Paperless)
- List size 6400, with high patient satisfaction rates
- 4 Partners (currently 3.5 WTE)
- Share of extended hours but no OOH requirement
- Excellent, supportive and friendly multi-disciplinary team
- Medical student teaching

Apply in writing with full CV and covering letter to:
Practice Manager
Brunswick Surgery
Oakhill Health Centre
Oakhill Road, Surbiton, Surrey KT6 6EN
Tel: 020 8390 5321
Email: david.potton@nhs.net

www.brunswicksurgery.co.uk

SALARIED GP with a view to PARTNERSHIP
5 - 6 SESSIONS PER WEEK
SOUTHWATER/HORSHAM, WEST SUSSEX

An opportunity has arisen in this modern, forward thinking GMS practice.
We currently have 3 Partners, 7500 patients, superb modern premises and high QOF achievement. Our location is in a pleasant, semi-rural area, adjacent to the market town of Horsham.

We are looking for a dynamic, enthusiastic and highly motivated team player who can demonstrate high standards of clinical excellence.

Initially, this will be a negotiable salaried position. For the right applicant, who demonstrates a commitment to working within our team and is keen to help drive the practice forward, we will offer the opportunity of a profit share partnership.

Applications by CV and covering letter to Felicity Belkin, Practice Business Manager, The Village Surgery, Station Road, Southwater, West Sussex RH13 9HQ or email felicity.belkin@nhs.net
Informal visits to the practice will be welcomed

Closing date: 28 September 2012
Interview date: Week commencing 8 October 2012

Check out our website: www.southwatersurgery.co.uk

Millport, Isle of Cumbrae

Full time GP, Retirement vacancy
6 session per week plus OOHs rota

- Friendly island community. List size 1300 patients
- Golf, sailing, cycling, walking
- High achieving schools
- Beautiful, spacious, recently converted premises with stunning views (watch the seals play in the bay)
- Emis PCS
- Skilled admin/Nurse Prescriber
- Community Hospital/Minor Trauma Unit which currently triages OOH calls
- Less than an hour from Glasgow, including ferry crossing

GPs retiring April 2013 Health Board, in partnership with local community currently undertaking review of all services. Opportunity for enthusiastic GP to participate in challenge of creating new model of health care. Starting before April 2013 negotiable.

Informal visits or enquiries welcome

Letter and CV to Anne Brown, Practice Manager, Cumbrae Medical Practice Garrison House, Millport, Isle of Cumbrae, Ayrshire, Scotland KA28 0DE or Email anne.brown@aapct.scot.nhs.uk. Tel 01475 531400

GROSVENOR MEDICAL CENTRE, STALYBRIDGE

- Salaried GP required for 6 sessions, Monday, Thursday, Friday.
- Friendly, supportive, training practice.
- Three part-time Partners and one salaried GP.
- Good work/life balance.
- Newly refurbished building.
- Emis Web and Docman.
- No on call or OOH.
- Salary negotiable depending on experience.

Please send or e-mail CV with covering letter to
Jane Lamb, practice manager, at jane.lamb@nhs.net or Grosvenor Medical Centre, 62 Grosvenor Street, Stalybridge, Cheshire, SK15 1RZ.
Closing date for applications: 21st September 2012.

South East London - Lewisham
Lee Health Centre

Salaried GP

Required for 6 sessions, plus extended hours

Friendly well established PMS three doctor practice

- Six sessions
- 6500 patients
- EMIS PCS migrating to EMIS Web shortly
- High QOF achievement
- Excellent nursing and admin support team

Applications with CV by email to:
Dr Leo Antony, Partner, leo.antony111@yahoo.co.uk
Closing date 28th September 2012

Salaried GP – 4 sessions – Cathedral Medical Group, Chichester

A salaried GP required from January 2013.

Cathedral Medical Group is a long established practice with @ 12500 patients. We are located within walking distance to Chichester Town Centre.

We are looking for:

- 4 sessions a week
- Desirable high level computer skills
- Committed to clinical excellence
- Specialist skills and personal development welcomed

We offer:

- A friendly PMS Training Practice
- 6.5 WTE GPs (comprising of Partners, Salaried GPs and Retainer GP)
- List size 12500
- TPP System One clinical system and data accreditation
- High QOF achievement and enhanced services
- 6 weeks' annual leave plus one week study leave pro rata
- Dispensing Practice

Applications welcome from newly qualified and experienced GPs

Closing Date: 14 September 2012

Please send a CV to: Sue Crowley, Practice Manager, Cathedral Medical Group, Cawley Road, Chichester, West Sussex. PO19 1XT. Email: sue.crowley@nhs.net For practice information please visit our website: www.cathedralmedicalgroup.co.uk

SELF-EMPLOYED ASSISTANT/SALARIED GP
(WITH A POTENTIAL PARTNERSHIP OPPORTUNITY)

Dr Laws & Partners, Shadbolt Park Surgery, Worcester Park, Surrey

We are looking for an enthusiastic GP to join our busy, friendly PMS plus practice, 30 minutes from London and close to the rolling downs of Epsom Race Course, to work 4 to 5 sessions a week starting late September.

