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BriefingMedia

At the heart of general practice since 1960

GPs to be forced to use Choose and Book

DH says GPs who refuse must adopt 'labour-intensive' alternatives or face sanctions

By Jaimie Kaffash

GPs will be forced to refer patients through Choose and Book or call around multiple hospitals to check appointment availability in person, under radical Government plans to extend choice of NHS services.

Practices will be expected to adopt 'labour-intensive' alternatives if they refuse to use the controversial electronic referral service, with the Department of Health consulting on sanctions for those who refuse, in a move condemned by the GPC as 'highly inappropriate'. The DH is even looking at giving patients direct access to Choose and Book through NHS Choices so they can book their own appointments.

The proposals are part of a wide-ranging DH initiative to force GPs to engage with the choice agenda, outlined in the *Liberating the NHS: No decision about me, without me* consultation published last week.

GP use of Choose and Book will be published so patients can 'exert pressure' on practices to provide choice, while GPs will also be asked to offer patients a choice of diagnostic providers, initially for MRI scans and non-obstetric ultrasound.

EDITORIAL ▶

A tangle of logical contradictions 12

The Government will also begin routinely using alternative providers to treat patients who miss the 18-week target, with pilots this year focusing on orthopaedic services and full rollout from next April.

The Government's national target is for 90% of referrals to be made through Choose and Book, but in January Pulse revealed the DH had launched an investigation after use fell to just 50%, from a high of 57%.

The fall came after many PCTs removed LES incentives for GPs' use of the system.

In its new strategy, the DH said a 'cultural change' was needed on choice and that it was determined to ramp up Choose and Book use.

'We are working to maximise use of Choose and Book so that more referrals are made through it,' the DH said. 'Where Choose and Book is not being used, formal requirements to support greater choice for patients will have to be met by alternative, potentially labour-intensive, methods.'

The DH told Pulse it would be up to GPs to find alternative ways of providing choice, but said this could include phoning round providers to check their services and sending hard-copy referral letters.

Sanctions for GPs found not to offer choice were being consulted on, a spokesperson said: 'GP practices that don't use Choose and Book will need to make alternative arrangements to ensure people have more choice in their care. Alternatives may well create more burdens on doctors.'

GPs responded angrily, with GPC negotiator Dr Chaand Nagpaul claiming it was 'highly erroneous' to blame GPs for not using Choose and Book: 'The main reason they don't is it is too slow and interferes with consultations. It is inappropriate for GPs to be pursuing any "labour-intensive" approach to a choice political agenda when the priority must be time with patients.'

Dr Andrew Mimnagh, chair of Sefton LMC and a GP in Waterloo, Merseyside, said: 'If the software actually worked, it would be used.'

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Plans to extend choice

Choose and Book
GPs must use it or make other arrangements

Diagnostics
Patients allowed to choose provider

Private treatment
Offered if NHS cannot meet waiting times

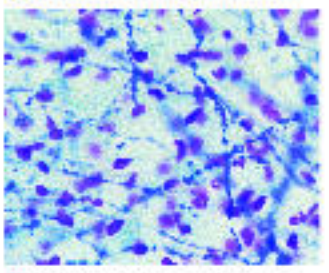
BALLOTS WERE ON GPs' MINDS AT THE LMC CONFERENCE

Industrial action ballot

GPs will learn the result of the historic ballot on industrial action over pensions this week. Check Pulse's website for the result and the BMA's decision on what action to take. ▶ pulsetoday.co.uk/news

LMC Conference

For full coverage of LMC Conference 2012, including votes on pensions, turn to pages 4-5



The week in general practice

INSIDE

Dame Barbara Hakin

MORE ONLINE

▶ pulsetoday.co.uk/news

The DH will close its flagship website offering patients access to their electronic records in the next year, as it is too 'difficult' for patients to use
▶ pulsetoday.co.uk/politicalnews

The RCGP has launched new DH-backed guidance to support GPs in responding to signs of domestic violence
▶ pulsetoday.co.uk/clinicalnews

Video of the week
Watch GPC chair Dr Laurence Buckman's keynote speech to the annual LMC conference in Liverpool
▶ pulsetoday.co.uk/videos

PULSENEWS

Boundary pilot faces 120,000 new patients

NHS analysis reveals single practice in the City to be overwhelmed – with 50 new GPs needed

EXCLUSIVE
By Jaimie Kaffash

The abolition of practice boundaries will see inner-city practices overwhelmed with commuters, with 120,000 patients set to register in the City of London alone, according to official research commissioned by NHS managers.

