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PULSE

20.06.12

Issue 22 | Volume 72

BriefingMedia

At the heart of general practice since 1960

Pensions action hit by contract threat

Sharp fall in support as just one in four practices confirms they will take industrial action

EXCLUSIVE

By Jaimie Kaffash

Thousands of GPs are facing the prospect of having contract payments withheld if they take industrial action, as Pulse reveals as few as one in four practices have committed to stopping routine care.

In a blow to the BMA pensions campaign, early figures from trusts across the country suggest a majority of practices have decided not to take action on 21 June and will be open as normal.

On the eve of the first industrial action by doctors since 1975, around 22% of practices across the UK have notified their primary care organisation that they will be taking part, with this proportion dropping to one in 10 in some areas.

The figures come after hundreds of practices in London were served with notice that they could be hit with 'compensation' claims from NHS managers if they are found to be in breach of contract on 21 June.

A letter sent by PCT clusters to all 1,331 practices in London warned they were obligated to offer a 'full service' even if they decided to take industrial action.

It said: 'The local NHS may decide to withhold certain payments due to a contract holder by way of compensation for any breach, should it occur. In addition, formal contract breach notices would be issued.'

Legal experts said this could mean practices facing a 'termination notice' in extreme cases.

Lynne Abbess, a partner at Hempsons Solicitors, told Pulse: 'GPs have no in-built right to strike. It would constitute a breach of contract if they only provide urgent care and in a worst-case scenario, it could lead to the end of the contract.'

Figures obtained by Pulse from 30 PCOs that were able to provide data suggest that the contract threats – alongside concerns over public perception and additional workload – were putting GPs off taking action.

Some 281 out of 1,265 practices have so far committed to taking industrial action – a disappointing return for the BMA after a ballot in which 79% of GPs who voted backed industrial action.

Dr Jackie Applebee, a GP in Tower Hamlets, said she was confident the industrial action was not a breach of contract, but warned the threats could dissuade GPs from taking action: 'I think it will put some people off, especially those who aren't as plugged in to the GP community, such as single-handed practitioners.'

Proportion of GPs taking action

Source: Pulse poll of PCOs

In other areas, however, PCOs have said they will not take action against practices who take part and GPs have instead blamed the low numbers participating on the type of action proposed.

In Nottinghamshire and Nottingham City, only 28 out of 161 practices said they were taking action. Nottinghamshire LMC chair Dr Greg Place said local GPs were 'steaming furious' about pensions, but were concerned about workload: 'We will have to do everything we don't do on Thursday on Wednesday and Friday instead. The only people who will suffer are us.'

In other areas even fewer practices will take part. In Surrey, just 15 out of 129 practices – 12% – have said they will take action.

Although it is not too late for practices to inform PCOs they will be participating, in some areas the majority of surgeries have already ruled out action. Across Buckinghamshire, Oxfordshire and Suffolk, 134 of the combined 207 practices have confirmed they will remain open.

Dr Chaand Nagpaul, GPC negotiator, said threats of contract sanctions were unwarranted: 'I think it is unfortunate if PCTs colour requests for factual information with threats.'

Health secretary Andrew Lansley wrote to the BMA this week to urge GPs taking industrial action to work the following weekend: 'I would ask your members who are GPs to consider working on Saturday 23 June to clear the backlog of appointments they will have created.'

The idea was quickly rejected by the BMA. A spokesperson said: 'We do not anticipate the need for additional clinics.'

feedback@pulsetoday.co.uk

READY FOR ACTION

'This is part of an attack on the NHS'

GPs in Tower Hamlets are to stage a protest against the Government on the day of industrial action. Dr Kirsten Shirke, a GP in the borough, said: 'All the doctors in our practice are supportive of action. We see the pension reforms as one part of an attack on the NHS. We all feel very angry about these proposals.'

LIVE COVERAGE

Email us your pictures and stories from the day of action and follow all the developments on 21 June

pulsetoday.co.uk/dayofaction

CPD in this issue: 3.5 hours

Earn CPD for our Key questions and post-op problems articles, as well as our feature on flu campaigns

Seminars

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Will your practice be taking action?

We asked 10 prominent GPs if their surgery would be taking industrial action on 21 June.

'My surgery will be open for urgent and emergency appointments. Almost all the doctors in my surgery are taking part. I am upset I have had to do this.

'I have never taken industrial action before and I would have hoped not to have started now.'
Dr Laurence Buckman, GPC chair

'To take industrial action that could in any way damage patient care is not necessary.

'The BMA Council just got it wrong. It is a spectacular own goal.'
Dr Peter Swinyard, Family Doctor Association chair

'In accordance with the guidance, I will be taking part. It is not about causing problems to patients, but about impacting on the Government.

'We aim to demonstrate and protest against unfair pension changes.'
Dr Chaand Nagpaul, GPC negotiator

'I was not balloted, but yes, I definitely support the action.

'I think what the Government is doing is grossly wrong, particularly for younger people coming through.'
Dr Brian Balmer, chief executive of Essex LMCs and locum GP

'I am a member of the BMA and if I were not to follow the guidelines that would be strange.'
Dr Fay Wilson, BMA Council member

'I will not be taking part because I think it is the wrong form of industrial action for GPs. I don't think we should do anything that impacts on patients.'
Dr David Jenner, PMS/GMS contract lead

'We are neither supporting nor not supporting the action. The principle must be that patients are at the centre of everything we do.'
Professor Steve Field, NHS Future Forum chair

'We have a funeral to attend that day, but we will be providing an emergency service and are arranging cover. We will be back later in the day to pick up the pieces.'
Dr John Canning, GPC member

RCGP chair Dr Clare Gerada and GPC deputy chair Dr Richard Vautrey declined to say if their practices would be taking action.

MORE ONLINE
For live coverage on the day
pulsetoday.co.uk/dayofaction

Boundary pilots register just 12 patients

Timetable for evaluation in doubt after it emerges pilots in four out of six areas are yet to get under way

EXCLUSIVE
By Alex Wellman

Just 12 patients across the country have so far decided to register with a practice near their place of work, almost three months after pilots of the abolition of practice boundaries were supposed to get under way, a Pulse investigation reveals.

Four of the six areas supposed to begin piloting the controversial policy in April have yet to do so, with three so far unable to convince a single practice to take part and the others signing up just a handful of GPs.

The severe delay has cast doubt on the timetable for the whole project, with the Department of Health suggesting the evaluation of the pilots – due to take place next spring ahead of any national rollout – could have to be reconsidered.

The pilots were agreed by the GPC and DH as part of the 2012/13 contract deal, and were intended to allow patients to either register or attend as an out-of-area patient across six areas. But they have been dogged by uncertainty over funding arrangements

EDITORIAL
Boundary pilots need more time 14

and an LMC-led boycott, and are now far behind schedule.

The pilots have begun in Manchester and Westminster, with the former signing up three practices and the latter 18. NHS Manchester said it had seen two registered patients and one 'day patient', while NHS Westminster put its 'preliminary number of patient sign-ups' at 10.

An NHS Westminster spokesperson added: 'We will begin work with practices to promote the service very soon and anticipate numbers will increase.'

Elsewhere, NHS Salford said six GP practices had signed up for the scheme, but it did not expect to go live until the end of June.

NHS Nottingham City expects its pilot scheme to begin 'in early July', while no GPs in NHS Tower Hamlets or City and Hackney PCT have yet opted in.

A spokesperson for NHS North East London and the City, which covers both PCTs, said: 'We are hopeful of having a solution in place later in the year.'

According to the *Patient Choice Scheme* directions issued

Practice boundary pilots: the story so far

NOV 2011
2012/13 GP contract deal includes one-year pilot of relaxed practice boundaries

DEC 2011
Andrew Lansley reveals pilots will take place in six sites across three cities

APR 2012
Pilots fail to begin as scheduled, with LMCs in east London staging boycott

JUN 2012
Pilots finally begin in two areas – but just 12 patients have registered so far

APR 2013
Planned deadline for end of pilots – but could this now be put back?

The week in general practice

INSIDE

MORE ONLINE
pulsetoday.co.uk/news

The GPC has urged CCGs not to 'flog off' local enhanced services to the private sector
pulsetoday.co.uk/commissioning-news

Cartoon
Our exclusive cartoon portrays the life of a GP receptionist
pulsetoday.co.uk/practice-business

Download of the week
Read correspondence between the health secretary and BMA chair Dr Hamish Meldrum over the industrial action on pensions
pulsetoday.co.uk/news-analysis

E-booking demand questioned

Dr Sella Shanmugadasan: funding still a sticking point

By Alex Wellman

GP leaders have questioned the Government's drive to get all practices providing appointment booking on the internet by 2015 – after the GP patient survey showed less than a third of patients want to book online.

The 2011/12 patient survey showed high levels of satisfaction with GP services, with 88% of patients rating the overall experience of their practice as good.

The survey also asked patients how they wanted to book appointments.

The most preferred method was by phone, with 90% of patients doing so currently and 81% of patients preferring to book this way.

Just 29% of respondents said online booking would be their preferred method, and only 3% of patients used it currently.

Health secretary Andrew Lansley said the figures showed large numbers of patients had a good experience from the NHS, but that patients wanted more choice over how they booked appointments.

Mr Lansley said: 'Almost three-quarters of GP practices use IT systems that include options for booking appointments online, but less than half of them offer this service. We want GPs to make use of these systems and ensure that their patients know that they can book appointments in a way that may be more convenient for them.'

But GP leaders interpreted the figures differently, arguing it was 'daft' to push ahead with plans that the majority of patients did not want.

The Government's 10-year Information Strategy – published last month – pledged to give all patients the option of booking

This is daft. People are not saying 'we want it' with these figures.
Dr Brian Balmer

their GP appointments and receiving their test results online from 2015.

Dr Brian Balmer, chief executive of Essex LMCs, said the policy promised patients something they did not need: 'Pushing something that does not have widespread support is daft. People are not saying "we want it" with these figures.'

Dr George Rae, a GP in Whitley Bay, Tyne and Wear, and a member of BMA Council, said: 'We have had online [booking] for a while, but the vast majority are not using it. If one becomes too much involved in that, is that not prejudicial to those familiar with computers?'
feedback@pulsetoday.co.uk

Government delays launch of 111 urgent care line

by the DH, the pilots are due to conclude on 1 April 2013. But the DH told Pulse it was keen to extract the maximum possible learning from practices which join the pilots later than planned, and it is understood to be willing to look again at the timetable.

Dr Richard Vautrey, GPC negotiator, said an extension to the evaluation deadline could be warranted, but only if the pilots were not causing 'problems'.

Dr Sella Shanmugadasan, chair of Tower Hamlets LMC, said funding remained a sticking point: 'We have to pay for the additional services for the patients – the practice has to absorb that cost.'
feedback@pulsetoday.co.uk

The Government has announced a delay in the rollout of the NHS 111 urgent care number, after accepting concerns that the April 2013 deadline for introducing the new 24/7 urgent care service was too tight for some CCGs.

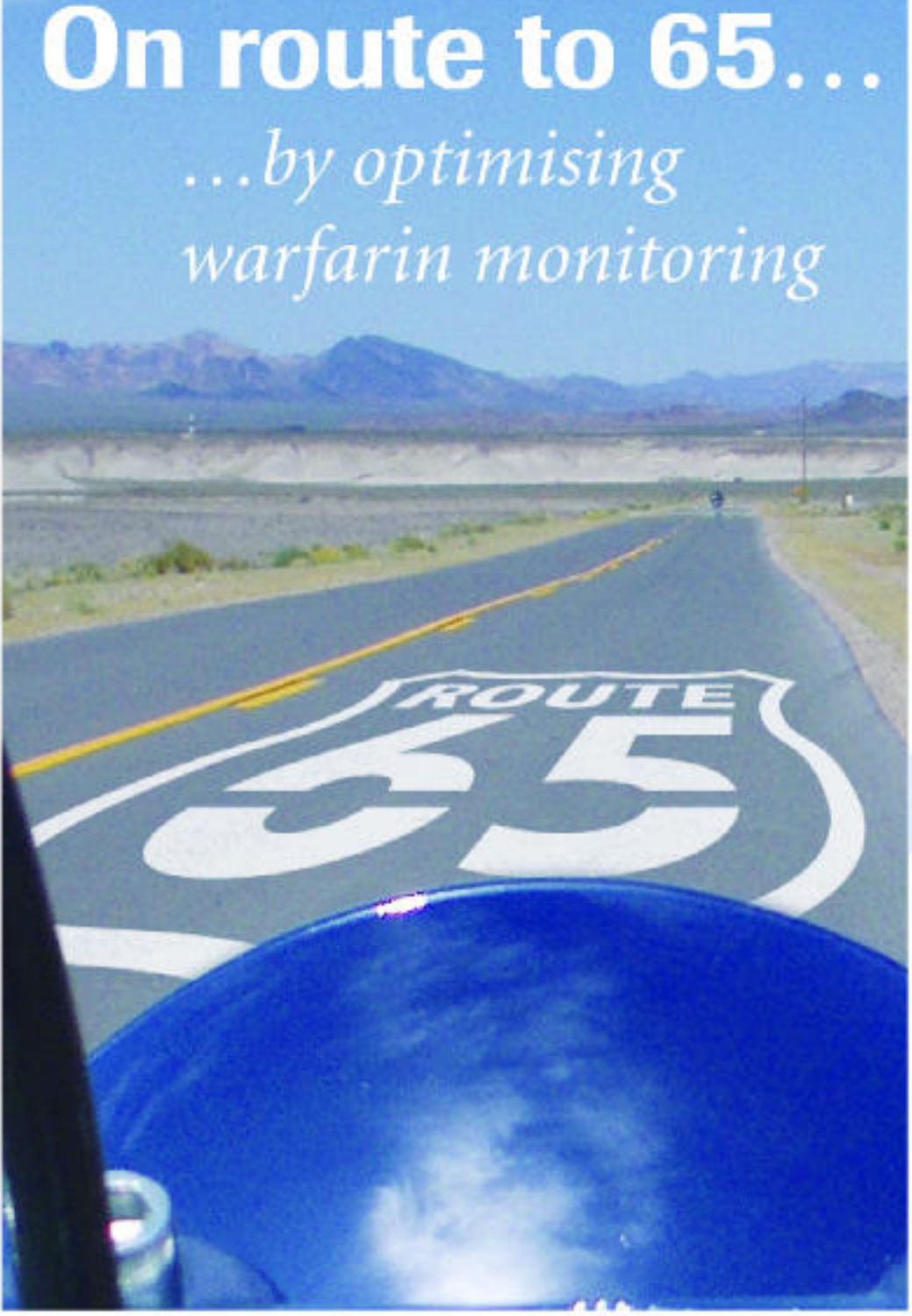
In a letter to NHS colleagues, Jim Easton, national director for improvement and efficiency at the Department of Health, said CCGs wishing for an extension of up to six months would need to apply to an expert clinical panel by 27 July.

Mr Easton said the move 'should not delay rollout in those areas that are ready to move ahead', but said it would 'help ensure that in those areas that need it, time can be taken fully to engage local clinicians and build delivery models for NHS 111 that have the support and endorsement of all local stakeholders'.

The decision comes after pressure from the BMA to delay the rollout. Last month's LMC conference raised 'serious concerns' that forcing CCGs to procure the service by April 2013 could compromise patient safety and pile additional work on GPs.

NHS Direct, which is bidding to run the service in many areas, has also called for a delay to the rollout, as has private firm Capita.

Dr Laurence Buckman, GPC chair, welcomed the decision: 'Hopefully now there will be sufficient time to ensure local clinicians are properly involved so services can be designed that will be safe, reliable and genuinely benefit patients.'



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1. Connolly SJ et al. *Circulation* 2008;**118**:2029-2037.
2. Garcia-Alamino JM et al. *Cochrane Database Syst Rev* 2010;**4**:CD003839.

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Date of preparation: March 2012

Roche

Snapshot diagnosis: swollen joints
▶ page 27

DEPRESSION

QOF depression checks proposed

NICE committee calls for 'biopsychosocial' assessment in all patients newly diagnosed with depression

By Madlen Davies

GPs would have to review all patients with depression within a month and make a full 'biopsychosocial' assessment of their living conditions and social support, under two proposed new QOF indicators.

The indicators were approved for development for next year's QOF by the NICE QOF indicator advisory committee at a meeting in Manchester last week, and will significantly extend the checks on patients with depression if given the green light by the GPC and NHS Employers.

The indicators require practices to make a full biopsychosocial assessment as part of diagnosis and also give points for reviewing recently diagnosed patients with depression within 10 to 35 days.

The biopsychosocial analysis will be divided into 16 'themes', including a patient's symptoms, any alcohol and substance use, suicidal ideation and any family history of mental illness.

GPs will also have to look at the quality of interpersonal relationships, an assessment of social support, living conditions and any employment or financial worries, and have a discussion about treatment options.

The indicators have been criticised by GPs, who accused NICE of trying to get primary care to 'solve social problems'.

The depression checks would cover 16 broad 'themes'

But the indicators were piloted in 30 practices, with over 46% in favour of the first indicator (see box, right) and 77% in favour of the second.

However, only 33% of pilot practices felt that the impact on workload would be 'minimal'.

Members of the NICE committee said telephone reviews should be permitted if a GP was very experienced and had known the patient a long time, but face-to-face consultations were preferred.

The indicators were approved for further development in pilot practices for the 2013/14 QOF and the committee will look at them again in December.

Dr Ian Walton, a GP in Tipton, West Midlands, and chair of the charity Primary Care Mental Health and Education, said: 'They're trying to get GPs to solve social problems, but where are the services to help us?

'We'd refer them to social services that have been slashed to ribbons.'

Dr Dean Marshall, GPC negotiator, said: 'This biopsychosocial assessment sounds like something many of us do anyway. Whether it needs incentivising is another question.'

@madlendavies

Proposed new indicators

1 Percentage of patients with depression in the preceding year who have had a biopsychosocial assessment by the point of diagnosis with a reasonable time frame before and after.

2 The percentage of patients with depression in the preceding year who have been reviewed within 10 to 35 days of the diagnosis.

Note: Wording may change after recommendations from pilot practices

SEMINAR

NAPC Annual Conference 2012 – napcannual.co.uk

RHEUMATOID ARTHRITIS

Annual checks for RA patients

GP practices could be required to annually review all patients with rheumatoid arthritis and assess their cardiovascular and fracture risks from next year, under a menu of proposed QOF indicators from NICE.

The indicators would incentivise practices to produce a register of all patients aged 16 and over with a 'definite' rheumatoid arthritis diagnosis from a rheumatology specialist.

They would also award points for giving those patients annual face-to-face reviews, regular cardiovascular risk assessments in those aged 40 to 85 years, and fracture risk checks.

The indicators were approved by NICE advisers at last week's meeting. They will now be considered by the GPC and NHS Employers for inclusion in the QOF in 2013/14.

The proposals were piloted in 30 practices, who reported the indicators were popular with patients as it made them feel 'special', though there were concerns the indicators would duplicate work done in secondary care.

Dr Chaand Nagpaul, GPC negotiator, said: 'We will review the evidence put forward by NICE, but we have to put this into the context of GPs having had additional work forced on them because of changes to the QOF. GPs at the LMC conference voted for stability in the QOF.'