We are an urban practice, but set in a park with beautiful views:

- 3 GP Partners, 2 Salaried GPs and 2 Associate GPs
- List size 7791, young demographics
- EMISWeb - we use the latest web based computer system
- High QOF points achieved
- 4 practice nurses, an HCA, & phlebotomy services
- Extensive enhanced services and PMS clinics such as in house Cardiology including 24hr BPs & 24hr ECGs, Minor Surgery, Warfarin clinics and a Podiatric clinic, also Antenatal and Family Planning clinics
- On site Ultrasound Service
- FY2 training and we are looking to become a Registrar training practice in the future.
- Members of Locality CG and Surrey Downs CCG.
- Active PPG

There are plans to expand and we hope to offer a partnership of possibly 6-8 sessions in the near future.

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

Mrs Nicky Goeker (Practice Manager)
Dr Kate Laws & Partners
Shadbolt Park House Surgery
Salisbury Road, Worcester Park, Surrey, KT4 7BX.

Tel 020 8335 9879 – Email [illegible]

THE AVENUES MEDICAL CENTRE

Part Time Salaried GP Vacancy with a view to partnership – 5 sessions per week.

An enthusiastic salaried GP is required to join two existing partners in a City Practice.

We are a friendly, supportive SystmOne practice achieving high QOF targets, with a list size of 6100.

We are close to good schools, varied housing, good culture and leisure and have easy national and international access.

For further information, or to make an informal visit, please contact:

Caroline Whitaker, Business Manager,
147-153 Chanterlands Avenue, Hull, HU5 3TJ,
on 01482 303876 or carolinewhitaker@nhs.net

Applications in the form of a full CV including the details of two referees should be sent to Caroline Whitaker at the above address or email address.

DOCTORS/GPS REQUIRED

THURSO, HIGHLANDS, SCOTLAND (www.thursohalkirkmp.co.uk)

ADDITIONAL PARTNER REQUIRED

We are looking for an additional partner to join our innovative GPMS practice in an area of outstanding local beauty in the North of Scotland. We require an enthusiastic, hardworking and committed GP who will play an active role within the practice to maintain our values and help develop patient services for the future. We are committed to providing high quality health care with a wide range of services tailored to meet the needs of our patients.

- 6 – 9 sessions (but could be flexible)
- Non Equity or Equity Partner position
- List size approximately 6,000 (currently four partner practice)
- Dispensing branch surgery (six miles from town)
- Established Training Practice – Specialist Registrars and Undergraduate teaching, Practice Based Small Learning Group (PBSLG)
- High patient satisfaction survey scores
- Clinical support team includes Practice Nurses and Health Care Assistant
- In the final stages of recruiting a Nurse Practitioner/Prescriber
- Happy and enthusiastic administrative team
- GP led community hospital next door
- IT – INPS (Vision), FrontDesk and Docman clinical systems with on site VC facility for training / meeting purposes and telemedicine
- Well equipped premises
- Enhanced services and extended hours offered
- No out of hours commitment (although opportunities exist locally)
- Clinics provided by visiting Midwife and Physiotherapist
- Generous annual leave plus 5 public holidays (includes 5 days study leave)
- Maternity/paternity pay written into contract
- Excellent local facilities, housing and schools, low crime rate
- Twenty miles from nearest airport
- Vacancy available now but willing to wait for the right person
- Applications welcome from current ST3s, newly qualified and experienced GPs

Further information, including Practice Profile, GP/Locum testimonials and the results of our patient satisfaction survey are available on our newly updated practice website at www.thursohalkirkmp.co.uk. Information together with a promotional video on the town of Thurso and the surrounding area can be found at www.thursotown.co.uk.

If you would be interested in joining our friendly, forward thinking and high quality practice team in this beautiful part of Scotland, please write (enclosing CV) to: Christine Tait, Management Partner, Thurso & Halkirk Medical Practice, 69 Princes Street, Thurso, Caithness KW14 7DH. For more information or for informal enquiries please contact Christine on 01847 895495 or c.tait@nhs.net.