QOF MEETING: IN BRIEF

- **An indicator for referring patients with heart failure for an exercise-based rehabilitation programme was recommended as part of a package of indicators put forward for 2013/14.**
- **Other indicators put forward for next year's QOF included asking male patients with diabetes about erectile dysfunction and offering treatment, recording the oxygen saturation of COPD patients and different blood pressure targets for patients aged over 80 years.**
- **Another indicator proposed for 2013/14 incentivises practices to review cancer patients by phone or in person within three months of a confirmed diagnosis.**
- **Indicators for targeted alcohol screening and brief interventions by GPs were rejected by the committee due to insufficient evidence.**
- **Indicators assessing the emotional and psychological needs of carers for people with dementia and encouraging ambulatory blood pressure monitoring will also be piloted.**

MORE ONLINE

▶ pulsetoday.co.uk/qof

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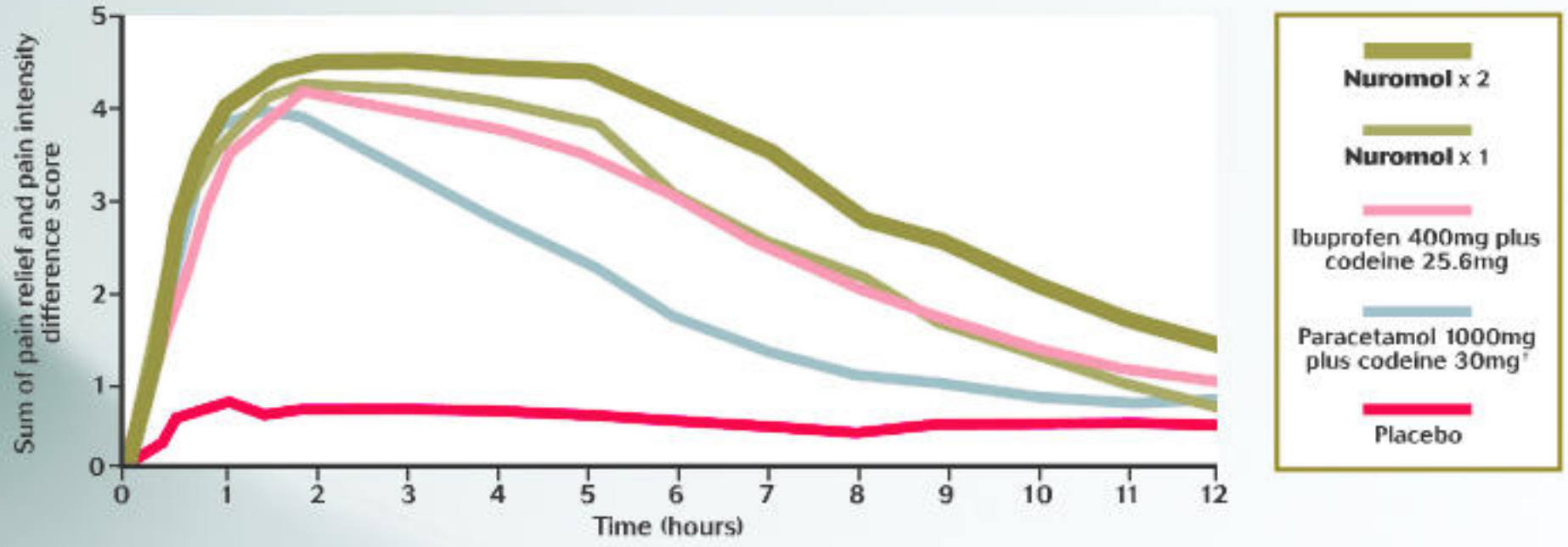

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References

1. RB Data on file: Study No. NL0811.2010. * Two Nuromol tablets compared with two tablets of Ibuprofen 200mg and Codeine 12.8mg.

Ten top tips: managing and investigating vertigo
▶ page 26

Dr Richard Scott: claimed GMC was excessively zealous

GMC warning for GP who discussed Jesus

GMC rules GP caused 'distress' by telling patient Christianity could help

By Jaimie Kaffash

A Christian GP has been issued with a GMC warning for a 'significant departure' from good medical practice after telling a patient Jesus could help cure him.

The GMC's investigations committee found Dr Richard Scott, who practises in Margate, Kent, had caused 'distress' he should have foreseen, and that it was appropriate to give a warning.

Dr Scott's case sparked widespread controversy last year over the role of religion in general practice, with GPs sharply divided over whether he should face sanctions.

The investigations committee rejected Dr Scott's claim that the discussion of Christianity lasted two and a half minutes and accused the GP of being evasive in his answers.

The ruling noted Dr Scott's previous good record, but said: 'On this occasion you caused the patient distress which you should have foreseen.

'While the allegations relate to what occurred on a single occasion, your actions nevertheless constitute a significant departure from the principles in *Good Medical Practice*. The committee considers it is appropriate, proportionate and in the public interest for the protection of the reputation of the profession to issue you with a warning.'

The hearing was postponed from last year after the patient refused to appear. The committee allowed the patient to give evidence over the phone, a move that was criticised by Dr Scott.

During the hearing last week, the prosecution had claimed Dr Scott had pushed his views on the 'psychologically troubled' 24-year-old man, known as Patient A.

Cross-examined by Andrew Hurst, counsel for the GMC, Dr Scott said it was an 'absolute fabrication' that he had 'belittled' the patient's own religion or sought to convert the patient to Christianity.

The GP, who is being treated for cancer, claimed the GMC had pursued his case with 'excessive zeal' and was 'singling out Christianity' as part of a 'wider trend to marginalise Christianity'.

Dr Scott cited research claiming Christians had less chance of getting depressed, recovered faster and were 85% less suicidal.

'I'm not just a maverick doctor reaching out to patients,' he added.

The committee heard the patient had been happy to talk about religion in the consultation and Dr Scott said he was told 'go for it'. Patient A then turned on Dr Scott, he told the committee.

Dr Scott added: 'Saying I pressed it too hard, I do not accept. I was eager, but not overeager. Had it been an entire 25-minute preach, that would have been outside guidelines.'

But Dr Jeremy Brown, a GP in Lichfield, Staffordshire, said: 'Of course we must share some of our values if we are going to help patients. Would the GMC have been involved if a discussion about meditation had caused offence?'

Dr Abbas Jeraj, a GP in Clapton, east London, said: 'Although I am a practising "religious" person myself, I don't think I would bring it up in a consultation as it does not seem appropriate.'

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1. National Institute for Health and Clinical Excellence. Technology appraisal guidance 256. May 2012.

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Use is not recommended in patients: with creatinine clearance <15ml/min; receiving concomitant systemic treatment with azole-antimycotics or HIV protease inhibitors; with prosthetic heart valves; for treatment of acute pulmonary embolism. If invasive procedures or surgical intervention are required, stop Xarelto use at least 24 hours beforehand. Restart use as soon as possible provided adequate haemostasis has been established. See SmPC for full details. Xarelto contains lactose. **Interactions:** Concomitant use with strong inhibitors of both CYP3A4 & P-gp (e.g. ketoconazole, itraconazole, voriconazole, posaconazole, ritonavir) is not recommended as increased rivaroxaban plasma concentrations to a clinically relevant degree are observed (may increase risk of bleeding). Avoid co-administration with dronedarone. Use with caution in patients concomitantly receiving other anticoagulants (e.g. enoxaparin), NSAIDs (including acetylsalicylic acid) or platelet aggregation inhibitors due to the increased bleeding risk. Strong CYP3A4 inducers (e.g. rifampicin, phenytoin, carbamazepine, phenobarbital, St. John's Wort) should be used concomitantly with caution as they may reduce rivaroxaban plasma concentrations. **Pregnancy & breast feeding:** Contra-indicated. **Effects on ability to drive and use machines:** Adverse reactions like syncope & dizziness are common. Patients experiencing these effects should not drive or use machines. **Undesirable effects: Common** anaemia, dizziness, headache, syncope, eye haemorrhage, tachycardia, hypotension, haematoma, epistaxis, GI tract haemorrhage, GI & abdominal pain, dyspepsia, nausea, constipation, diarrhoea, vomiting, pruritus, rash, ecchymosis, pain in extremity, urogenital tract haemorrhage, fever, peripheral oedema, decreased general strength & energy, increase in transaminases, post-procedural haemorrhage, contusion. **Uncommon** thrombocythaemia, allergic reaction, allergic dermatitis, cerebral & intracranial haemorrhage, haemoptysis, dry mouth, abnormal hepatic function, urticaria, cutaneous & subcutaneous haemorrhage, haemarthrosis, renal impairment, feeling unwell, localised oedema, increased bilirubin, blood alkaline phosphatase, LDH, lipase, amylase, GGT, wound secretion. **Rare** jaundice, muscle haemorrhage, increased conjugated bilirubin. **Frequency not known** pseudoaneurysm formation following percutaneous intervention, compartment syndrome secondary to a bleeding, renal failure/acute renal failure secondary to a bleeding sufficient to cause hypoperfusion. Occult or overt bleeding from any tissue or organ which may result in post-haemorrhagic anaemia and complications with variable severity (including fatal outcome). Prescribers should consult SmPC in relation to full side effect information. **Overdose:** Rare cases of overdose up to 600mg have been reported without bleeding complications or other adverse reactions. Due to limited absorption a ceiling effect is expected at supratherapeutic doses of 50mg rivaroxaban or above. No specific antidote is available. Use of activated charcoal to reduce absorption may be considered. For management of bleeding complication associated with rivaroxaban please refer to the SmPC. **Legal Category:** POM. **Package Quantities and Basic NHS Costs:** 15mg – 28 tablets: £58.80, 42 tablets: £88.20, 100 tablets: £210.00; 20mg – 28 tablets: £58.80, 100 tablets £210.00. **MA Number(s):** EU/1/08/472/011-21. **Further information available from:** Bayer plc, Bayer House, Strawberry Hill, Newbury, Berkshire RG14 1JA, U.K. Telephone: 01635 563000. **Date of preparation:** November 2011.

Xarelto® is a trademark of the Bayer Group.

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 Bayer plc. Tel.: 01635 563500, Fax.: 01635 563703, Email: phdsguk@bayer.co.uk

UK.RH.GMOXAR.2012.226e June 2012

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Decapeptyl® SR can help you meet your QIPP targets

Benefits for your **patients**

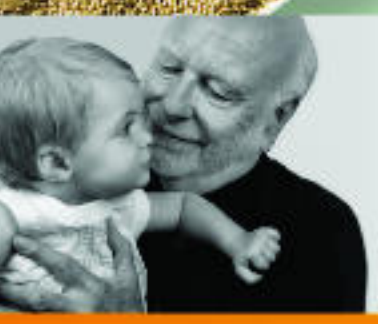
- Efficacy equivalent to the gold standard,[1] surgical castration[2-8]
- 6-monthly injections preferred by 68% of patients to 1- or 3-monthly injections[9]

Benefits for your **practice**

- Prescribing budget savings vs Zoladex® LA (19%) and Prostap®3 (8%)[10*]
- Reduction in appointment burden with 6-monthly Decapeptyl® SR

Benefits for your local prostate cancer care **pathway**

- Predictable disease control[4-6] minimises risk of additional visits or treatment
- 6-monthly injections aligned with recommended intervals for PSA tests



Decapeptyl® SR 22.5mg
triptorelin
Extending your options in prostate cancer

NOW 6 months between injections

Prescribing Information
DECAPEPTYL® SR 3mg, DECAPEPTYL® SR 11.25mg and DECAPEPTYL® SR 22.5mg
Presentation: Powder for suspension for injection. Vials for all preparations contain an overage to ensure the licensed dose is administered. Decapeptyl SR 3mg: Triptorelin acetate 4.2mg. Decapeptyl SR 11.25mg: Triptorelin acetate 15mg. Decapeptyl SR 22.5mg: Triptorelin pamoate 28mg. Triptorelin acetate and triptorelin pamoate are bioequivalent. **Uses:** Treatment of locally advanced, non-metastatic prostate cancer, as an alternative to surgical castration, and treatment of metastatic prostate cancer. As adjuvant treatment to radiotherapy in patients with high-risk localised or locally advanced prostate cancer (Decapeptyl SR 3mg, 11.25mg and 22.5mg). **Dosage and Administration:** Decapeptyl SR 3mg: One intramuscular (i.m.) injection every four weeks (28 days). Decapeptyl SR 11.25mg: One i.m. injection every 3 months. Decapeptyl SR 22.5mg: one i.m. injection every 6 months. Additional dosing information: No dosage adjustment necessary in the elderly. The injection site should be varied periodically. Inadvertent intravascular administration must be avoided. **Contraindications:** Hypersensitivity to LHRH, its analogues or any other component of the medicinal product. **Precautions and Warnings:** Long-term use of LHRH agonists is associated with an increased risk of bone loss and may lead to osteoporosis and increased risk of bone fracture. Particular caution in patients with risk factors for or established osteoporosis is necessary. Rarely, LHRH agonist treatment may reveal the presence of a gonadotropin cell pituitary adenoma. Mood changes, including depression have been reported. Patients with known depression should be monitored closely during therapy. Initially, Decapeptyl SR, like other LHRH agonists, causes a transient increase in serum testosterone levels. As a consequence isolated cases of transient worsening of signs and symptoms of prostate cancer (tumour flare) and cancer related (metastatic) pain may occasionally develop during the first weeks of treatment and should be managed symptomatically. During the initial phase of treatment, consideration should be given to the additional administration of a suitable anti-androgen to counteract the initial rise in serum testosterone levels and the worsening of clinical symptoms. As with other LHRH agonists, isolated cases of spinal cord compression or urethral obstruction have been observed. Careful monitoring is indicated during the first weeks of treatment, particularly in patients suffering from vertebral metastases, at risk of spinal cord compression, and in patients with urinary tract obstruction. After surgical castration, Decapeptyl SR does not induce any further decrease in testosterone levels. From epidemiological data it has been observed that patients may experience metabolic changes (eg glucose intolerance), or an increased risk of cardiovascular disease during androgen deprivation therapy (ADT). Patients at high risk for metabolic or cardiovascular diseases should be carefully assessed before commencing treatment and their glucose, cholesterol and blood pressure adequately monitored during ADT at appropriate intervals not exceeding 3 months. Administration of triptorelin in therapeutic doses results in suppression of the pituitary gonadal system. Normal function is usually restored after treatment is discontinued. Diagnostic tests of pituitary gonadal function conducted during and after discontinuation of therapy with LHRH agonists may therefore be misleading. **Interactions:** Drugs which raise prolactin levels should not be prescribed concomitantly as they reduce the level of LHRH receptors in the pituitary. When Decapeptyl SR is co-administered with drugs affecting pituitary secretion of gonadotropins, caution should be exercised and it is recommended that the patient's hormonal status be supervised. **Pregnancy and Lactation:** Not applicable. **Undesirable effects:** Very common: Asthenia, hyperhidrosis, back pain, paraesthesia in lower limbs and hot flush. Common: Nausea, fatigue, injection site erythema, injection site inflammation, injection site pain, injection site reaction, oedema, musculoskeletal pain, pain in extremity, dizziness, headache, erectile dysfunction and loss of libido. Rarely, cases of anaphylaxis and hypersensitivity have been reported. Prescribers should consult the Summary of Product Characteristics in relation to other side effects. **Overdosage:** No human experience of overdosage. **Pharmaceutical Precautions:** Do not store above 25°C. Reconstitute only with the suspension vehicle provided. Decapeptyl SR is a suspension, therefore once reconstituted it should be used immediately. **Legal Category:** POM. **Basic NHS cost:** Decapeptyl SR 3mg £69.00 per vial. Decapeptyl SR 11.25mg £207.00 per vial. Decapeptyl SR 22.5mg £414.00 per vial. **Marketing Authorisation Numbers:** Decapeptyl SR 3mg: PL 34926/0002. Decapeptyl SR 11.25mg: PL 34926/0009. Decapeptyl SR 22.5mg: PL 34926/0013. **Marketing Authorisation Holder:** Ipsen Ltd, 190 Bath Road, Slough, Berkshire, SL1 3XE, UK. Tel 01753 627777. Date of preparation of PI: December 2011.
Ref: UK/DEC/0622a (On Adjuvant licence)

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 the Ipsen Medical Information department on 01753 627777 or medical.information.uk@ipsen.com

1. Heidenreich A et al. Guidelines on Prostate Cancer. European Association of Urology 2011.
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10. MIMS January 2012.

* £1 NHS list price and licensed posology

Date of preparation: January 2012. DEC0622b

Relax, Urgency controlled

Vesicare®

solifenacin

ABBREVIATED PRESCRIBING INFORMATION

Presentation: Vesicare® film coated tablets containing 5 mg or 10 mg solifenacin succinate. **Indication:** Symptomatic treatment of urge incontinence and/or increased urinary frequency and urgency as may occur in patients with overactive bladder syndrome. **Dosage:** *Adults:* Recommended dose: 5 mg once daily. If needed, the dose may be increased to 10 mg once daily. *Children and adolescents:* Should not be used. **Contraindications:** Urinary retention, severe gastrointestinal condition (including toxic megacolon), myasthenia gravis or narrow-angle glaucoma and in patients at risk for these conditions. Patients hypersensitive to the active substance or to any of the excipients, or undergoing haemodialysis, or with severe hepatic impairment, or with severe renal or moderate hepatic impairment and on treatment with a potent CYP3A4 inhibitor. **Warnings and Precautions:** No clinical data are available from women who became pregnant while taking solifenacin. Caution should be exercised when prescribing to pregnant women. The use of Vesicare® should be avoided during breast-feeding. Assess other causes of frequent urination before prescribing. Use with caution in patients with clinically significant bladder outflow obstruction, at risk of urinary retention, gastrointestinal obstructive disorders, risk of decreased gastrointestinal motility, autonomic neuropathy, severe renal or moderate hepatic impairment (doses not to exceed 5 mg), concomitant use of a potent CYP3A4 inhibitor, hiatus hernia/gastroesophageal reflux and/or patients currently taking medicines that can cause or exacerbate oesophagitis. Angioedema with airway obstruction has been reported with some patients on Vesicare. Patients with rare hereditary problems of galactose intolerance, the Lapp lactase deficiency or glucose-galactose malabsorption should not take this medicinal product. **Interactions:** Concomitant medication with other medicinal products with anticholinergic properties may result in more pronounced therapeutic effects and undesirable effects. Allow one week after stopping Vesicare® before commencing other anticholinergic therapy. Therapeutic effect may be reduced by concomitant administration of cholinergic receptor agonists. Can reduce effects of stimulators of gastrointestinal tract motility. If used concomitantly with ketoconazole or other CYP3A4 potent inhibitor, maximum dose should be 5 mg due to 2-3 fold increase in AUC of Vesicare. Pharmacokinetic interactions are possible with other CYP3A4 substrates with higher affinity and CYP3A4 inducers. **Adverse Effects:** Dry mouth, blurred vision, constipation, nausea, dyspepsia, abdominal pain, urinary tract infection, peripheral oedema, colonic obstruction, rash, urinary retention, hallucinations, confusional state, angioedema. In worldwide postmarketing experience, QT prolongation and Torsade de Pointes have been reported in association with Vesicare® use, but the frequency of events and the role of Vesicare® in their causation cannot be reliably determined. *Prescribers should consult the Summary of Product Characteristics in relation to other side effects.* **Basic NHS Cost:** Vesicare® 5 mg blister packs of 30 tablets £27.62; Vesicare® 10 mg blister packs of 30 tablets £35.91. **Legal Category:** POM. **Product Licence Number:** Vesicare® 5 mg PL 00169/0197; Vesicare® 10 mg PL 00169/0198. **Date of Revision:** October 2011. **Further information available from:** Astellas Pharma Ltd, 3rd Floor, Future House, The Glanty, Egham, Surrey, TW20 9AH. Vesicare® is a Registered Trademark. For full prescribing information please refer to the Summary of Product Characteristics. For medical information phone 0800 783 5018.

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 Astellas Pharma Ltd. Tel: 0800 783 5018.

Date of preparation: April 2012
VEST2142UKb

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Face-to-face appraisal 'unreliable'

Researchers suggest anonymous assessment of portfolios should judge if doctors are fit to practise

By Emma Wilkinson

GPs could be forced to submit a portfolio of work online to three anonymous assessors in order to prove they are fit to practise, under a much tougher model of appraisal developed by researchers.

The research – part-funded by the RCGP – raises questions over the reliability of a face-to-face appraisal as a basis for revalidating doctors. The team from Dundee University developed the model as they said there was a 'sparse evidence base' for the use of face-to-face appraisals and that anonymous appraisers offered a more 'robust' alternative.

The GMC, currently preparing to roll out revalidation from the end of this year, said the research offered 'useful insights' and could be used at a local level to improve appraisal methods in revalidation.

The researchers applied a new online method of gathering a portfolio of evidence called 'insightful practice' to a cohort of 61 GPs. The method involved GPs reflecting and setting goals based on a portfolio of colleague and patient opinions, clinical governance information, self-tested knowledge and practice complaints.

The study – published in *BMJ Quality and Safety* last month – found an anonymous evaluation of the portfolios by three appraisers scored GPs significantly lower than the usual assessments by a single face-to-face appraiser.

Dr John Ashcroft: appraisal process is 'fundamentally weak'

Face-to-face assessments found none of the portfolios were unsatisfactory, whereas repeat anonymous marking highlighted 23% (42 of 180 evaluations) that did not meet required standards.

The researchers concluded: 'Face-to-face appraisal could not be classed as reliable. In contrast, high reliability was demonstrated by anonymous global assessment by three assessors.'

Study leader Dr Douglas Murphy, senior clinical research fellow at the University of Dundee, said it was common sense that multiple opinions were always going to be more reliable than one: 'Our findings show that face-to-face judgment [by] one appraiser may be a bit too much to ask.'

Niall Dickson, chief executive of the GMC, said: 'This research offers useful insights as we implement revalidation.'

Dr John Ashcroft, a GP in Derbyshire, said: 'The whole appraisal process is fundamentally weak – I would like to see an exam brought in that has to be taken every five years.'

feedback@pulsetoday.co.uk

In numbers

180
Number of portfolios evaluated

42
Number of portfolios graded as unsatisfactory by anonymous appraisers

0
Number of portfolios graded as unsatisfactory by face-to-face appraisers

Source: *BMJ Quality and Safety* 2012, online 31 May

BMA: Plan to widen FTP hearings 'flawed'

The BMA has rejected plans to widen the scope of fitness-to-practise hearings, warning the proposals would place a 'huge strain' on doctors and would lead to 'flawed' judgments from the GMC.

The plans to remove the current five-year limit on investigating complaints and reduce the evidence threshold for complaints were heavily criticised in a strongly worded BMA response to a consultation on the proposals.

The response says the plans, which were developed by the Law Commission for all UK health departments, would undermine faith in the GMC and would be detrimental for doctors.

It said: 'It would be a huge commitment for the regulators to investigate all allegations, not to mention a huge strain on professionals whose conduct has been brought into question.'

Pulse revealed in March that the Law Commission proposals would mean GPs could be investigated over events from many years ago, and potentially for the same incident twice.

Co-author of the BMA response Dr Richard Vautrey, deputy chair of the GPC, said: 'We want to avoid fishing expeditions where an excuse is used to look for elements to justify an investigation.'

IN BRIEF

Satisfaction drops

Public satisfaction with the NHS has plummeted from 70% to 58% in a year, a survey has found.

Full story ▶ pulsetoday.co.uk/politicalnews

Age ban criticised

GP commissioning leaders have criticised the Government's 'knee-jerk reaction' in announcing a ban on age discrimination in the NHS.

Full story ▶ pulsetoday.co.uk/commissioningnews

DDA fights back

The Dispensing Doctors Association has hit back at what it called a campaign to 'blacken the name' of dispensing doctors.

Full story ▶ pulsetoday.co.uk/practicenews

Seven steps your practice can take to boost flu vaccine uptake
▶ page 29

DH backs elderly care standards

Guidance drawn up with RCGP sets new 30-minute target for GPs to respond to all urgent calls from elderly

By Pat Anderson

GPs should respond to all urgent calls for help from elderly patients 'within 30 minutes', according to new standards developed with the RCGP published this week.

The advice says the new 'clinical audit standard' is needed to reduce the 'greater variability' in response times from GP practices in hours, compared with out of hours.

The 'silver book' – endorsed by the Department of Health – also suggests an annual national audit of primary care response times to urgent requests from elderly people.

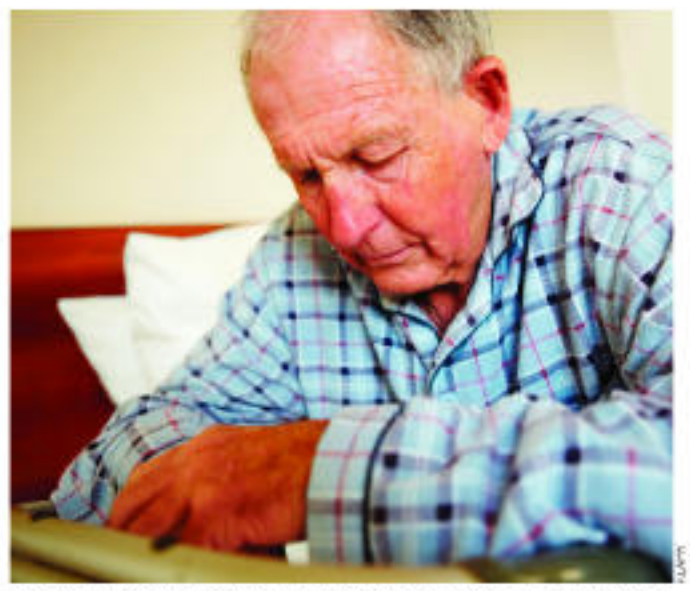
It says CCGs should set up multidisciplinary teams to respond to all requests from older patients who have conditions such as dementia, delirium or incontinence, and they should be assessed within two hours.

The standards – designed to ensure frail elderly people are kept out of hospital – were published by the University of Leicester and drawn up with representatives from several major medical organisations, including the British Geriatric Society, the Royal College of Physicians, the RCGP and the Royal College of Nursing.

They have also been endorsed by the DH national clinical directors for older people, dementia and urgent and emergency care.

'Acutely ill older people are very sensitive to delays in care,' the guidance says. 'The longer they wait for a definitive consultation, opinion, investigation and treatment, the more likely they are to end up attending the hospital.

'[There is] often greater variability in the urgent care response by GP practices during office hours compared to out of hours. There must be an initial primary care response to an urgent request for help from an older person within 30 minutes.'



The 'silver book' outlines a raft of new standards for elderly care

Co-author Dr Agnelo Fernandes, a GP in Croydon and chair of the Croydon commissioning group, insisted the advice was feasible for practices to implement.

He added: 'Given that [elderly patients] have a high probability of ending up in hospital, if a call comes in, a GP should carry out a telephone investigation to determine the urgency and get an idea of what's needed.'

But Dr Robert Morley, secretary of Birmingham LMC, described the 30-minute standard as 'nonsense' and warned it could 'distort' clinical priorities: 'Bringing in arbitrary targets and deadlines isn't going to help.

'Some requests need to be dealt with within seconds and others within several days.'

A DH spokesperson said the 'silver book' was a 'welcome publication': 'It is about what good practice looks like, not conducting additional assessments.'

feedback@pulsetoday.co.uk

What the 'silver book' says

- **Initial response to an urgent request for help from an older person should occur within 30 minutes.**
- **A 24/7 single point of access should be commissioned to provide a two-hour multidisciplinary response for frail patients.**
- **GPs should consider medication review to identify inappropriate prescribing, and should not over-use urine dipstick testing.**

Source: University of Leicester. *Quality standards for the care of older people with urgent and emergency care needs*. June 2012

Clinics 'don't tell GPs about AF'

Patients with pacemakers are being left at a higher risk of stroke because pacing clinics are not informing GP practices when they develop atrial fibrillation (AF), say UK researchers.

Their study found a quarter of patients at pacing clinics were not being considered for anticoagulation therapy after they developed AF. The retrospective review of the records of 282 patients attending routine outpatient pacing clinics in Norwich found around a third – 95 patients – developed AF.

But the researchers – presenting their data at the British Cardiovascular Society's annual conference in Manchester last month – also warned half of those with AF were not on anticoagulation therapy and that a major factor was that GPs were not being told.

For a quarter of the patients, their GP and hospital specialist were not informed that the patient had developed AF, so were never considered for anticoagulation therapy.

Lead author Dr Vassilis Vassiliou, a specialist registrar in cardiology at Papworth Hospital in Cambridge said: 'A routine pacing clinic review offers an ideal opportunity for identification of AF. Liaising with the GP however, is essential to optimise anticoagulation uptake.'

Ignore CMO advice on flu initiatives, says GPC

Practices have been advised by the GPC to ignore instructions from the chief medical officer over how to invite eligible patients for flu vaccination.

A recent letter from Professor Dame Sally Davies outlining details of the 2012/13 flu vaccination campaign said GPs should send all eligible patients a letter inviting them to a clinic or to make an appointment. But the GPC has said this 'does not reflect the requirements' of the national directed enhanced service and it is up to practices how they advertise flu vaccination.

Dr Bill Beeby, chair of the GPC clinical and prescribing subcommittee, said: 'We have been looking at other ways including messages in the surgery or reminders with repeat prescriptions – there are a number of ways which don't include sending letters. It is up to practices to decide how to communicate with their population.'

▶ Seven steps to achieving better flu vaccine uptake, page 29

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Balneum Plus Cream Prescribing Information: (Please refer to full Summary of Product Characteristics [SmPC] before prescribing) Balneum Plus Cream contains lauromacrogols 3.0 % w/w and urea 5.0 % w/w. Uses: For the treatment of pruritic, eczematous dermatoses and scaling skin conditions where an anti-pruritic and hydrating effect is required. It may also be used for the continued treatment and follow-up treatment of these skin diseases. Dosage and administration: Adults, the elderly and children: Apply to each affected area twice a day. The duration of treatment depends on the clinical response. Contraindications: Patients with known hypersensitivity to any of the ingredients. It should not be used to treat acute erythroderma, acute inflammatory, pustular or infected skin lesions. Special warnings and precautions for use: May cause irritation if applied to broken or inflamed skin. Pregnancy and lactation: There are no specific restrictions concerning its use during pregnancy, but it is not to be used on the breasts immediately prior to breast feeding during lactation. Undesirable effects: Balneum Plus Cream has been reported to cause a sensitisation reaction, manifested by the formation of pustules, aggravation of eczema if applied to inflamed skin areas. Contact allergic reactions have been reported. Package quantities: 100 g tube and 500 g pump pack. Basic NHS cost: 100 g £7.26, 500 g £14.96. Legal category: GSL. Product licence number: PL 39010/0010. Product licence holder: Almirall Hermal GmbH, Scholtzbrücke 3, Postfach 1220, D-21481, Reinbek, Hamburg, Germany. Date of preparation: January 2011. Further information is available from: Almirall plc, 4 The Square, Stockley Park, Uxbridge, UB11 1ET.

Adverse events should be reported. Reporting forms and information can be found at www.yellowcard.gov.uk. Adverse events should also be reported to Almirall Ltd on 0800 00 87399.

Date of preparation: January 2011. (ASDV060)

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THE DOSE SHOULD ONLY BE INCREASED ON MEDICAL ADVICE[4]

Once Daily
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References:
1. Donohue JF. *et al. Am J Respir Crit Care Med* 2010;**182**:155-162. **2.** Buhl R. *et al. Eur Respir J* 2011;**38**:797-803.
3. Yorgancioglu A. *et al.* Poster presentation at European Respiratory Society Annual Congress, Vienna, September 2009.
4. Onbrez Breezhaler, Summary of Product Characteristics, July 2011.

Date of preparation: March 2012 IND12-C052

Prescribing information can be found overleaf

NOVARTIS

Onbrez® Breezhaler® ▼150 and 300 microgram inhalation powder, hard capsules (indacaterol)
Indications: Onbrez Breezhaler is indicated for maintenance bronchodilator treatment of airflow obstruction in adult patients with chronic obstructive pulmonary disease (COPD). **Presentation:** Clear colourless capsules for inhalation containing indacaterol maleate equivalent to 150 or 300 micrograms of indacaterol. **Dose and administration:** The recommended dose is the inhalation of the content of one 150 microgram capsule once a day using the Onbrez Breezhaler device. The dose should be increased only on medical advice. The inhalation of the content of one 300 microgram capsule once a day using the Onbrez Breezhaler device has been shown to provide additional clinical benefit with regard to breathlessness, particularly for patients with severe COPD. The maximum dose is 300 micrograms once daily. Onbrez Breezhaler should be administered at the same time of day each day. No dose adjustment is required for elderly patients or patients with renal or mild-to-moderate hepatic impairment. There are no data on patients with severe hepatic impairment. Onbrez Breezhaler capsules are for inhalation use only and must not be swallowed. There is no relevant use of Onbrez Breezhaler in patients under 18 years. **Contraindications:** Hypersensitivity to the active substance, lactose or gelatin. **Precautions:** Onbrez Breezhaler is not for use in asthma due to the absence of long-term data. As with other inhalation therapy, administration of Onbrez Breezhaler may result in paradoxical bronchospasm that may be life-threatening. In this event Onbrez Breezhaler should be discontinued immediately. Onbrez Breezhaler is not indicated for the treatment of acute episodes of bronchospasm. In the event of deterioration of COPD during treatment, re-evaluation of the patient should be undertaken. Indacaterol should be used with caution in patients with cardiovascular disorders, patients with convulsive disorders or thyrotoxicosis, and in patients who are unusually responsive to beta$_2$-adrenergic agonists. Indacaterol may produce a clinically significant cardiovascular effect in some patients as measured by pulse rate, blood pressure and/or symptoms. Beta$_2$-adrenergic agonists may produce significant hypokalaemia in some patients, which has the potential to produce adverse cardiovascular effects. The decrease in serum potassium is usually transient, not requiring supplementation. Inhalation of high doses of beta$_2$-adrenergic agonists may produce increases in plasma glucose. Diabetic patients should be monitored more closely upon initiation of Onbrez Breezhaler. **Drug interactions:** Concomitant administration of other sympathomimetic agents may potentiate the undesirable effects of Onbrez Breezhaler. Onbrez Breezhaler should not be used in conjunction with other long-acting beta$_2$-adrenergic agonists. Methylxanthine derivatives, steroids or non-potassium-sparing diuretics may potentiate the possible hypokalaemic effect of beta$_2$-adrenergic agonists. Beta-adrenergic blockers may weaken or antagonise the effect of beta$_2$-adrenergic agonists: Onbrez Breezhaler should not be given together with beta-adrenergic blockers. In those situations, cardioselective beta-adrenergic blockers are preferred. Inhibition of CYP3A4 and p-glycoprotein raises the systemic exposure of Onbrez Breezhaler, though the magnitude of exposure in clinical studies up to one year does not raise any safety concerns. **Undesirable effects:** Common (≥1/100 to <1/10) Nasopharyngitis, upper respiratory tract infection, sinusitis, cough, pharyngolaryngeal pain, rhinorrhoea, respiratory tract congestion, diabetes mellitus, hyperglycaemia, headache, ischaemic heart disease, muscle spasm, peripheral oedema. Uncommon (≥1/1000 to <1/100) Paraesthesia, atrial fibrillation, non-cardiac chest pain. Cough In clinical studies 17-20% of patients experienced a sporadic cough that occurred usually within 15 seconds of inhalation and typically lasted 5 seconds. This cough was generally well tolerated and there is no evidence that cough experienced post-inhalation is associated with bronchospasm, exacerbations, deteriorations of disease or loss of efficacy. **Quantities and based NHS price (excl. VAT):** Onbrez Breezhaler with 30 day supply of capsules: 150 micrograms £29.26, 300 micrograms £29.26. **Marketing authorisation number** 150 micrograms: EU/1/09/593/001-005, 300 micrograms: EU/1/09/593/006-010. **Legal category:** POM. **Date of last revision of prescribing information:** August 2011

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Cochrane review questions benefit of tight control in type 2 diabetes

DIABETES

Hypo risk may outweigh benefit of lower HbA$_1$c

By David Swan

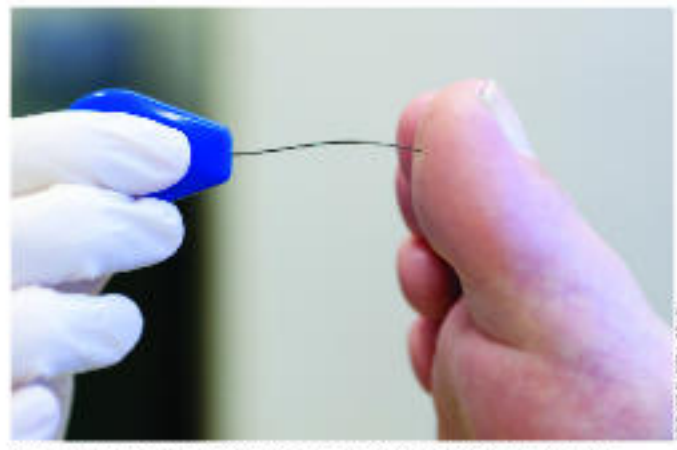
Aggressively lowering blood glucose in patients with type 2 diabetes only slightly reduces the risk of developing neuropathy, but greatly increases the risk of hypoglycaemia, according to the authors of a Cochrane review.

They found patients with type 2 diabetes had less than a 1% reduction in the risk of neuropathy when their HbA$_1$c levels were lowered below 9.6mmol/l (7%), but a threefold increase in hypoglycaemic events.

The US researchers said the results suggest GPs have to maintain a delicate balance when choosing whether to aggressively reduce blood glucose.

The systematic review looked at 17 trials involving patients with type 1 and type 2 diabetes that ran for at least 12 months, where the presence of peripheral neuropathy had been measured.

They assessed the risk of developing neuropathy in patients with both type 1 and type 2 diabetes whose blood glucose was lowered below 9.6mmol/l (7%) and compared it with those who had standard treatment – defined as an HbA$_1$c of 9.6-13.5mmol/l (7-9%).



Neuropathy risk is only slightly reduced with tight control

There was a significant 1.84% difference in the annual risk of developing neuropathy between the intensive and standard treatment groups in patients with type 1 diabetes.

But the outcomes for patients with type 2 diabetes were less impressive – with a difference in annual risk of just 0.58% in favour of those treated aggressively.

For patients treated aggressively with type 1 diabetes, three of the seven studies reported a threefold increase in hypoglycaemic events, while another found 3.9% of glucose measurements were in the hypoglycaemic range in intensively controlled patients, compared with 2.2% in the standard care group.

Similar rates of hypoglycaemia were present in patients with type 2 diabetes, with the three largest studies also showing threefold increases in risks.

The authors said their data left GPs with a dilemma over the aggressive control of glucose in patients with type 2 diabetes, although the benefits were clearer in patients with type 1 diabetes.

Study leader Dr Brian Callaghan, a neurologist at the University of Michigan, US, said: 'While these results show clear improvement in the prevention of neuropathy in those with type 1 diabetes and potential benefits to those with type 2 diabetes, the precise glucose control target remains to be defined and potential adverse events must be weighed in the decision.'

Dr Rubin Minhas, clinical director of the BMJ Clinical Evidence Centre and a GP in Hoo, Kent, said: 'This adds to the increasing evidence that lowering glucose too far can be detrimental.'

***Cochrane Database Syst Rev* 2012, online 12 June**

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DEMENTIA

Depression increases dementia risk 'up to 70%'

Depressive symptoms that develop in midlife or late life are associated with a substantially increased risk of developing dementia, say US researchers.

The risk of developing Alzheimer's disease or vascular dementia was assessed in 14,000 Kaiser Permanente members, where depressive symptoms were recorded in their notes when they were aged between 40 and 55 years old, when they were around 70 years or older, or both. The overall risk of dementia was increased by 21% in those with midlife depression, 72% for later life depression and 77% for both.

Study leader Dr Kristine Yaffe, a psychiatrist at the University of California, San Francisco, said: 'We need to know whether adequate treatment of depression helps maintain cognitive function. Even a small reduction in dementia risk would have a tremendous public health impact.'

***Arch Gen Psychiatry* 2012;69: 493-8**

OBESITY

Low carb/high fat diet 'has no impact on BMI'

A low carbohydrate/high fat diet is associated with a rise in serum cholesterol and has no impact on BMI levels, according to a large population study in Sweden.

The Västerbotten Intervention Programme in north Sweden was set up in 1985 and looked the diet of 140,000 people over 25 years. It found that in 1986, fat made up 39% of men's energy intake and 35% of women's.

This dropped by 2.9% in men and 4.4% in women over the next six years, and then started to rise sharply – reaching 40% in men and 38% in women in 2010.

Serum cholesterol also started to rise at the same time, coinciding with the growing popularity of low carb/high fat diets.

Professor Anna Winkvist, professor of nutrition at the University of Gothenburg, said: 'The weight reduction claims for high-fat diets were not seen, and in fact BMIs rose.'

***Nutr J* 2012;11:40**

CVD

Pre-diabetes increases stroke risk by 25%

Patients with pre-diabetes have around a 25% increased risk of stroke independent of other cardiovascular risk factors, concludes a large meta-analysis.

Researchers examined data from 15 studies involving more than 700,000 patients. In trials that defined pre-diabetes as NICE does – a fasting blood glucose between 6.1-6.9mmol/l – there was a 21% increase risk of stroke after adjusting for CVD risk factors, compared to people with normal blood glucose.