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DWS Medics
Providing medical professionals to Australia

Salaried GPs in Luton

6 sessions at Moakes Medical Centre

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

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

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

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

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

6 sessions

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

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

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

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

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

6 weekday sessions +/- Saturday morning option

Salaried GP or GP Trainer

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

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

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

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

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

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

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

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

Partner or 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

The Kakoty Practice

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

We have a vacancy for a full-time salaried GP.
We are seeking an enthusiastic doctor, willing to help us delivery high quality health services to a challenging population including Asylum Seekers and Substance Misusers.

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

Practice website: www.thekakotypractice.nhs.uk
Informal enquiries and visits welcome.
Written application including CV to: Dr P C Kakoty, GP Partner, Sheffield Road Surgery, 170 Sheffield Road, Barnsley S70 4NW
tel: Business Manager - Marie Hoyle on 01226 209969 or email marie.hoyle@nhs.net.
Closing date: 14th September 2012.

SALARIED GP

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

Dr. Bevan and Partners, Spinney Brook Medical Centre
Northamptonshire

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

- 6 GP Partners (5 male)
- List size 12,800
- Modern purpose built premises (Main and Branch Surgery)
- Dispensing Branch Surgery
- High QOF points achieved
- PMS Practice
- Secure QOF Management
- 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 5QA

Tel: 01933 650593 – Email: alison.fenncoles@gp-k83026.nhs.uk

THE MARISCO MEDICAL PRACTICE

FULL TIME PARTNER REQUIRED EAST COAST LINCOLNSHIRE

We are seeking to recruit an enthusiastic and highly motivated GP to replace a retiring partner. Start date to be agreed but before end 2012 if possible.

About us:
9 Partners based in new flagship premises
Training Practice
GMS Contract
Well organised and supportive primary care team
SystmOne clinical system, paperless practice
Maximum QoF Achievement
List Size – 14,000 patients
No Out of Hours requirement
Excellent housing in rural villages at competitive prices
Excellent Grammar Schools and environment

Please see our Practice Website: www.marisco.gpsurgery.net

Apply in writing with CV to Janet Goult, Practice Manager Marisco Medical Practice, Stanley Avenue, Mablethorpe LN12 1DP
For an informal chat or to arrange a visit, telephone 01507 474190
Email: Janet.Goult@lpct.nhs.uk

Closing date: 21st September, 2012

Part Time Salaried GP with partnership potential
Parkview Surgery

About Us
Growing GMS practice in South East London current list size of 4100 seeking a part time (4-6 sessions) Salaried GP with partnership potential.

- High QOF achievement
- Paper light EMIS Web system
- Team of two GPs & practice nurse
- Purpose built premises close to excellent schools leisure activities and transport links.

We can offer
- Competitive salary.
- Six weeks holiday/study leave pro rata

You
Looking for an enthusiastic, excellent communicator with good interpersonal skills to work as part of a team to provide high standard of patient care and achieve targets. Special Interest in woman's health including Coil/Sub Dermal implant fitting is a great advantage.

Willing to wait for the right candidate.
Please email applications with CV to: ndias@nhs.net

FULL – TIME SALARIED G.P.

with a view to partnership

Croston, Lancashire
Starting Date: 1st January 2013

Two doctor GMS semi-rural Practice run from a purpose built premises and supported by full Practice staff, including Practice Nurse and a Practice Manager

EMIS LV system - High QOF achiever

The existing partners are contemplating retirement.

Please reply, with full CV, to
Practice Manager
Croston Medical Centre, 30 Brookfield, Croston, Leyland, Lancashire PR26 9HY. Telephone: 01772 600081

Closing date for applications: 30.09.2012
Informal enquiries/visits are welcome

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Rural Dispensing Practice

In the Heart of the National Forest
Requires a **Salaried Partner.**

Initially 6 sessions per week rising to 8 after 6 months with a view to future profit sharing partnership.

Written applications enclosing CV to:-
Dr V P Parmar, Overseal Surgery,
1 Hallcroft Ave, Overseal, Swadlincote, Derbyshire DE12 6JF
Informal enquiries welcomed
Tel: 01283 760595
www.oversealsurgery.co.uk

REPLACEMENT PARTNER

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

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

The Castle Hedingham Surgery

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- **No out of hours commitments**

Please apply in writing with a CV to

Rachel Howard, Practice Manager,
The Castle Hedingham Surgery, 10A Falcon Square,
Castle Hedingham, Halstead, Essex, CO9 3BY
Tel 01787 461784 Fax 01787 469402

DOCTORS/GPS REQUIRED

Ballards Walk Surgery Basildon, Essex.

Salaried GP required.

We are looking for a salaried G.P. for eight / nine sessions a week to join or established practice, which is supported by a well motivated and friendly team. Start date ASAP.