In trials where patients had a level of impaired glucose tolerance or impaired fasting glucose that was undefined, the risk was greatest, with an increase of 26%.

Study leader Professor Bruce Ovbiagele, director of the stroke programme at the University of California medical centre, said: 'An immediate implication of our finding is that people with pre-diabetes should be aware they are at increased risk of stroke.'

***BMJ* 2012, online 7 June**

DEPRESSION

Adult depression 'not helped by exercise'

Adults with depression receive no additional benefit from exercise as an adjunctive treatment for depression, a new study has found.

The trial allocated 361 adults who had recently consulted their GP with symptoms of depression to usual care, or usual care plus exercise.

Those in the exercise group had up to three face-to-face sessions and 10 phone calls with a physical activity facilitator over eight months. Both groups started with a mean Beck depression inventory score of 32.1 and those in the exercise group had a mean score of 12.59 at 12 months' follow-up, compared with 13.47 in the usual care group – a non-significant difference.

Study leader Professor John Campbell, professor of general practice at the Peninsula Medical School, Exeter, said: 'There are many other benefits, but drugs and talking therapies should be first line.'

***BMJ* 2012, online 6 June**

GRÜNENTHAL

ADVANCING KNOWLEDGE IN ANALGESIA

THE BURDEN OF CHRONIC PAIN ON THE NHS

Dr Martin Johnson, a GP and Clinical Champion for Pain, Royal College of General Practitioners

May I start with a question for you? How do you truly view the accurate assessment of chronic pain problems in your patients? Worthwhile? Easy? Time-consuming? These are some of the responses that I get when I ask the same question when I give my lectures on chronic pain. Fundamentally many health care professionals fail to realise what chronic pain is and also the burden it creates on society and the individual. In this brief article I will address these issues and some of the initiatives that have been set up to tackle the problem.

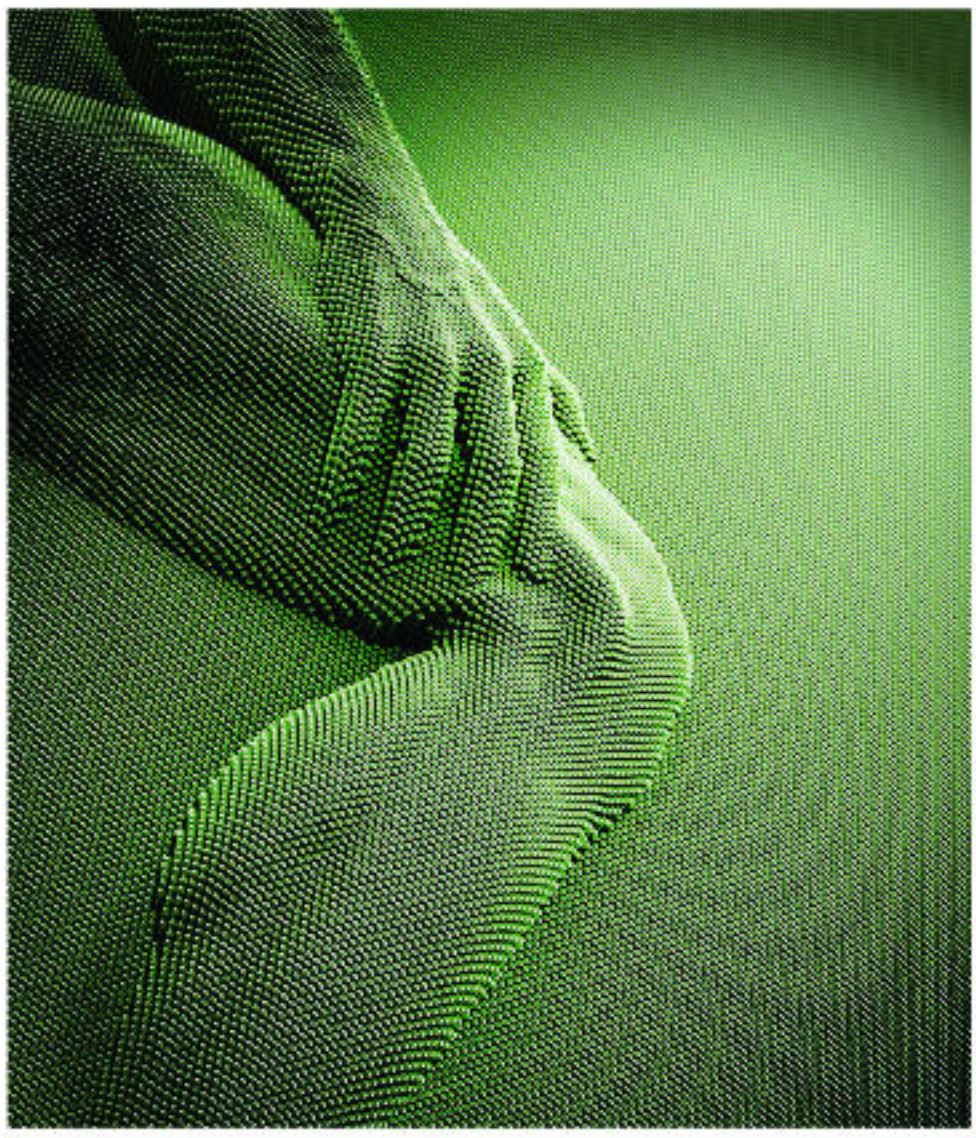
Chronic pain should not simply be looked at as acute pain that is repeated many times. Usually chronic pain is thought to exist if the pain persists for more than three months, especially if it is beyond the normally expected healing time. Research is increasing our knowledge that chronic pain is caused by changes in the structure and function (with amplification of transmission and reduction of inhibition)[1] of the nervous system (brain, spinal cord and periphery) enough for many to believe that chronic pain is a disease in it's own right[2] and that it should be regarded as a Long Term Condition (LTC). Unfortunately many seek to 'solve' the initial cause of the pain failing to understand that the cause is the development of chronic pain, often separate from the initial causative factor. The result? Multiple unnecessary referrals within an overburdened NHS.

Statistics abound in chronic pain. It is often quoted that the prevalence of pain in the UK is 13%[3] but just one Joint Strategic Needs Assessment from a PCT[4] found that one in three patients had pain problems which were rated by patients as having a higher impact on their lives than any other LTC.

Back pain alone costs the UK economy £12 billion[5] with the same report showing that £584 million was spent on prescriptions for pain. Chronic pain is a presenting condition in 22% of primary care consultations;[6] patients with chronic pain consult their general practitioners five times more frequently that those without pain.[6]

There is often a delay in the diagnosis of chronic pain, shown by the diagram to the right.

Chronic pain is known to have adverse effects on employment status, daily activities, relationships, mood, sleep and all aspects of general health.



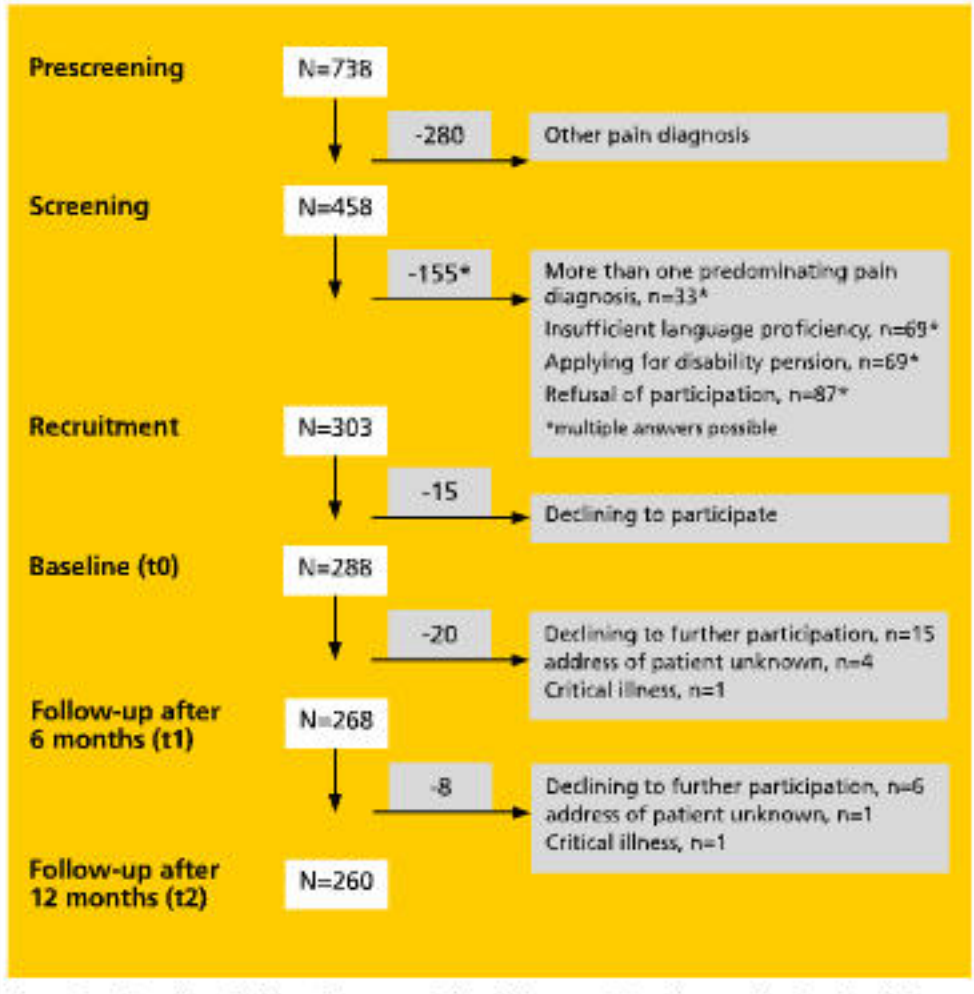


Chart of patient flow: Findings from a study involving over 300 patients with chronic pain[7]

To help deal with the problem of chronic pain several initiatives are in progress; the Royal College of General Practitioners made pain a clinical priority (2011 to 2014),[5] a National (England) Pain Summit took place in London in November 2011 looking at developing strategies in Education, Public Health & Commissioning for chronic pain,[8] and the British Pain Society and the Map of Medicine are developing five national pathways in chronic pain – all to be launched this year.[9]

At a European level a White Paper has made several recommendations, including that pain should be a Public Health Priority.[10]

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For further education on chronic pain you may wish to consider 'CHANGE PAIN' www.change-pain.co.uk – an innovative educational programme sponsored by Grünenthal Ltd. It is a non-promotional resource providing UKCEA-approved learning modules and has an objective to share knowledge with healthcare professionals in order to advance the management of patients suffering from chronic pain.

To quote a recent article that I co-authored in the British Journal of General Practice,[11] 'general practice can be characterised as the art of unravelling the medically unexplained – good pain assessment and management is a core component of general practice.'

Dr Johnson has received guidance and an honorarium from Grünenthal Ltd for writing this article. Grünenthal Ltd have had no editorial control over the content but it has been checked for factual accuracy. All costs associated with the production of this advertorial have been funded by Grünenthal Ltd.

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CT2 0001 Date of Preparation: April 2012

Boundary pilots need more time

Giving patients a greater choice of GP is one of those long-standing ministerial ambitions that seems to have been lingering forever on the Department of Health's to-do list.

In 2003, for instance, then-health secretary John Reid was talking dual registration. In 2005, the community health white paper was expected to end GPs' right to set boundaries. In 2006 it was Patricia Hewitt's turn, then Lord Darzi's. And in 2009, Andy Burnham finally set in motion the plans that have resulted, belatedly and under a new Government, in the current practice boundary pilots.

Those pilots, reluctantly agreed by the GPC as part of the 2012/13 contract deal, have been slow to get off the ground. They were supposed to begin in April, then LMCs in east London announced a boycott. Almost three months on the whole project is in disarray, with four of the six pilot areas yet to begin and three still to persuade a single GP to take part.

Steve Nowottny
Acting editor

In the meantime, official hyperbole has continued unabated, with NHS research predicting 120,000 commuters could choose to register in the City of London alone. So far, somewhat bathetically, the six pilot areas between them have registered just 12.

Why are practices so wary? Most GPs are not against the notion of offering choice – they just doubt it's something patients want a cash-strapped NHS to prioritise. But on boundaries, they are cautious – because they know the devil is in the detail. Who will cover urgent care and home visits? How and where will patients be given access to community-based services? Who will pick up the prescribing and secondary care costs for 'day patients'? And how will commissioning budgets be affected? These are the kind of complex but crucial questions the pilots haven't even begun to thrash out.

Currently, the DH is vague on exactly when the pilots will be evaluated. The official Patient Choice Scheme directions underpinning the pilots state they will end on 1 April 2013, although this week the DH insisted it wanted to learn from practices that joined late, and suggested the deadline could be in doubt.

Judging by the progress so far – or lack of

it – concluding the pilots next April is simply not realistic. Last week the Government reluctantly pushed back its deadline for the rollout of the 111 urgent care number. Now it must do the same on practice boundaries.

If ministers are to press ahead with a national rollout, it will be vital to have properly trialled the policy first and worked through the small print. After a decade or more of waiting, a further delay of six months or a year will be time well spent.

But it may also be that once the pilots are completed, the DH realises the policy it has been so doggedly pursuing is neither practical nor cost-effective. The pilots must determine not just how boundaries are abolished – but whether it really makes sense to abolish them at all.

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PhilPeverley

A pussy-footed sort of protest

What's the point of taking industrial action if nobody is inconvenienced except us, asks **Phil**

So, tomorrow, we're all on strike. That's the public perception. That's what everybody thinks, if they think about it at all, which most people won't. There may be about a million interactions between the public and primary care on any given weekday, which sounds a lot. But it also means that there are another 59 million interactions across the UK that don't happen.

It's not a strike, of course, it's industrial action (although the press and our political leaders seem keen to promote it as a strike). But the more you chase this abstract concept, the more elusive it seems. What exactly does industrial action mean? When I heard the result of the BMA ballot, I was immediately online looking for one of those braziers that you apparently have to stand around if you want anyone to take you seriously as a picket line. But donkey jacket sales remain resolutely flat, and the offer of police overtime is not pulling in many punters.

Here in the northeast, the Metro train drivers have chosen to go on strike on the two days of the two big concerts at Sunderland's Stadium of Light. The Coldplay gig has already been disrupted, and at the time of writing, another strike is planned for tomorrow. Want to see Bruce Springsteen? Don't go by the Metro. The drivers want you to feel the pain.

We GPs, on the other hand, seem to want to have the most pussy-footed and deferential industrial action in the entire history of proletarian protest. What is the point of hoisting a placard if our main stated aim is not to inconvenience anybody, to the point where they'd not notice that we were doing anything at all? And why, if we're being pragmatic, should we refuse to do any work when we are perfectly well aware that nobody else is ever going to do it for us and we'll just have twice as much to do the next day?

Take my own practice. I'm not a member of the BMA for ideological reasons – I've resigned twice on points of principle, and it would look odd if I joined again for a third time – but I'm the only one who plans to take any action on the day. So I won't see any booked patients, but I will see 'urgent extras', and as it is our patients who define the word 'urgent', it is a given that I'll see the same number of patients that I usually do. My last patient today, for example, insisted on seeing me this afternoon even if it did mean her and me staying back half an hour after everyone else had left the building. The psoriasis on her scalp remained, I am assured, even after the 10 years since the diagnosis, very itchy.

We seem desperate for our patients to love us

But what's the point? I'm not actually paid by anyone, as we are self-employed and take profits from a company, so nobody can deduct anything from my salary. If we partners persuaded our salaried colleagues to take action for the day but still be on the premises for emergencies, we could technically dock their pay and be better off ourselves. (I'll personally come round and beat up any GP who does that, by the way.) And our registrars and F2 trainees, our colleagues most vulnerable to this detestable and cynical manipulation of our previously-agreed pension arrangements, are paid by authorities over which we have no control.

We seem to be desperate for our patients to love us. I don't believe we need to bother about that. I've had conversations about medical pensions with three intellectually literate patients of mine, all of whom agreed that we have been royally screwed. Nobody else expressed an interest, despite my lapel badge.

I don't intend to die in the saddle at the age of 68. But a single day of propping up a placard outside the practice is no way of ensuring this. We have to go further, or we have to capitulate. It's up to us.

Dr Phil Peverley is a GP in Sunderland

MargaretMcCartney

A strike aimed at the wrong target

GPs should have drawn a line in the sand over the health act, not pensions, says **Margaret**

There's something badly wrong with this strike. I believe fully in the right of a worker to withhold his labour. I think that the Government has treated doctors – and other public service workers – unfairly when it comes to pensions. But there is a bigger problem, and it's the NHS reforms. We should have vowed to strike, first, over that.

It's easy for politicians to spin doctors as being greedy or rich, and I fully expect this is what they will do. It would have been less easy for politicians to explain away doctors downing stethoscopes because of their fury over the health bill. This, we could have said, was because it was bad for patients and good only for the shareholders looking to the bits of the NHS carcass capable of turning a profit.

True, that bill (now an act) will allow for a few GPs to stop seeing so many patients and to make a whole lot of hay at cost to the taxpayer.

But fundamentally, it will mean far more doctors will be left with the responsibility to care for patients in a fractured, messy jigsaw of services which are liable to appear and disappear with the ebb and flow of profit and loss. It will mean more unfairness – for how can a company whose aim is to reward its shareholders care for patients better than one that does not?

As usual, the most ill will lose most. Good doctors may feel that their only option is to get involved and to make commissioning less bad, but frankly, this feels like something set up to fail.

This strike should be far more about the way in which doctors are being treated in the new NHS. What GPs do best is to care for patients. Yet we are being moved out of the consulting room and into management, where rationing decisions are to be repeated across England.

We have seen the same happen to nurses. Good nurses, risen to a high grade and delivering excellent front-line care to patients, have found their best chance of promotion has been into management, and away from direct front-line care.

It is on our watch, and we must take some responsibility

We should be protesting because our core work, that complex, stressful, challenging and difficult duty which we trained for, is repeatedly undervalued. The fact that intensity of work has not matched resources; the fact that people have more, interacting, long-term diseases; the fact that revalidation requires more tick-boxes and time that takes us away from patients – all this is being politically ignored.

Instead, the response from the Government has been to start non evidence-based 'league tables' for GPs, as though we should simply behave like a supermarket or a corned beef factory. We don't, because otherwise we would just get rid of the most time-consuming parts of our work – our sickest patients.

What should we do? We should consider, at least, withdrawing from revalidation (which a systematic review in 2010 found brought no evidence of improvement of performance) en masse – this would result in Governmental embarrassment but no inconvenience to patients. We should also consider telling the Government that we wish nothing further to do with commissioning, as it can only fail our patients.

The BMA should be shouting louder about the health act. It is on your and my watch, and we must take some responsibility. I need our leaders to come out and tell us what to do.