List size 7100
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Please send your C.V. and covering letter to
Practice Manager
Ballards Walk Surgery
49 Ballards Walk, Basildon, Essex. SS15 5HL.
Or e mail C.V. to jackiemellia@nhs.net

Stratford Village Surgery, London E15

Salaried GP (Maternity Cover) and .5 part time salaried GP required

We are looking for a salaried GP for eight/nine sessions a week to join an established practice, which is supported by a well motivated and friendly team. Start date ASAP.

List size 8,900+
High QOF Achiever and EMIS Web user
Please send your C.V. and covering letter to
Karen Stubbs- Business manager
Stratford Village Surgery
50c Romford Road, Stratford, London. E15 4BZ
Or e-mail to karenstubbs@nhs.net

Full time salaried GP
(would consider two part time / job share)

Are you a highly motivated, caring GP?
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Mayfield Medical Centre
Park Road, Jarrow, Tyne and Wear, NE32 5SE
or email sharon.thompson@stpct.nhs.uk

For further information contact
Sharon Thompson on 0191 4897183

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Closing date: 28th September 2012

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Closing date for all applications 19.9.2012

Please send CVs or any enquiries to

Dr S Ali: snali_uk@yahoo.com

GP PARTNER SALARIED PART FULL TIME GRAVESEND

Seeking an enthusiastic GP for six-eight sessions initially to join our friendly team in a well established practice. The incoming doctor must be fully committed to develop the practice and take over full control from the retiring senior partner.

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- No OOH commitment
- High QOF achiever

Wendy Hopkins
186 Parrock Street, Gravesend, Kent DA12 1EN
Tel: 01474-567888 parrock.surgery@nhs.net

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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.

PRIVATE GP

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

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

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EDITOR'S CHOICE

Miles away from the NHS

An elective placement in Sri Lanka opened my eyes to the order in the NHS, says registrar Dr Suzanne Reilly

My first week in Sri Lanka has been a real eye opener...

I was accepted to work at Sri Jayadenapura General in the capital and assigned to the busy emergency department, which is the first point of call for many patients who have not previously sought help in the community.

Initial medical intervention for many patients is a cannula placed in situ, often preceeded by intravenous saline – although I'm not sure yet why all patients require such a painful intervention as a first-line treatment before they are even examined.

In the UK, there is a strong link between primary and secondary healthcare. But he said in Sri Lanka, this link is – at best – extremely weak.

Dr Sudath Dhamsinghe, a GP who runs clinics at the hospital, was able to tell me more about the Sri Lankan healthcare system.

In primary care, patients are seen without appointments and attend many different practices, leaving little hope for continuity of care. Monitoring of healthcare in the community verges on the impossible in many cases...

Dr Suzanne Reilly: made me appreciate the NHS

Dr Suzanne Reilly is a FY4 from London, studying at the Peninsula Medical School

MORE ONLINE
Read more about Dr Reilly's experience of working in general practice in Sri Lanka
pulsetoday.co.uk/off-duty

OFF-DUTY

Remember Dr Kate Granger, the registrar who wrote for Pulse back in April about being on the 'other side' of the consulting table when she was diagnosed with cancer? She writes for us again on her return to work and living with the burden of a terminal illness. There is also an opportunity to review her new book.

▶ pulsetoday.co.uk/off-duty

WHAT YOU'VE BEEN SAYING

▶ pulsetoday.co.uk/forum

"Time the BMA got some lawyers on board to negotiate."
... on the Government's U-turn excluding GPs from the Doctors and Dentists Review Body's pay review

"I knew that if I did that to a dog I would be taken up for cruelty."
... on figures showing flat-lining numbers of GP trainees

"Good luck Clare. Please do extensive ironing before it gets to me."
... on the news that RCGP president Dr Clare Gerada will be among the first GPs to be revalidated

SURVEY

Have your say on rationing

Pressure on NHS resources is increasing and Pulse is keen to find out how this is impacting GPs' daily practice.

But what is the truth behind the headlines? Have your say on how you and your patients are affected by rationing in Pulse's rationing survey.

All entries received before Monday 10 September will be entered into a prize draw to win a £25 Amazon voucher.

SURVEY
Have your say here
pulsetoday.co.uk/rationing

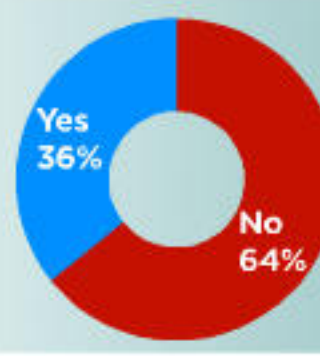
THIS WEEK'S POLL

Should patients be allowed to top up their personal budgets?

Vote at ▶ pulsetoday.co.uk/polls

Last week's poll

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



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