Dr Margaret McCartney is a GP in Glasgow

NEW

Trajenta®

(linagliptin) 5mg film-coated tablets

ONE DOSE ONCE DAILY 5mg

Control and care matter

***Trajenta®* (linagliptin)** *is suitable for your hyperglycaemic adult type 2 diabetes patients as monotherapy in metformin-inappropriate patients and add-on to metformin alone or metformin + a sulphonylurea*[1]

Efficacy

- significant HbA_{1c} reductions vs placebo[2–4]
- HbA_{1c} reduction sustained over 102 weeks as add-on to metformin + a sulphonylurea in the completer population (319 patients out of 544 enrolled patients)[5]

Generally well tolerated

- Trajenta® (linagliptin) has an overall incidence of adverse events that is similar to placebo[1]

Different

- the first one dose, once-daily DPP-4 inhibitor excreted primarily via the bile requiring no dose adjustment[1,6–11]

Prescribing Information (UK) ▼ **TRAJENTA® 5 mg film-coated tablets**

Film-coated tablets containing 5 mg linagliptin. **Indication:** Trajenta is indicated in the treatment of type 2 diabetes mellitus to improve glycaemic control in adults: as monotherapy - in patients inadequately controlled by diet and exercise alone and for whom metformin is inappropriate due to intolerance, or contraindicated due to renal impairment; as combination therapy: - in combination with metformin when diet and exercise plus metformin alone do not provide adequate glycaemic control; - in combination with a sulphonylurea and metformin when diet and exercise plus dual therapy with these medicinal products do not provide adequate glycaemic control. **Dose and Administration:** 5 mg once daily. If added to metformin, the dose of metformin should be maintained and linagliptin administered concomitantly. When used in combination with a sulphonylurea, a lower dose of the sulphonylurea may be considered to reduce the risk of hypoglycaemia. Patients with renal impairment: no dose adjustment required. Pharmacokinetic studies suggest that no dose adjustment is required for patients with hepatic impairment but clinical experience in such patients is lacking. Elderly: no dose adjustment is necessary based on age however, clinical experience in patients > 75 years of age is limited. The safety and efficacy of linagliptin in children and adolescents has not yet been established. No data are available. Trajenta can be taken with or without a meal at any time of the day. If a dose is missed, it should be taken as soon as possible but a double dose should not be taken on the same day. **Contraindications:** Hypersensitivity to the active substance or to any of the excipients. **Warnings and Precautions:** Trajenta should not be used in patients with type 1 diabetes or for the treatment of diabetic ketoacidosis. Caution is advised when linagliptin is used in combination with a sulphonylurea; a dose reduction of the sulphonylurea may be considered. **Interactions:** Linagliptin is a weak competitive and a weak to moderate mechanism-based inhibitor of CYP isozyme CYP3A4, but does not inhibit other CYP isozymes. It is not an inducer of CYP isozymes. Linagliptin is a P-glycoprotein substrate and inhibits P-glycoprotein mediated transport of digoxin with low potency. Based on these results and *in vivo* interaction studies, linagliptin is considered unlikely to cause interactions with other P-gp substrates. The risk for clinically meaningful interactions by other medicinal products on linagliptin is low and in clinical studies linagliptin had no clinically relevant effect on the pharmacokinetics of metformin, glibenclamide, simvastatin, warfarin, digoxin or oral contraceptives (please refer to Summary of Product Characteristics for information on clinical data). **Fertility, pregnancy and lactation:** Avoid use during pregnancy. A risk to the breast-fed child cannot be excluded. A decision must be made whether to discontinue breast-feeding or to discontinue/ abstain from Trajenta therapy taking into account the benefit of breast-feeding for the child and the benefit of therapy for the woman. No studies on the effect on human fertility have been conducted for Trajenta. **Undesirable effects:** Adverse reactions reported in patients who received linagliptin 5 mg daily as monotherapy or as add-on therapies (pooled analysis of placebo-controlled studies). The adverse reactions are listed by absolute frequency. Frequencies are defined as very common (≥1/10), common (≥1/100 to <1/10), uncommon (≥ 1/1,000 to < 1/100), rare (≥ 1/10,000 to < 1/1,000), or very rare (<1/10,000), not known (cannot be estimated from the available data).

Very common: hypoglycaemia (combination with/add on to metformin and sulphonylurea). Uncommon: nasopharyngitis (monotherapy; combination with/add on to metformin); hypersensitivity (combination with/add on to metformin); cough (monotherapy; combination with/ add on to metformin). Not known: nasopharyngitis (combination with/add on to metformin and sulphonylurea); hypersensitivity (monotherapy; combination with/add on to metformin and sulphonylurea); cough (combination with/add on to metformin and sulphonylurea); pancreatitis (monotherapy; combination with/add on to metformin; combination with/add on to metformin and sulphonylurea). Prescribers should consult the Summary of Product Characteristics for further information on side effects. **Pack sizes and NHS price:** 28 tablets £32.26. **Legal category:** POM. **MA number:** EU/1/11/707/003. **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 September 2011.

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

References: 1. Trajenta® Summary of Product Characteristics, August 2011. **2.** Barnett AH *et al.* Poster No. 1023-P. The European Association for the Study of Diabetes 46th Annual Meeting, 20–24 September 2010, Stockholm, Sweden. **3.** Taskinen M-R *et al. Diabetes Obes Metab* 2011; 13:65–74. **4.** Owens DR *et al. Diabet Med* 2011;28:1352–61. **5.** Boehringer Ingelheim, data on file UM11-066a. **6.** Vincent SH *et al. Drug Metab Dispos* 2007;35:533–538. **7.** Januvia (sitagliptin) Summary of Product Characteristics. Available at: http://www.medicines.org.uk/EMC/medicine/19609/SPC/JANUVIA+100mg+film-coated+tablets/ (accessed May 2012). **8.** Galvus (vildagliptin) Summary of Product Characteristics. Available at: http://www.medicines.org.uk/EMC/medicine/23774/SPC/Galvus+50+mg+Tablets/ (accessed May 2012). **9.** Onglyza (saxagliptin) Summary of Product Characteristics. Available at: http://www.medicines.org.uk/EMC/medicine/22315/SPC/Onglyza+2.5mg+%26+5mg+film-coated+tablets/ (accessed May 2012). **10.** Deacon CF. *Diabetes Obes Metab* 2011;13:7–18. **11.** Blech S *et al. Drug Metab Dispos* 2010;38:667–678.

UK/TRJ/0004a Date of preparation: May 2012

Boehringer Ingelheim

Lilly

Yet another stick to beat us with

Benchmarking lab test use is just the latest step in the drive to performance manage GPs, says **Dr Robert Morley**

We hear the phrase 'yet another stick with which to beat GPs' so often, I suspect it's the demand for these sticks that's the biggest contributor to the destruction of the rainforests.

The latest beatings coming our way relate to our use of pathology services. We were told last month GPs will be benchmarked on the laboratory tests they order and '20% efficiency savings must be found'.

The underlying message – while couched in terms of 'reducing variation' and 'driving up quality' – is as always that GPs are profligate and need 'sorting out'.

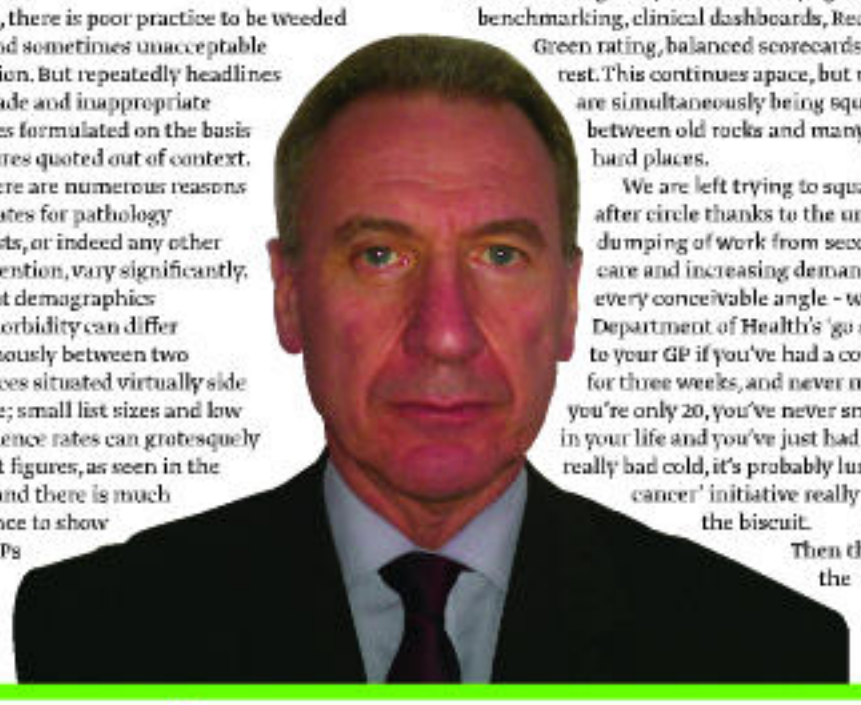
Community pathology services are also to be 'reconfigured' – put out to tender. We all know this means they will be handed over to the cheapest bidder. Never mind the quality, or the long-term relationships built between GPs and their local hospital pathology departments – relationships that are often crucial for the care of patients with long-term haematological or biochemical conditions.

We've heard it all before. Patients attend A&E because of poor GP access, take up hospital beds because of poor GP care, attend outpatients because of the laziness and incompetence of GPs, and get killed and poisoned by reckless GP prescribing.

As ever, it's cost – not quality – that's the real issue. Of course we must constantly seek to improve the care we provide. But it must be done in the right way – through genuine, clinically driven peer review, supported by proper, formative appraisals and appropriate feedback.

Yes, there is poor practice to be weeded out, and sometimes unacceptable variation. But repeatedly headlines are made and inappropriate policies formulated on the basis of figures quoted out of context.

There are numerous reasons why rates for pathology requests, or indeed any other intervention, vary significantly. Patient demographics and morbidity can differ enormously between two practices situated virtually side by side; small list sizes and low prevalence rates can grotesquely distort figures, as seen in the QOF; and there is much evidence to show that GPs with particular experience or interests actually investigate more, not less, in their area of expertise.



A changing landscape

Not only is our care being scrutinised and criticised more than ever, but the landscape in which this is being done has changed dramatically.

Since the advent of PCTs we have been subject to relentless performance management, with its bewildering array of associated jargon – benchmarking, clinical dashboards, Red Amber Green rating, balanced scorecards and the rest. This continues apace, but now we are simultaneously being squeezed between old rocks and many new hard places.

We are left trying to square circle after circle thanks to the unfunded dumping of work from secondary care and increasing demand from every conceivable angle – with the Department of Health's 'go straight to your GP if you've had a cough for three weeks, and never mind if you're only 20, you've never smoked in your life and you've just had a really, really bad cold, it's probably lung cancer' initiative really taking the biscuit.

Then there's the unprecedented financial squeeze on general practice funding, frozen year-on-year while the rest of the NHS continues to get annual uplifts. General practice now gets only 7% of total NHS funding, down from over 9% before our new contract.

And to top this, the NHS reforms. Make no mistake, CCGs will be leaned on by the NHS Commissioning Board to deliver the GP performance-management goods. At a recent NHS Commissioning Board conference on primary care performance management, this expectation was made explicit. Responsible officers – deciding on GP revalidation – will also have a conflicting role as local senior primary care commissioning managers.

As ever it's cost – not quality – that's the real issue

So the agenda is crystal clear: GP appraisal, revalidation, professional, contractual and commissioning performance management all conflated and placing GPs in impossible conflict. It's not an edifying prospect.

Dr Robert Morley is secretary of Birmingham LMC and deputy chair of the GPC contracts and regulation subcommittee, writing in a personal capacity

LETTERS

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The minister is clearly deluded

LETTER OF THE WEEK

From Dr Andrew Parkin
Whitstable
via pulsetoday.co.uk

Simon Burns MP, you are as deluded as you are ill-informed and naïve about the forthcoming industrial action ('Strike action will come to nothing', pulsetoday.co.uk/opinion).

If this isn't enough to bring you back to the table for a fair negotiation so that all public-sector workers pay a similar percentage – which means higher earners pay more, in case you missed basic maths – then expect escalation. I would quite happily fully strike, withdraw from CCG work and hand in my resignation before bending over to allow you to add 6% tax to my pension, which is what this equates to.

If we give in now you'll be back in a couple of years to dip your hand in for some more. Australia, among others, treats their hard-working doctors with a lot more finesse. Do you want to lose all the juniors that have trained for six-plus years to other countries?

Is the Department of Health prepared for an escalation?

I feel strikes only ever hurt the public more than the Government, but as a BMA member feel I need to support all my fellow union members.

GPs won an 18% pay rise 30 years or so ago by refusing to sign Med 3 certificates.

This caused a lot of disruption without adversely affecting clinical care, and resulted in a significant pay rise.

Rather than action that is unpopular with patients and causes some clinical disquiet (as all patients feel they are 'urgent'), something smaller but significant and applicable across the board may have a better impact.

Doctors still wrote private certificates (at a discretionary charge) and so did not necessarily cause a problem for patients.

Perhaps this is something that could be looked up in the archives, shared and considered.

We should target fit notes

From Dr Mina Goyal
Dagenham

I do not support the strike as paperwork that we have to put off will make a mountain the next day?

Instead, we should threaten to withdraw from commissioning until the Government comes back to the table and moves on pensions.

But perhaps too many of our leaders are already tied into the commissioning process to make this a workable option.

Or quit commissioning

From Dr Richard Adams
Leeds

What is the point in 'striking' as a GP when we've still got to see our patients, and the routine

Above all, we must protect our patients

From Dr Gary Taylor
Woodbridge, Suffolk

We should not do anything that will directly affect patient care – our strongest assets are our patients.

What would hurt the Government the most?

If we pulled out of the new reforms – and especially anything to do with the CCGs – then we'd see some action from the Department of Health.

The way this has been handled by the BMA is poor, and I do feel this is turning into an own goal.

I for one will not be withdrawing services on 21 June.

Dr Prit Buttar has done the right thing

From Dr Geoff Hall
Retired GP, Alicante
via pulsetoday.co.uk

I'd like to congratulate Dr Prit Buttar for his decision ('Senior GP commissioner quits over pension changes', pulsetoday.co.uk/news).

Disengagement from commissioning is by far the most effective form of protest available to GPs.

Without us on board, the Government will not achieve its aims, and this form of action will not antagonise patients.

Back pain study won't alter practice

From Dr Michael Burke
Wirral
via pulsetoday.co.uk

It is difficult to know what messages the recent study on back pain has for UK practice ('Early physiotherapy referral "best for back pain"', pulsetoday.co.uk/news).

It does not comment on the difference in outcomes between the 7% referred for physical therapy and the 93% who weren't, other than to note that the healthcare costs were larger for the physical therapy group.

NICE guidance for low back pain gives us advice for back pain persisting for six weeks to one year only – so doesn't help.

One UK study (*BMJ* 2004;329:708) concluded 'routine physiotherapy for patients with mild to moderate low back pain is no more effective in the long term than advice given by a physiotherapist'.

I cannot see how this study would alter my current practice.

Current best practice for care of patients with low back pain would be to take on board the recommendations for stratification of management published in the *Lancet* last October, which showed that a stratified approach results in a mean increase in generic health benefit with modest cost savings at one year.

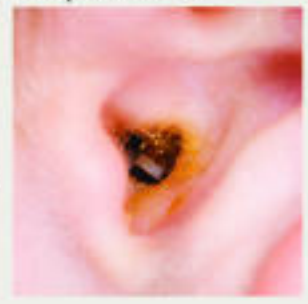
For the record

A letter published in last week's letters section on the forthcoming industrial action was mistakenly attributed to Dr Nicola Williams from Castleford in West Yorkshire ('I will be taking action', pulsetoday.co.uk/letters).

The letter was in fact from a different Dr Nicola Williams in Preston, and Dr Williams from Castleford would like to make it clear she does not share the sentiments expressed in the letter published. Pulse apologises for this error.

Pulse Clinical

In this issue



As the tympanic membrane heals, the grommet extrudes

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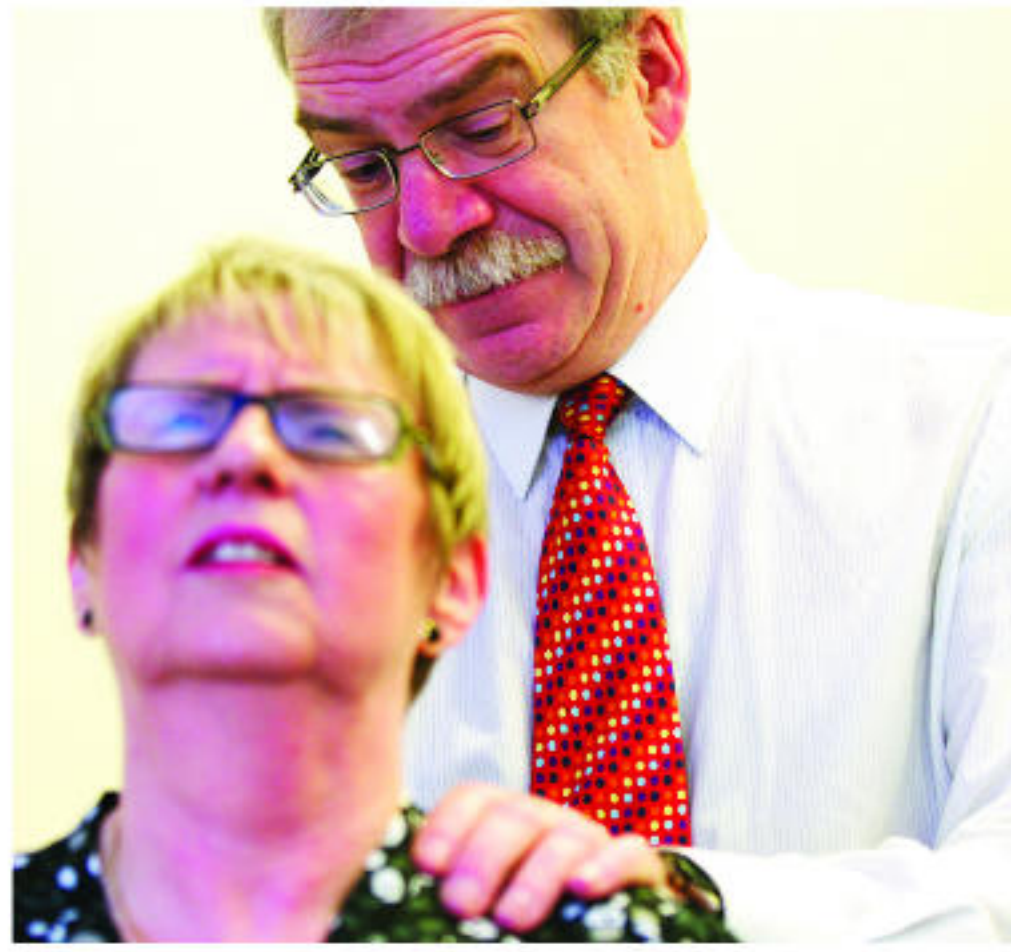
Resource of the week
An NHS leaflet explaining self-treatment exercises for vertigo

KEY QUESTIONS

Back pain



GP and musculoskeletal researcher Dr Nefyn Williams answers questions from GP Dr Melanie Wynne-Jones on investigating and managing back pain

1 Many patients still request an X-ray – but lumbar spine X-rays deliver a big dose of radiation. When are they justified? When are MRI or CT scans indicated for low back pain?

I reserve the use of plain radiography for patients with red flag symptoms such as trauma, non-mechanical pain and systemic symptoms. See the box, right, for further details of red flags in back pain.

MRI and CT scans are better than plain radiographs at identifying serious pathology such as tumour, fracture or infection, and also at confirming prolapsed intervertebral discs in patients with nerve root pain prior to disc surgery. But they can be misleading for most patients who have non-specific back pain, as there are many false positive findings such as disc bulges and prolapses, which might better be described as normal, age-related change. There is a risk that such incidental findings will result in unnecessary referral and investigation.

2 If an X-ray shows a wedge fracture, what investigations should be performed?

In the absence of significant trauma, most wedge fractures are caused by osteoporosis, but other pathologies such as lytic lesions from bony metastases, primary tumours and infection should be excluded. I would perform blood tests for calcium, alkaline phosphatase, ESR, CRP, PSA (if the patient is male) and myeloma screen. I would send urine for Bence-Jones proteins and would refer for a DXA scan to assess bone density. Have a low threshold for referral back to secondary care if there is a history of malignancy.

3 How long should we wait before referring someone with foot drop or genuine sciatica? What should we do in the meantime?

Sudden onset of a foot drop because of L4 nerve root compression should be considered a surgical emergency, as prompt surgery may restore function.

Genuine sciatica – lumbar nerve root pain – needs to be distinguished from leg pain referred from the back. Lumbar nerve root pain is a characteristic sharp, shooting or burning pain radiating down the posterior lateral aspect of the leg, usually to the foot or the ankle in a segmental distribution, and often aggravated by coughing or sneezing.

Signs of genuine sciatica include a provocation test for dural irritation such as a straight leg raise test, which restricts the degree of flexion at the hip by reproducing the characteristic leg pain. There may also be loss of power and sensation affecting a single nerve root.

I would refer if the lumbar nerve root pain persists for six weeks, but earlier if the pain is severe and uncontrolled. For all these patients, refer urgently to the spinal clinic and if there is access to MRI, refer for a scan. In the meantime I would prescribe amitriptyline, gabapentin or pregabalin as a neuropathic pain modulator. Amitriptyline has the additional advantage of being a sedative.

4 What would make you suspect metastatic bone disease, and what investigations would you do?

Always suspect bony metastases if there is

Red flags in back pain

Extremes of age
Patients presenting before the age of 20 or with a new or different pain after the age of 55 are most likely to have serious disease.

Trauma
Severe trauma from a motor vehicle accident or a fall from height is required to fracture a spine in normal circumstances. But minor trauma may be enough to fracture osteoporotic bone in post-menopausal women or patients exposed to long-term steroids.

Non-mechanical pain
Non-mechanical pain is unrelated to time or physical activity and is a red flag, particularly if progressive and unrelenting. Rest or exercise does not relieve it and the patient may not be able to find any position of comfort.

Previous medical history
Many systemic diseases can affect the lumbar spine – such as tuberculosis, carcinoma, osteoporosis and HIV infection. Drug misuse and immune suppression may predispose to infection. Systemic steroids and premature menopause are risk factors for osteoporosis.

Systemic symptoms
Alarm symptoms include abnormal weight loss and general malaise.

Structural deformity
Deformity may be a sign of bony destruction or osteoporotic vertebral collapse.

Widespread abnormal neurological findings
Nerve root pain may be associated with loss of power or weakness involving a single nerve root. Serious spinal pathology may result in widespread or progressive motor weakness. Central lumbar disc prolapse may result in cauda equina syndrome.

Inflammatory disorders
Features include a gradual onset of symptoms, morning stiffness, limited spinal movement in all directions, peripheral joint involvement, a past medical history of iritis, psoriasis, colitis or urethritis, or a family history of ankylosing spondylitis.

a history of cancer, particularly breast, prostate, lung or colon.

Characteristically, the pain is non-mechanical – it is progressive and unrelenting and is not related to the time of day or particular physical activities. In these circumstances I would have a low threshold for referring the patient back to their oncologist. In the meantime, I would order a plain radiograph and organise blood tests for calcium, alkaline phosphatase, PSA (if there is a history of prostate cancer), ESR and CRP.

5 What are the symptoms and indications for referral for spinal stenosis?

Symptoms of spinal stenosis are caused by compression of nerve roots arising from the spine and include leg pain with walking (which might be associated with paraesthesia), loss of power and loss of sensation. Patients typically get relief from bending forwards, which opens up the intervertebral foramina. They may report that walking downhill is more problematic than walking uphill. I refer patients with persistent, troublesome symptoms to the spinal clinic. Features of cauda equine syndrome – bladder or bowel symptoms, or saddle anaesthesia – should be treated as an emergency.

6 When would you suspect ankylosing spondylitis? What investigations and treatment would you arrange?

Ankylosing spondylitis typically presents in young men as pain in the back or buttocks with early morning stiffness that improves with exercise but is worse with rest. Early diagnosis in primary care is particularly challenging as a definite diagnosis is made by finding radiographic changes of sacroiliitis with one of the following:

- at least three months' history of back or buttock pain which is worse with rest, but improved by exercise
- limited movement of the lumbar spine with restricted Schoeber's test
- limited chest expansion.

Plain radiographic changes of sacroiliitis are a late sign, but a probable diagnosis of ankylosing spondylitis can be made if all three of the above features are present. MRI can detect earlier signs of ankylosing spondylitis than plain radiographs. As GPs, we should be alert to the possibility of ankylosing spondylitis and refer suspicious cases.

Treatment is primarily exercise and physiotherapy, with NSAIDs to treat the symptoms of pain and stiffness to allow patients to exercise.

Biological agents targeting TNF-α – such as adalimumab and etanercept – are increasingly being used in secondary care rheumatology practice.

7 Many areas won't fund epidural injections. What is the evidence for and against these, and which patients might actually benefit?

Injection of steroids into the epidural space is a commonly used treatment for lumbar nerve root pain, or sciatica. Prolapsed intervertebral discs not only mechanically compress nerve roots but also release pro-inflammatory factors such as TNF-α, resulting in a radiculitis. The rationale for injecting steroids is to reduce this nerve root inflammation.

Systematic reviews of epidural steroid injections have reached conflicting conclusions on efficacy compared with placebo or other treatments.[1,2,3]

A recent systematic review I have been involved with found that epidural injections were significantly better than placebo for reducing pain and improving function in the short term (after about six weeks), but that there was no statistically significant difference in the medium term (after about six months) or in the longer term.[4] Similar short-term improvements were found when epidural injections were compared with usual care.

In an analysis where we indirectly compared all treatment categories simultaneously, there was a statistically significant improvement following epidural injection compared with placebo and with usual care. I am not aware of any particular subgroup of patients with nerve root pain who benefit most from epidural injections.

I think of their use as part of a stepped-care model, which first involves the prescription of neuropathic modulating drugs in primary care, then referral to a spinal clinic for outpatient physiotherapy and if symptoms persist, an epidural injection.

Dr Nefyn Williams is a GP and osteopath in Llanfairfechan, north-west Wales, and a clinical senior lecturer in general practice at Bangor University. He has a particular interest in musculoskeletal medicine

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Go online to read an extended version of this article, with Dr Williams answering questions on opiates, lumbar supports, referred back pain and scoliosis

What's inside?

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
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DANONE HEALTH AFFAIRS

POST-OP PROBLEMS

ENT surgery complications

Professor Tony Narula, consultant ENT surgeon, **Miss Anna Slovick,** ENT SpR, and **Mr Raul Cetto,** ENT trainee, look at post-op complications

Most ENT operations are day cases, so early complications are often seen in primary care. GPs may consult an ENT senior house officer or registrar who can help decide how urgently the patient should be reviewed. Complications can be classified as immediate (within six hours), early (six to 72 hours) or late (after 72 hours).

Tonsillectomy

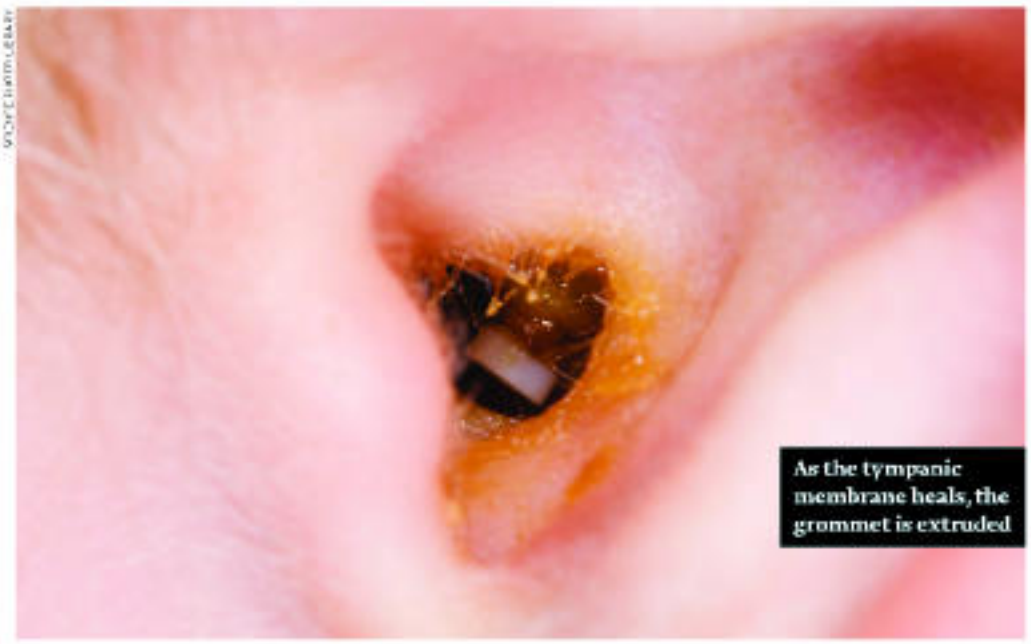
Each year around 50,000 patients undergo tonsillectomy in the UK, often jointly with adenoidectomy. Following tonsillectomy, patients are advised to take two weeks off work or school. They can expect white slough in the tonsillar fossa, which may cause halitosis or infection - this can be reduced by thoroughly chewing and swallowing food. Post-operative recovery can be painful and analgesia should be provided for two weeks.

Early complications

- *Bleeding* should not occur - with the exception of small specks of blood from the nose or in the saliva. Rarely, a primary haemorrhage occurs within 24 hours and this requires immediate surgery.
- *Pain* should be controlled with regular analgesia as well as breakthrough analgesia.
- *Nausea and vomiting* can be caused by anaesthetic drugs, pain and uvular or tongue oedema due to surgical manipulation. Patients should be prescribed antiemetics during the early post-operative period.
- *Dehydration* can be caused by the inability to eat and drink because of inadequate analgesia or antiemetic control. Adequate analgesia and fluid replacement is recommended. If the patient does not respond, consider hospital referral.
- *Airway obstruction*, due to uvular oedema, tongue swelling or foreign body in the airway, requires hospital referral.
- *Damage to teeth and gums* may occur, but this is usually identified during surgery. If the patient has concerns afterwards, the GP can refer directly to a dentist and contact the ENT department.
- *Otalgia due to referred pain* usually subsides within a week and does not indicate infection.

Late complications

- *Pain* usually peaks at day six after surgery, but can last longer. Regular analgesia and breakthrough codeine can be helpful.
- *Infection and fever* can present as soon as 24 hours post-surgery or up to two weeks later. A course of co-amoxiclav can be useful.
- *Haemorrhage* will result in readmission to hospital for around five out of 100 patients undergoing tonsillectomy, but only around one in 100 will require further surgery.
- *Inability to eat and drink* should be managed as above.
- *Severe neck pain* may occur about a week after surgery, with limitation in neck movements and torticollis. Consider specialist referral.



As the tympanic membrane heals, the grommet is extruded

Adenoidectomy

Adenoidectomy is often associated with other surgical procedures such as tonsillectomy and grommet insertion. And some complications are similar to those following tonsillectomy.

Early complications

- *Damage to teeth and gums*, as above, is usually identified during surgery.
- *Immediate haemorrhage* from the site occurs in about 0.4% of cases. This usually presents as epistaxis and can be controlled with a vasoconstrictor such as oxymetazoline. If bleeding persists, consider hospital referral.
- *Nausea and vomiting* should be managed as above. Follow-up is recommended.
- *Blocked nose* may present in the early days after the operation - caused by tissue trauma. It usually settles within a week. Oxymetazoline can be prescribed for one week to help with symptoms.

Late complications

- *Velopharyngeal insufficiency* occurs transiently in more than 50% of patients undergoing adenoidectomy because of incomplete closure of the palate. Patients complain of nasal regurgitation of fluids and food, and hyponasal speech. This should resolve in two to three weeks - if it does not, refer.
- *Nasopharyngeal stenosis* is rare. Patients complain of nasal obstruction or hyponasal speech. Treatment is usually surgical.
- *Neck pain* presents as above, following tonsillectomy. Consider specialist referral.
- *Mandibular condyl fracture* is extremely rare and specialist input is required.
- *Eustachian tube injury* is extremely rare and if suspected, specialist input is recommended.

Grommet insertion

Most patients should only need simple analgesia after the operation. Improvement in hearing is immediate, and children may complain that everything is too loud until they adapt to it.

As the tympanic membrane heals, the grommet is extruded. This can take six months to a year or more.

Early complications

- *Infection*, caused by liquid penetrating into the middle ear, commonly manifests as otorrhoea. This usually settles with a one-week course of antibiotic ear drops, such as ciprofloxacin or ofloxacin. It is recommended that patients avoid swimming for at least two weeks after the operation, and avoid dirty or soapy water to prevent infection.
- *Blockage of grommets* can be caused by dry blood, wax or debris and can affect the patient's hearing. A course of sodium bicarbonate or antibiotic drops can help.
- *Early extrusion* may require that grommets be replaced sooner than expected.

Late complications

- *Infection* can be managed as in the early stages, above.
- *Residual perforation* occurs in 1-2% of patients with short-term grommets and 17% of patients with long-term grommets. If patients are troubled with persistent otorrhoea, or are keen swimmers, it may require surgery.

Functional endoscopic sinus surgery (FESS)

FESS is a minimally invasive technique to open the osteomeatal complex and facilitate sinus drainage.

Indications include chronic rhinosinusitis, nasal polyposis and orbital decompression. Major complications are very rare - with eye

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complications in one in 500 operations, and spinal fluid leaks in one in 1,000.

Early complications

- *Nasal obstruction* may be due to swelling, packs or splints within the nose. The nose will feel blocked. Swelling can take a few weeks to settle, and some surgeons will give post-operative topical steroids or saline douches.
- *Minor nasal bleeding* is common for the first couple of days. Advise patients not to blow their nose or sneeze with their mouth open. If a patient has heavy bleeding, they will usually be managed in hospital.
- *Orbital haematoma* presents with a small amount of bruising around the eye, which will settle without intervention. Very rarely, the patient may rapidly develop eye swelling, proptosis, diplopia and reduced visual acuity, and this requires emergency open or endoscopic decompression to prevent optic nerve ischaemia.
- *Blindness* can occur due to orbital haematoma or direct injury to the optic nerve during surgery.
- *Cerebrospinal fluid leak* is usually recognised during surgery and repaired, but may present to the GP with clear rhinorrhoea which can be tested for glucose or ß-2-transferrin to confirm the diagnosis. The treatment is bed rest and prophylactic antibiotics to reduce risk of meningitis. If the leak persists, surgery may be needed.

Late complications

- *Serosanguinous nasal discharge* can occur up to two weeks post-operatively. One week off work is advised, as is avoidance of heavy lifting, flying and hot baths.
- *Infection* presents with a foul-smelling discharge and requires antibiotics.
- *Adhesion/synechiae formation* can cause obstruction of the maxillary sinus ostium and further sinusitis. Dissolvable packs can be used to reduce adhesions.
- *Loss of smell* may be temporary or permanent due to injury to the olfactory neuroepithelium. Refer early for consideration of high-dose oral steroids.
- *Nasolacrimal duct injury* can lead to stenosis and epiphora in 0.3-1.7% of patients.
- *Symptoms of chronic rhinosinusitis* may recur due to nasal polyposis regrowth or nasal adhesions, and may require further surgery if conservative management fails.

Septoplasty

Septoplasty, the removal of deviated cartilaginous and bony parts of the nasal septum, aims to correct nasal obstruction due to an acquired or congenital deviated nasal septum.

Early complications

- *Nasal obstruction* because of oedema and use of dissolvable packs can occur. Symptoms generally settle within two weeks and patients are warned they will need to breathe through their mouths during this period.
- *Serosanguinous nasal discharge* usually settles within 72 hours of surgery. Patients should refrain from work and heavy lifting for a week, and elevate their head when resting during the first 24 to 48 hours.
- *Epistaxis* which does not resolve with nasal pressure for 20 minutes should be seen in A&E.
- *Septal haematoma* may present with excruciating pain, swelling, nasal obstruction and a fever. Management consists of either needle or incisional drainage with nasal splints or packing, and oral antibiotics.
- *Infection* presents with foul-smelling discharge. If there is fever or excess nasal pain, refer to ENT to rule out septal abcess.
- *Toxic shock syndrome* is very rare, with symptoms including fever, nausea, diarrhoea, erythroderma and eventual hypotension. This requires urgent referral.
- *Cerebrospinal fluid leak* is very rare, but serious. As above, it is usually identified during surgery. Patients can be advised to reduce intracerebral pressure by sneezing with their mouth open, not straining on the toilet and avoiding heavy lifting.

Late complications

- *Adhesions* may reduce nasal airflow. If patients are symptomatic, synechiae can be surgically divided and silastic splints inserted post-operatively.
- *Septal perforation* is rare, normally presenting several months post-operatively. It is secondary to septal haematoma and infection, with patients complaining of crusting, epistaxis and a whistling sound during normal respiration. It can be managed conservatively with moisturisers such as topical neomycin, saline douching or a septal button, or it can be surgically repaired.
- *Saddle nose deformity* is a long-term complication, presenting with a sunken dorsum or a drooping nasal tip. Refer routinely.

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- *Dental numbness* is a rare complication due to anterior alveolar nerve injury. It should gradually improve, although it may take months.
- *Persistent obstruction* after resolution of post-operative oedema may be due to residual deviation not corrected at the time of surgery, movement of the septum or adhesions. Another trial of topical steroids or re-operation can be considered. Other causes include concomitant allergic or non-allergic rhinitis, or incompetent nasal valves.
- *Loss of smell* is very rare and usually temporary. It is minimised by re-approximation of the septal flaps with mattress sutures, head elevation and topical steroids to reduce congestion.

Professor Tony Narula is a consultant ENT surgeon, Miss Anna Slovick is an ENT SpR and Mr Raul Cetto is an ENT trainee and clinical research fellow at St Mary's Hospital, London

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GUIDELINE UPDATE

NICE alcohol misuse: guidance

Dr Jane Marshall – a GP who works in a drug and alcohol misuse service – provides an update on the latest of three NICE guidelines on alcohol use disorders

The guideline

NICE. Alcohol use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence. NICE 2011; CG115

The key points at a glance

- Choose a screening tool that can pick up harmful drinking as well as dependence.
- The AUDIT-C and FAST tools are recommended in the guidance, but CAGE is not.
- The SADQ tool can be used to assess severity.
- In patients with depression or anxiety, any alcohol misuse should be addressed first.
- Hazardous and harmful drinking should be initially addressed with brief advice or extended brief interventions.
- An alcohol-focused psychological intervention such as CBT should be offered to those with mild alcohol dependence.
- Those with moderate or severe alcohol dependence should be considered for specialist assessment.
- Assisted withdrawal should be considered for anyone who is classified as alcohol-dependent.

Almost 90% of the population regularly drink alcohol, and although most drink sensibly much of the alcohol drunk in the UK is consumed by a minority who have become dependent.

Clinically-defined alcohol dependence affects 4% of 16- to 65-year-olds in England and is a bigger problem in men (6%) than in women (2%).[1] But more than 26% of all adults (38% of men and 16% of women) drink alcohol in a way that is harmful or potentially harmful to their health or wellbeing.[1]

The extent of the problem is one worry, but the extent of under-treatment is another – only 6% of people who are alcohol-dependent receive treatment.[1]

This article will outline the recommendations in the latest NICE guidance on alcohol use disorders.[2] This is the third and final piece of NICE guidance on alcohol-related problems. The other two were published in 2010 and some of the points discussed below refer to these. NICE has brought together the recommendations from the three pieces of guidance into an integrated care pathway, which is available from pulsetoday.co.uk/tools-and-resources.

The two earlier guidelines covered:

- how the development of hazardous and harmful drinking might be prevented[3]
- the diagnosis and clinical management of alcohol-related physical complications.[4]

One of the major barriers to improving the detection and management of alcohol use disorders is that alcohol misuse services are currently fragmented and both patients and healthcare professionals are unclear how to access them.

This article will focus on the NICE recommendations most relevant to primary care that relate to identification and initial assessment of alcohol misuse, assessment of severity and interventions for depression and anxiety associated with alcohol misuse. It will also briefly outline the recommendations on interventions for particular patient groups. The guideline refers to harmful drinking and alcohol dependence as alcohol misuse and this article will use the same terminology.

Use AUDIT tool to screen

Firstly, it is worth distinguishing between hazardous drinking, harmful drinking and alcohol dependence.

- Hazardous drinking is a pattern of alcohol consumption that increases someone's risk of harm.
- Harmful drinking is a pattern of alcohol consumption that is causing mental or physical damage.
- Alcohol dependence is characterised by withdrawal, craving, impaired control and tolerance of alcohol and is associated with a higher rate of mental and physical illness than harmful drinkers, as well as a wide range of social problems.

The key to identifying alcohol misuse in primary care is the use of validated screening questionnaires. We should be using one of these tools routinely in newly registered patients and in the management of any patient in whom we suspect alcohol misuse.

We should be particularly aware of those at increased risk of alcohol-related harm, including:

- patients who are known to have other drug problems
- patients we suspect of being at risk of self-harm
- patients who repeatedly suffer accidents or minor trauma, including domestic abuse
- patients known to be involved in crime or antisocial behaviour.

NICE recommends the Alcohol Use Disorders Identification Test (AUDIT) tool and the guideline is based around its use. AUDIT was devised by the World Health Organisation and is a 10-question test that has been shown to effectively identify alcohol misuse and classify it into three groups, based on the final score:

- AUDIT score 8–15 is classified as hazardous drinking (which is likely to be eventually harmful)
- AUDIT score 16–19 is classified as harmful drinking
- AUDIT score 20 and above is classified as alcohol dependence.

However, it can be impractical to use the full AUDIT as a routine screening tool in general practice and the guidance does recommend the use of a shorter screening tool 'if time is limited'.

Some shorter tools, such as FAST and the Paddington Alcohol Test, were developed for use in A&E settings but there are two shortened versions of AUDIT that might be more suitable for use in primary care. AUDIT-PC is a five-question version while AUDIT-C (see opposite) contains only the first three questions.[5]

A total AUDIT-C score of five or more should prompt the GP to ask the patient to complete the full AUDIT tool.

The brief alcohol screening tool probably most familiar to GPs – CAGE – is not one of those recommended in the guideline. CAGE identifies patients with alcohol dependence at any time in their lives, but is not good at identifying those with hazardous or harmful drinking.[6]

It is these patients who could benefit from brief counselling about their drinking, so it is vital that a primary care screening tool picks them up.

CAGE is not included in the current alcohol-related risk reduction scheme DES either, which uses both AUDIT-C and FAST as screening tools, with a fuller assessment through AUDIT for patients who screen positive.

Advice on when to use assisted alcohol withdrawal

Although alcohol dependence is defined in both ICD-10 and DSM-IV as being either present or absent, we know dependence actually exists on a continuum of severity.

So it is helpful from a clinical perspective to subdivide dependence into mild, moderate and severe, and the NICE guidance uses these categories to recommend whether treatment should involve assisted alcohol withdrawal.

The Severity of Alcohol Dependence Questionnaire (SADQ) contains 20 questions designed to assess the potential for withdrawal symptoms.

AUDIT-C screening test

Question	Score 0	1	2	3	4
How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week
How many units of alcohol do you drink on a typical day when you are drinking?	1-2	3-4	5-6	7-9	10+
How often have you had ≥6 units if female or ≥8 if male on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

An AUDIT-C score of five or more should prompt the GP to ask the patient to complete the full AUDIT test

- A SADQ score of 15 or less corresponds to mild dependence and these people will not usually need assisted alcohol withdrawal.
- A SADQ score between 15 and 30 denotes moderate dependence, which will usually need assisted alcohol withdrawal, probably in a community setting unless there are other risks.
- A SADQ score of more than 30 suggests severe alcohol dependence and these people will need assisted withdrawal, typically in an inpatient or residential setting.

Treat alcohol misuse first

In patients who misuse alcohol and have comorbid depression or anxiety disorders, it's important to treat the alcohol misuse first as this may lead to significant improvement in the depression and anxiety.

If depression or anxiety continues after three to four weeks of abstinence from alcohol, then the problem should be reassessed and managed in line with the relevant guideline.

Clearer guidance on managing specific patient groups

Interventions for hazardous and harmful drinking

The NICE integrated care pathway recommends offering a session of structured brief advice on alcohol for these patients.

If this cannot be given immediately, offer an appointment as soon as possible, taking around 15 minutes to:

- cover the potential harm caused by their level of drinking and reasons for change, including benefits to health and wellbeing
- outline the practical strategies to help reduce alcohol consumption, but also discuss barriers to change
- develop a set of goals.

If on follow-up this has been ineffective, NICE recommends patients should then be offered an extended brief intervention of motivational interviewing or motivational enhancement lasting 20-30 minutes from someone trained in these techniques, depending on local availability.

Where necessary, up to four additional sessions or referral to a specialist alcohol treatment service should be offered.

Interventions for mild alcohol dependence

Offer a psychological intervention such as cognitive behavioural therapy that focuses specifically on alcohol-related cognitions, behaviour, problems and social networks.

If service users have not responded to psychological interventions alone, or specifically request a pharmacological intervention, consider also offering acamprosate or oral naltrexone – although the latter is an unlicensed indication.

Interventions for moderate and severe alcohol dependence

These patients should be considered for specialist assessment. Assisted withdrawal should be considered for anyone who is classified as alcohol-dependent, consisting of a fixed-dose pharmacological regimen plus psychological support.

Preferred medication for assisted withdrawal is a benzodiazepine (chlordiazepoxide or diazepam).

Mild and moderate dependence can often be managed at home after risk assessment by the community alcohol service. Administration should follow appropriate training in alcohol withdrawal.

Inpatient detoxification should be considered in:

- those with severe dependence
- those with mild to moderate dependence with complex needs
- those with previous withdrawal-related seizures or psychiatric, cognitive or physical comorbidities
- children and young people aged 10-17.

After a successful withdrawal for a patient with moderate or severe alcohol dependence, acamprosate or oral naltrexone should be considered.

Dr Jane Marshall is a GP in Birmingham who works in a local alcohol misuse service

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TEN TOP TIPS

Vertigo

Mr Andy Bath, ENT consultant, gives practical hints on managing vertigo

1 Not all dizziness is vertigo.

Dizziness is a common, non-specific symptom. It is an all-encompassing term within which patients may describe vertigo, presyncope, disequilibrium or lightheadedness. Pathologies that may cause dizziness include disorders of the vestibular, cardiovascular and central nervous systems. Anxiety, depression or panic attacks may also present with dizziness.

It is really important to obtain a good history – since most patients presenting with dizziness can be diagnosed by history alone.

2 Be aware of the symptoms of peripheral vestibular dysfunction.

Most lesions causing vertigo are because of peripheral vestibular dysfunction. These tend to cause severe, prostrating, rotatory vertigo associated with nausea and vomiting.

Patients usually clearly describe the onset, duration and precipitating factors. Associated symptoms suggesting an inner ear cause include hearing loss, tinnitus and aural fullness.

3 Exclude CNS disorders if there is loss of consciousness.

CNS disorders causing vertigo are considerably less common than peripheral vestibular dysfunction, and may be associated with evidence of focal neurological dysfunction such as diplopia, dysarthria, dysphagia, paresis, paraesthesia and incontinence. If loss of consciousness occurs, CNS or cardiac abnormality must be excluded.

4 Examine the ears and eyes.

Examine the ears to exclude active ear disease. Tuning fork tests may reveal a conductive or sensorineural hearing loss.

Abnormal eye movements may suggest either peripheral or central vestibular dysfunction. Also, a lying and standing blood pressure may reveal postural hypotension.

Perform a Hallpike manoeuvre as benign positional vertigo is the most common inner ear cause of vertigo and is treatable.

A description of how to perform the Halipike manoeuvre is available in *Case-based learning: vertigo* and tuning fork tests are covered in *Key questions: hearing problems*. Both are available on pulse-learning.co.uk.

5 Look out for cochlear symptoms or neurological dysfunction.

Any cochlear symptoms such as a unilateral sensorineural hearing loss or persistent tinnitus, or suggestion of neurological dysfunction, require further assessment by a specialist and probably an MRI scan to exclude intracranial pathology.

6 Try asking patients to hyperventilate.

Often GPs are presented with a patient suffering with a degree of anxiety that may either cause, or heighten, their symptoms.

In the absence of any abnormal signs on examination, asking the patient to hyperventilate for one minute may reproduce their symptoms and allow a diagnosis of psychogenic dizziness to be made.

7 Stop vestibular suppressants as soon as possible.

Vestibular suppressants should be used to treat the acute symptoms of vertigo, especially when they last for hours or days, but should be discontinued as soon as the patient's symptoms allow – tapering them off over about a week.

Avoid drugs such as prochlorperazine long term – they can cause drowsiness, which may exacerbate the symptoms of dizziness or cause poor central compensation from a peripheral vestibular insult. They can also increase the risk of Parkinson's disease.

8 Consider referring for vestibular rehabilitation.

Damage to the vestibular system causing vertigo may leave the patient with persistent unsteadiness. Central compensation usually occurs over the following few weeks, but this is less likely if patients lose confidence and limit their activities.

Many audiology departments offer vestibular rehabilitation, repeating different exercises – a sort of physiotherapy of the balance system – which can be very effective.

9 Don't forget to reassure patients.

It is important to remember that the symptoms of vertigo can be frightening. In most patients, symptoms are self-limiting and not life-threatening – and most will recover with no major problems.

But all patients benefit from the knowledge that they will recover and from, if possible, information regarding their prognosis.

10 Seek advice for patients with intractable symptoms.

In the last few years, there have been new treatments for diseases such as Meniere's disease, including intratympanic gentamycin and intratympanic steroids, along with the introduction of the Meniette device – which is used by the patient to generate a low-pressure pulse through a grommet to the middle ear space. For patients who have intractable symptoms it is always worth seeking further advice.

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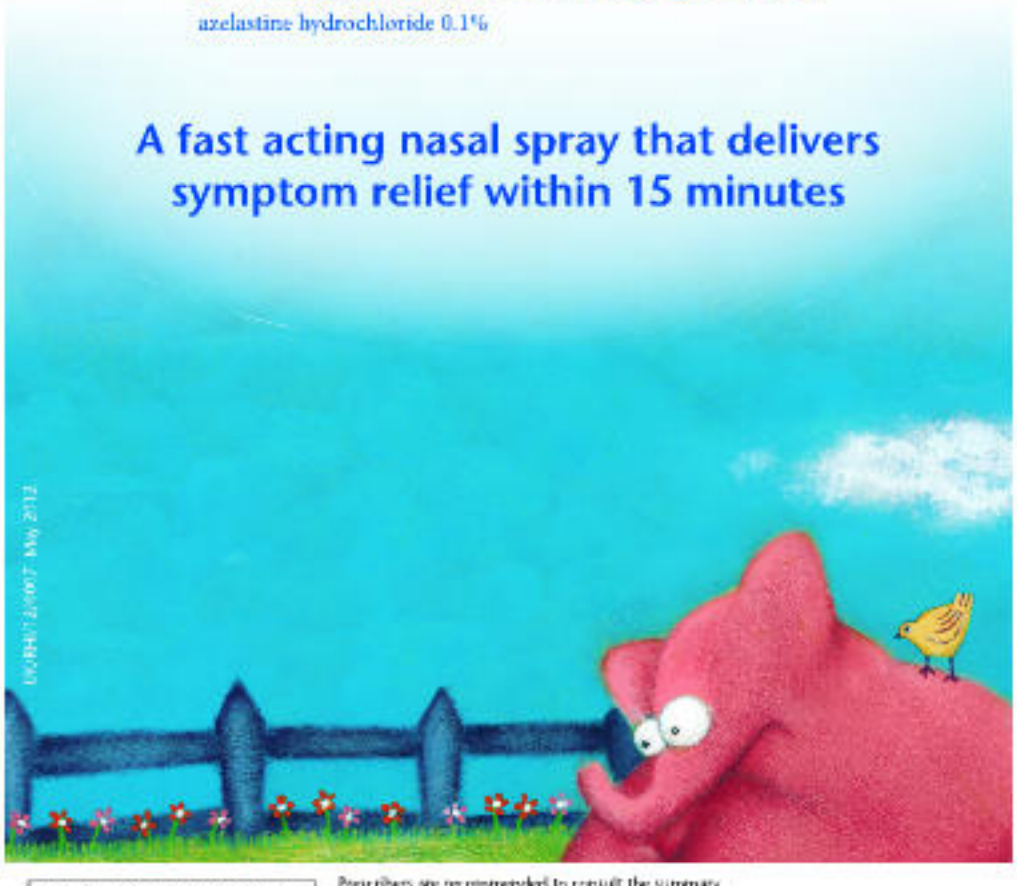

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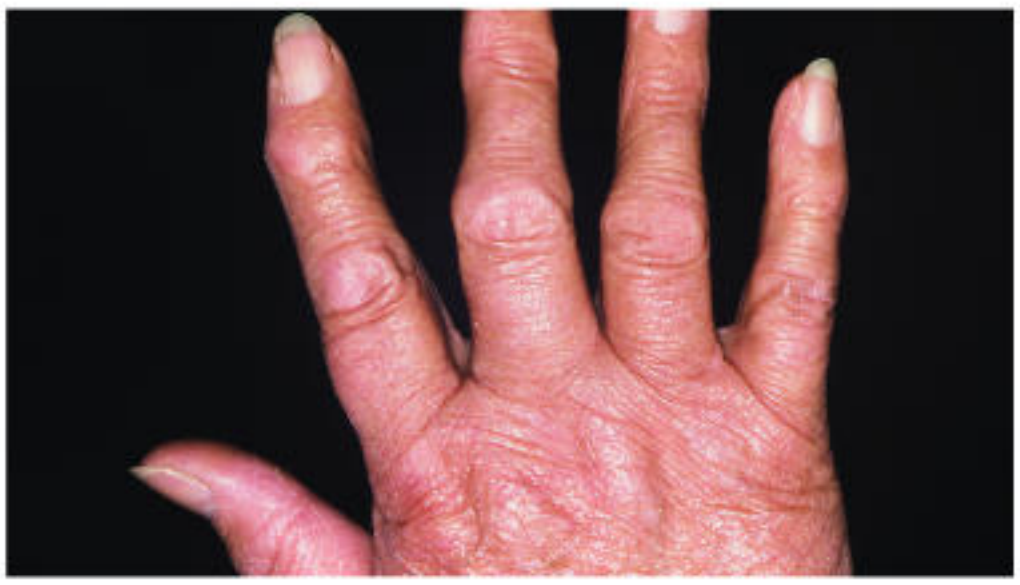
MEDA

Mr Andy Bath is an ENT consultant at Norfolk and Norwich University Hospital

Dr Keith Hopcroft describes how he reached the right diagnosis in this woman with painful, swollen joints



SNAPSHOT DIAGNOSIS

Swollen joints

THE PATIENT

This 65-year-old woman presented with painful, swollen joints in her hands, which had developed over the last few weeks. She routinely took a paracetamol-codeine combination for osteoarthritis of her knee, but said this wasn't really helping her new symptoms. She reported that the swelling seemed permanent, but the pain and stiffness were worse in the morning and after she'd been using her hands. She was otherwise well – her weight was static and her only other medication was a bronchodilator for mild asthma. She was particularly concerned about these new symptoms as she was about to go on holiday.

First instinct

My first thought was that she was developing an inflammatory arthritis – given the relatively recent onset, together with joint swelling and stiffness. Examination revealed a swollen and slightly warm right middle proximal interphalangeal joint, with the same possibly developing on the adjacent ring finger. There was an obvious Heberden's node on the index finger of the same hand. Her other hand seemed less affected, although there seemed to be some proximal interphalangeal joint swelling developing on her left little finger. The joint swellings were slightly warm and very firm.

Differential diagnosis

- Inflammatory arthritis, for example rheumatoid arthritis
- Osteoarthritis
- Gout
- Ganglions.

This woman had osteoarthritis of her knee, and the presence of a Heberden's node suggested her hand was affected too. But this clinical presentation was much more suggestive of an inflammatory rather than mechanical process.

Gout – as an acute polyarticular attack or in the form of gouty tophi – crossed my mind. But she had no history of previous episodes and the appearance certainly wasn't typical.

A final possibility was ganglions. We do see small ganglions on the hands, especially on the distal interphalangeal joints. But it seemed unlikely that a number would appear at the same time, or that they would cause pain and stiffness.

So I was left with the possibility of an inflammatory arthritis, probably rheumatoid, as the frontrunner, despite some features – such as the asymmetry – being atypical.

The hidden clue

I ordered a blood screen, prescribed some anti-inflammatories with PPI cover, and arranged to see her again in a few weeks – after her holiday. I fully expected to arrange a rheumatological referral. But on her return, the blood results were normal and she was delighted to report that – though the swelling remained – the stiffness and pain had completely resolved. This wasn't because of the NSAIDs – despite the PPI, she had suffered dyspepsia and stopped them immediately. So the main symptoms had resolved spontaneously. She was just left with these firm swellings on her proximal interphalangeal joints, which were now starting to make sense.

Getting on the right track

The pattern now pointed towards an acute presentation of osteoarthritis in the hands, sometimes known as nodal arthritis. So these swellings were Bouchard's nodes, which explained why they felt bony, rather than spongy like a synovitis. This was confirmed on review a couple of months later – no pain, obvious Bouchard's nodes and an unconcerned patient.

Dr Keith Hopcroft is a GP in Laindon, Essex

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Seven steps to achieving better flu vaccine uptake

Professor Niroshan Siriwardena explains how newly published advice on flu vaccine programmes can help improve uptake and lift your QOF score

Professor Niroshan Siriwardena found several ways GPs can improve vaccine uptake

The annual flu vaccination programme has become a regular feature of GPs' yearly work plan – so advice on *how* best to improve flu vaccination rates based on recently published research could provide evidence for practices organising their campaign.[1]

The study, which I worked on, examined data from 795 GP practices and identified seven strategies that increased the number of high-risk patients vaccinated.[2]

Flu vaccination is an important preventive measure. It is effective and cost-effective in reducing cases of influenza by around 50%: about two in every 23 people aged over 60 are affected by influenza each winter, and one of these cases is prevented by vaccination.[3]

By reducing influenza there will be consequent reductions in health service use, hospitalisation and death – it is estimated that during epidemic years, an extra 12,000 people die each year during the flu season.[4]

Although it is generally believed that most deaths are because of respiratory complications, in fact two-thirds are because of respiratory disease and a third are because of cardiovascular disease.[5]

This explains why there is a national target to reach vaccination rates of at least 75% in high-risk groups.

According to our study, the main factors linked to higher vaccination rates were clear leadership, processes for review of performance, good co-ordination and teamwork, planning for ordering vaccines and starting administration early in the season, and effective systems for identification, call and recall of patients.

The strategies identified here have been summarised by the Department of Health as a 10-point checklist, which if followed could help practices substantially increase their seasonal flu vaccination rates.

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1 Pick a flu vaccination lead

Appoint a lead member of staff to plan and co-ordinate the practice's flu vaccination campaign. Leadership, co-ordination and teamwork are fundamentally important to a campaign's success – and appointing a lead staff member was found to boost uptake among at-risk patients under 65 from 46% to 54%.

One observation we took from the study – and bear in mind we were only studying association, not cause and effect – was that practices that achieved QOF targets were more likely to have higher vaccination rates, probably because practices that are well organised are more likely to achieve both.

2 Write a report reviewing flu vaccine uptake rates

Practices that produced written reports are better able to organise more effective campaigns and achieve higher performance.

The DH now asks GPs to submit accurate data on the number of its patients eligible to receive flu vaccine and the flu vaccinations given to its patients on ImmForm (immform.dh.gov.uk) – this task will be made much easier if the practice manages data on eligible patients and vaccine records on its own behalf.

The report should include:

- past uptake rates for patients aged 65 and over
- past uptake rates in specific risk groups for under-65s
- past uptake rates overall, including those for pregnant patients
- how many vaccines were ordered the previous year and what proportion were used
- how well the practice achieved against national and QOF targets for flu vaccine, and how both those things affected practice profits.

It is also good to identify how much staff time you should assign to flu vaccination, especially once you have costed the volume of populations and potential gain in the QOF.

Practices may also like to review who led the last campaign and what kinds

30

of resources it required – for example, to provide weekend clinics.

While the survey didn't find that weekend clinics offered a direct benefit, practices often said it helped their workload if vaccination was assigned to a specific out-of-hours clinic rather than taking up time around appointments during the normal working day.

3 Prepare your vaccine order

Be sure to order sufficient vaccine. Many practices ordered vaccine on the basis of the previous year's uptake, and 20% did not order sufficient vaccines to even reach the flu vaccine target of 75%.

Preparing a report will help you forecast this year's uptake accurately.

4 Target at-risk patients

Nominate a member of staff to identify eligible patients using the practice computer system's search facility. Good registers and identification of at-risk groups in order to invite them for vaccination was an important prerequisite for achieving flu targets, and on average raised vaccination rates in the over-65s by four percentage points.

Influenza mortality is higher in patients of any age with underlying health problems.

The risk groups defined by our study were:

- all patients aged 65 years and over
- patients with chronic respiratory, heart, kidney, liver or neurological disease aged six months or older
- patients with diabetes aged six months or older
- patients with immunosuppression aged six months or older
- pregnant women
- people living in long-stay residential care homes or facilities where flu is likely to spread rapidly and cause high morbidity and mortality
- carers.

The list is not exhaustive, and the medical practitioner should apply clinical judgment to take into account the risk of flu exacerbating any underlying disease that a patient may have, as well as the risk of serious illness from flu itself.

Flu vaccine should be offered in such cases even if the individual is not in the clinical risk groups specified above.

The DH recommends that the GP practice has a register that can identify all patients under 65 years in risk groups, those aged 65 years and over, and pregnant women – including those who fall pregnant during the flu season.

5 Send a personal invitation to all eligible patients

Personal invitations, either alone or in combination with general publicity, were associated with higher vaccination rates, raising them by an average of seven percentage points.

The DH recommends sending a letter, and chasing up by letter or phone patients who don't respond or fail to take up the invitation.

The practice can also offer vaccination by putting on dedicated clinics or recommending vaccination as and when patients attend the surgery.

6 Co-ordinate your vaccination plan with midwives

Working with community health staff including midwives to reach at-risk groups was an effective strategy. The provision of flu vaccine by midwives was associated with a 4% higher rate among pregnant women.

7 Aim for national targets

Continue the vaccination programme until national targets – including QOF targets – for flu vaccination are reached. This year's DH target is to vaccinate at least 75% of those at greatest risk before the season starts.

QOF indicators linked to influenza vaccination

Indicator	Points	Payment stages (%)
CHD12 **The percentage of patients with coronary heart disease who have had influenza immunisation in the preceding 1 September to 31 March**	7	50–90
STROKE 10 **The percentage of patients with stroke or TIA who have had influenza immunisation in the preceding 1 September to 31 March**	2	45–85
DM18 **The percentage of patients with diabetes who have had influenza immunisation in the preceding 1 September to 31 March**	3	45–85
COPD8 **The percentage of patients with COPD who have had influenza immunisation in the preceding 1 September to 31 March**	6	45–85

Professor Niroshan Siriwardena is professor of primary and pre-hospital healthcare at the University of Lincoln and a GP in the city

MORE ONLINE
Download the DH's 10-step guide to vaccine programme success, developed from Dr Siriwardena's recommendations, and learn more about the risk groups for flu

References

1 Department of Health. The flu immunisation programme 2012/13. May 2012
2 Dexter L, Teare M, Dexter M et al. Strategies to increase influenza vaccination rates: outcomes of a nationWide cross-sectional survey of UK general practice. *BMJ Open* 2012;2:e000851
3 Moore A. Influenza vaccination in the elderly. *Bandolier* 1995;1:87-8
4 Warren-Gash C, Smeeth L and Hayward A. Influenza as a trigger for acute myocardial infarction or death from cardiovascular disease: a systematic review. *Lancet Infect Dis* 2009;9:601-10
5 Schanzer D, Langley J and Tam T. Comorbidities associated with influenza-attributed mortality, 1994-2000, Canada. *Vaccine* 2008;26:4697-703

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Dr Ivan Benett describes how setting up a LES helped turn around re-admission rates

How we halved hospital admissions for heart failure

The problem

Unnecessary hospital admissions are bad for the patient and expensive for commissioners. Inpatient care makes up the majority of the costs of heart failure treatment, and there are evidence-based interventions that reduce hospital admissions, and prolong life, that are not being implemented in practice.

In 2007, admissions from central Manchester practices were running at about four per 1,000 population per year, and around one patient in four was being readmitted again soon after discharge. This was much higher than other areas, and was attributed to Manchester having high levels of 'deprivation'. There is a large tertiary cardiology centre in the middle of our patch – but no community heart failure service.

I wanted to challenge the notion that we should accept poor performance just because we work in a deprived area.

What we did

The first step was to persuade people in the PCT and the tertiary cardiologists that it might be possible to make a difference to the patients. I devised a local enhanced service (LES) specification (see box) based on NICE guidelines for heart failure management, which included patient education. The business case was made on projected outpatient savings, and I was able to win the argument to run it as a pilot.

I then had to devise an education programme and accreditation process for practices. One GP and one practice nurse from each practice needed to be accredited. I persuaded the local cardiology department to get involved, and they presented a one-day educational session.

The GP and practice nurse then attended at least three outpatient clinics, with a doctor and specialist nurse respectively. Each practice also had to undertake an audit of its care and a significant-event analysis of one of its a hospital admissions. These were presented at an accreditation meeting, alongside a description of how the practice intended to deliver the LES.

Five practices were successful on the first occasion, and a further five were accredited two years later. Since the LES began, we have been meeting about three times a year to discuss developments in heart failure, progress of the LES within practices and any problems we have encountered.

The heart failure LES is very much about implementing evidence-based interventions. Doctors are educated in those interventions and are responsible for up-titration of medication, regular review and for referral back to a specialist if necessary.

The task for the practice nurses is equally important, as they educate the patient and manage their concerns. Patients are taught to monitor themselves – in particular, they note their symptoms and weigh themselves regularly.

They are encouraged to contact the surgery, often through the practice nurse, if their symptoms deteriorate. They are also asked to make contact if they put on more than one kilogram in a day or two in a week, or if symptoms get worse. In that way the practice can intervene before the patient gets so ill they need admission.

With increased confidence, practices can manage people at the end of life and don't feel they need to rush patients into hospital when they deteriorate. Advanced care planning – set up back in 2007 in the Manchester area – can be more easily discussed and patients enabled to stay at home if they wish.

Lessons learned

Along the way, several lessons have been learned. These things take a long time to set up, so there needs to be a willing champion to carry the programme through difficulties and hard times.

The main problem was getting the LES to be accepted by the PCT and, in particular, its finance committee. These days it should be easier with the CCGs, but a sound business case will still need to be made.

It was vital to get the confidence of the secondary and tertiary care consultants. This was done by persuading them of the potential benefits and involving them in the accreditation and education programme.

Finally, I had to persuade a handful of practices that it was worth the effort and expense. To help things along they were given an education grant to cover attendance at the outpatient clinics.

Outcomes

For the LES practices, admissions fell to about 2.4 patients per 1,000 per year and readmissions to 0.6 per 1,000 per year within a year, and continued to fall to 1.6 and 0.2 admissions and readmissions respectively. They have stabilised at about this level since.

The cost of heart failure admissions added to the cost of running the LES is about £1,500 per 1,000 population covered by the LES practices per year. The cost for the population not covered by the LES is about £2,500 per 1,000 per year.

Stable heart failure patients, currently being followed up as outpatients, have now been discharged back to their practices for routine follow-up. There is an understanding that they can be referred back if necessary.

Although not quantifiable, another outcome has been to develop relationships between GPs and specialists, and practice nurses and specialist nurses.

The GP ensures gradual up-titration of medication and support for the practice nurse. The practice nurse's role is vital to patient education, as well as being a contact in the practice for the patient for advice (and monitoring if necessary).

One of the big advantages of this model is that there is a 'vertical' relationship developed between the GP and practice nurse and the hospital team.

Stable heart failure patients being followed up in outpatients have often been discharged to LES practices – and this saving has not been included in the costings of the LES, but is considered an extra financial benefit.

The main benefit has been to keep people – often towards the end of their lives – well enough to stay out of hospital. This outcome is priceless.

There have been other spin-offs. The hospital acute trust has become more confident that primary care can deliver change and provide high-quality management for our patients. This has allowed us to develop other areas of patient care.

We now have a clinical integrated care board that examines planned and urgent care and has started to develop integrated community teams. We have been able to dramatically reduce urgent and planned care activity too.

The future

For the immediate future, we are rolling out the LES to another five or so practices. I have also been able to persuade the CCG that we can use the same model to improve on diabetes care in central Manchester, where again we are said to be trailing others due to having a deprived population.

In Manchester, we perform less well than we could in diabetes care. There is a high admission rate and QOF indicators fall lower than the national average. When we audited referrals to secondary care, about one in three could have been managed by an up-skilled practice.

Thanks to the success of the heart failure model, the CCG has been able to invest in an education programme and LES for diabetes. The outcomes have so far been better QOF performance, fewer outpatient referrals and few urgent admissions for hypo- or hyperglycaemia.

In addition, we would like to use this LES to get practices that haven't been trained for the diabetes LES to refer to LES practices if the problem is glycaemic or one of blood pressure control.

Finally, by identifying and optimally managing cardiovascular disease, we aim to reduce the gap in life expectancy between our 'deprived' population and the rest of the country by one out of the three years it stands at currently.

Dr Ivan Benett is a GPSI in cardiology and clinical director for Central Manchester CCG

The LVSD LES

The LES specifically targeted specialised services for patients with left ventricular systolic dysfunction (LVSD) in primary care, and its stated aims were to improve the quality of care, wellbeing and satisfaction of patients with LVSD, and to reduce hospital admissions in the same group.

Clinicians were instructed to register patients who had LVSD, to perform an ECG to confirm diagnosis and to get patients onto a maximum tolerable dose of ACE inhibitors or ARBs before being seen by a cardiologist to assess the need for angiography or an implantable cardioverter defibrillator.

The patient would then be handed back to the practice for a series of six-monthly reviews concerning lifestyle, medication, weight and electrolyte measurement. The patients would also be taught more about the condition, and surveyed on their satisfaction with the service being given.

The practice gets a one-off payment of £278 for each newly diagnosed patient in the scheme, and an annual payment of £52 a year per patient to cover the two reviews in that period.

MORE ONLINE
Go to pulsetoday.co.uk/commissioning to download a copy of the LES

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Further information by request.

Closing Date: 8 July 2012

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Lancashire FY8 4GW
Tel: 01253 657319

carole.bonney@gp-81037.nhs.uk
www.ansdellmedicalcentre.co.uk

Please email or telephone to arrange an informal visit.

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Please apply with CV and covering letter to:
Kathryn Baines, Practice Manager, Saxon Spires Practice,
West Haddon Road, Guilsborough, Northamptonshire NN6 8QE
Tel: 01604 740210 Email: Kathryn.Baines@gp-K83064.nhs.uk

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For further information regarding this post please contact either Mr C E Colley or Dr A S Robertson.

Please apply in writing with your CV to the above address or email chris.colley@nhs.net

Closing date for applications is 31st July 2012.

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Nicholas Emery, Practice Manager,
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Closing date 13th July 2012

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Main surgery:
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For further information please call Angela Bonney on 07811 768103.

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Informal enquiry:
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GP PARTNER Opportunity
6 sessions per week
From 1st October 2012
(Salaried GP considered)

We are a friendly, forward thinking, five partner GMS practice based in Ilminster, Somerset.

- 7100 patients
- Training practice
- EMIS LV clinical system
- High QOF achievement
- Dispensing practice
- Committed to delivering enhanced services and actively engaging in local commissioning
- New purpose built premises from 1st September 2012

Applications in writing, with CV, to Susan Harris, Practice Manager, Summervale Medical Centre, Wharf Lane, Ilminster, Somerset, TA19 0DT
or susan.harris@summervale.ilm.nhs.uk
If you would like to arrange an informal visit or require further information please e mail or ring 01460 52354

SALARIED GP OR RETAINER

4 Sessions a week:
Tuesday and Thursday preferred
Starting ASAP

PRINCES GARDENS SURGERY, ALDERSHOT, HAMPSHIRE

We are a friendly, well established practice with a reputation for providing good patient care, with a strong, supportive team. We are a PMS practice in the centre of town in new purpose-built premises.

7,300 patients
Isoft Premiere (moving to Synergy)
4 partners and 2 salaried GPs
Training practice
Medical students
High QOF achievement
6 month period of mutual assessment as salaried GP

Please send a CV and covering letter to Elaine Beverley, Practice Manager by email only to elaine.beverley@nhs.net

Closing date for applications 13th July 2012

– SALARIED GPs –

Morden Hall Medical Centre is a friendly GP Practice in SW London currently looking to recruit ***salaried GPs*** to fill up to ten sessions per week. CVs initially to Stephen Hartley, practice manager – Stephen.hartley1@nhs.net

DOCTORS/GPS REQUIRED

THE SCOTT PRACTICE
G P PARTNER

Large, innovative, advanced training practice in Doncaster, easy access to transport links (just 30 minutes from Sheffield). We are looking to appoint a new GP Partner for 7 sessions a week, to join our existing team from December 2012.

13,600 patients
TSoft premiere (moving to Synergy)
9 Gp partners + Managing Partner
Advanced training practice – 5 Registrars
Medical students
High QOF achievement
Branch surgery
6 month period of mutual assessment as salaried GP

If you have high clinical standards, high commitment to General Practice, are motivated and flexible then you will fit in well.

If you feel this is you please send your CV with covering letter to: Mrs Rose Fells, Managing Partner, The Scott Practice, 1 Greenfield Lane, Balby, Doncaster DN4 0TG

Closing date for applications 25.6.12

Please note interviews will be held on Saturday 30th June only.

SALARIED GP / PARTNER
FULLTIME

The Partners are seeking an enthusiastic, motivated GP to join our well established, hard working and friendly team in the Royal Harbour town of Ramsgate, Kent.

- *Four doctor GMS/VISION practice: supportive nursing and admin team.*
- *Together we manage 7000 patients, emphasising clinical excellence and continuity of care.*
- *Committed to achieving high standards in QoF, delivering Enhanced Services and actively engaging in local commissioning.*
- *Planning stages for re-development of premises with the addition of a new 100 hour Pharmacy.*

The successful candidate would be committed to the provision of quality care and the onward development of the practice. Partnership would be considered after a successful mutual assessment period.

Closing date Friday 6th July 2012

Informal enquiries and visits welcome.
Please e-mail CV and letter of application Richard Lawson, Practice Manager richardlawson@nhs.net

---

Staunton Group Practice, Wood Green, London N22 8HE

Maternity Locum

required for approx seven sessions per week, starting a.s.a.p

Come and join a well established, modern GMS inner city training practice with seven partners and three salaried GPs serving a diverse population with a list size of 16,500 patients. We are a dynamic, friendly, primary care team providing a wide range of high quality health care to our practice population.

- High QoF Scores
- Under/Postgraduate training
- Attractive, purpose-built premises
- Paperlight using InPS Vision

Candidates preferring a shorter period or fewer sessions should still apply as we can be flexible. Pay and terms negotiable.

If you are interested, please send a CV with a covering letter (by email only) to: **Sanjiv Gupta, Practice Manager,** email: **staunton.group@nhs.net**

For Informal enquiries: **020 8826 1991**

WHETSTONE MEDICAL CENTRE
BIRKENHEAD, WIRRAL

SALARIED GP REQUIRED
FOR SIX SESSIONS PER WEEK

We are a six partner GMS urban practice with a vacancy due to retirement of a partner.

We are looking for an enthusiastic GP to join our friendly and supportive team, initially on a 12 month contract 8,900 patients.

EMIS LV due to move to EMIS web Oct12.

On site pharmacy, physiotherapy and counseling Involved in undergraduate teaching.

Starting date 1st September 2012

Closing date for applications 10th July

Applications in writing with CV to:-
Mrs Anita Jones, Practice Manager,
Whetstone Medical Centre,
44 Whetstone Lane, Birkenhead, Wirral CH41 2TF
e mail: anitajones2@nhs.net

BEDFORD
Two Full Time SALARIED GP's

For friendly training APMS Practice (11,800 pts) and Nurse led NHS Walk in Centre, ideally to start as soon as possible. Salary negotiable.

Please contact: Sam Paul, Practice Manager, Putnoe Medical & NHS Walk in Centre. Tel: 01234 319990. Email: sam.paul@nhs.net

---

Salaried GP

Upton Road Surgery-Watford, Herts

- Diverse outer London Area
- Close to M1 M25
- EMIS LV Practice, looking to move to EMIS web
- Full time (8 sessions) or two part time Doctors wanted
- GMS Practice
- To start as soon as possible
- View to partnership for the right person

Contact: Denise Cooper, Practice Manager,
Upton Road Surgery, 30 Upton Road, Watford WD18 0JS
Tel: 01923 226266

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or call on 020 7224 0030

We are seeking an enthusiastic salaried GP for 4 or 5 sessions per week Tuesday to Friday. We are a PMS Practice with 10,000 patients in Crowborough East Sussex.

A GP with an area of Special Interest and the flexibility to provide additional sessions as cover would be an advantage.

Please send a CV and covering letter to Frank Powell, Practice Manager, Beacon Surgery, Beacon Road, Crowborough, East Sussex TN6 1AH.

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EDITOR'S CHOICE

Gearing up for the Olympics

The influx of visitors for the Olympics offers GPs an opportunity to show the world the best of British primary care, says Dr May Cahill

Dr May Cahill: use Olympics to boost health campaigning

The Olympic and Paralympic Games represent one of the largest-ever peace-time events in terms of logistics. About 14,000 athletes from 205 nations will compete at more than 30 sports venues across the country, 12 of which will be in London. Ticket sales have topped 10 million and there are more than 600 major cultural events planned in London.

But what about our health services?

We can predict the predictable – we're planning for increased A&E attendances by people with alcohol and drug problems, and for disruption to transport with spin-off effects on business continuity. This is particularly relevant to staff working in the NHS and emergency services.

Primary care will, as ever, be one of the lynchpins in the provision and response of the local NHS.

There will be dedicated primary care facilities at the Olympic venue, along with a variety of walk-in and GP-led sites across the capital all ready to face the challenge of a rise in the number of visitors.

The burden on individual GP surgeries will vary, depending on how close they are to key tourist attractions.

And there will be an onus on practices to be flexible in their approach to treating visitors who may pitch up, and to help them navigate the health system to find the right services.

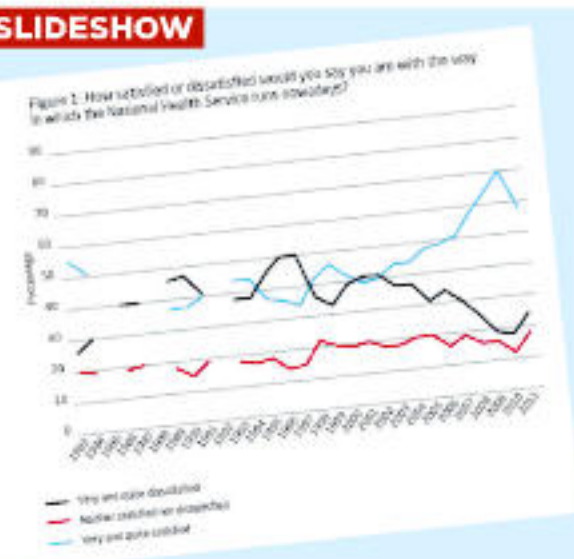
GPs can use the Olympics to reinforce our campaigns around healthy lifestyles, exercise, health promotion and improving wellbeing, and spread key public health messages.

The public will be on our doorstep, ready to watch the world's greatest athletes perform for six weeks: we may never have such a captive audience again.

Dr May Cahill is joint medical director at NHS North East London and the City and a GP in Hackney

▶ pulsetoday.co.uk/opinion

SLIDESHOW



'All in all, how satisfied or dissatisfied would you say you are with the way in which the National Health Service runs nowadays?' This is the question the King's Fund asked in its patient satisfaction survey *British social attitudes*.

So, what do patients really think of the NHS? Go online to see an interactive slideshow of graphs and data from the survey.

▶ pulsetoday.co.uk/news-analysis

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MARV 11.GB.Jun/011.JH

MSD

WHAT YOU'VE BEEN SAYING

▶ pulsetoday.co.uk/forum

> **I have come across doctors who attempt exorcisms.**
>
> ... after a GP was given a GMC warning for discussing religion with a patient

> **Somebody has forgotten to take their pills!**
>
> ... on GPs being threatened with 'breach of contract' notices over industrial action

> **A principled stance? Obviously not a real politician.**
>
> ... on the CCG lead who quit over the pension changes

GPs TO BE

Why a score out of 10?

Like a lot of people, I'm a bit confused about the NHS's decision to allow people to score their GP practice out of 10 on the NHS Choices website. A number doesn't really tell you much. Online feedback is easy, instant, permanent – and largely negative....

GPs TO BE
Read the rest of the post by Dr Martin Wicks at pulsetoday.co.uk/gpstobe

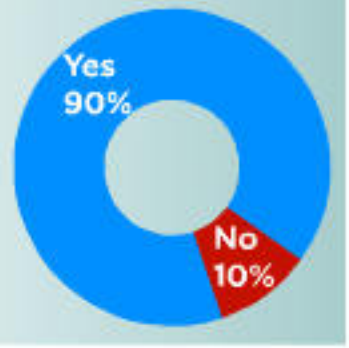
THIS WEEK'S POLL

Should practices offer patients online appointment booking?

Vote at ▶ pulsetoday.co.uk/polls

Last week's poll

Should the BMA boycott commissioning over pensions?



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