A report drawn up for the City of London Corporation and NHS North East London warns allowing patients to register near their workplace could stretch existing services to breaking point and create additional demand for more than a dozen GP practices.

The warning came as LMC leaders urged GPs in east London to boycott the Government's pilots of removal of boundaries, over fears an influx of patients would 'inevitably' result in cuts to existing services.

A survey of 2,519 workers included in the report – published this month – found 33% would prefer to register close to work, and 82% backed dual registration. If all patients who wished to register near to work did so, there would be an extra 120,000 registrations, requiring 14 practices to be opened to add to the one currently in the Square Mile, the report warned. It estimated 50 new GPs and 50 new practice nurses would need

33% of respondents would prefer to be registered with a GP near work rather than near home. Assuming the same percentage applies across the estimated 359,600 City workers, provision would be needed for just under 120,000 GP registrations... To meet this demand would therefore require a further 14 NHS GP practices.

Source: Public Health Action Support Team. *The public health and primary healthcare needs of City workers*. 2012

CCGs to link up

By Nigel Praities

GPs will be expected to work with drug companies on commissioning screening services and designing care pathways, under a Government-backed plan to promote partnerships between CCGs and the pharmaceutical industry.

A new scheme aims to make it easier for pharmaceutical companies to 'move beyond sponsorship' in working with CCGs and funding NHS case-finding projects. The guide to 'joint working agreements' has been drawn up by the Association of the British Pharmaceutical Industry with the support of the Department of Health.

But GP leaders warned the plans were fraught with conflicts of interest and could skew the priorities of emerging CCGs – and pile extra work on GPs.

'Popular areas for joint working include identification of undiagnosed patients, reviewing uncontrolled patients, improving patient adherence and treatment pathway redesign,' the document says.

The ABPI last year altered its code of practice to allow pharmaceutical companies to develop so-called 'risk-sharing agree-

'CCGs should not use this as a way to make short-term savings'
Dr Richard Vautrey

Ministers to block GPs from

Ministers have vowed to block any move by GP leaders to expand the private services GPs can offer to their patients.

The rebuff comes after LMC leaders urged the GPC to renegotiate the GMS contract to allow practices to charge for treatments not funded by the NHS.

In a knife-edge vote at last week's annual LMC Conference in Liverpool, GPs narrowly backed a call to expand on the current limited list of treatments practices can provide to their patients privately.

The motion was opposed by the GPC leadership and deeply divided LMCs, but was narrowly passed by 48% to 47%.

But the Department of

Dr Jacqueline Applebee: pilots treat healthcare as a commodity

to be recruited, and additional adult counselling services and extended-hours capacity would be required.

'Initially resource use might be even higher, as new patients tend to see their healthcare providers twice as frequently as patients who have been registered for a while,' the report said.

GPs working at the Neaman Practice in the City of London 'recognised the potential benefits of City workers being able to register with a GP practice closer to work', but were concerned they did not have the resources to cope, the report added. NHS City and Hackney is part of the current practice boundary pilot scheme along with NHS Tower Hamlets – where about 100,000 people work at Canary Wharf – Westminster, Nottingham, Salford and Manchester.

No practices have signed up from either City and Hackney or Tower Hamlets, even though the scheme was due to start in April, and few practices have signed up elsewhere.

Dr Sella Shanmugadasan, chair of Tower Hamlets LMC, said: 'They are not offering any additional resources during the pilot period to meet extra demands. We are already struggling to meet our needs.'

Last week's LMC conference voted in favour of abolishing the practice boundary pilots. Dr Jacqueline Applebee, a GP in Tower Hamlets, said the pilot 'treated healthcare as a commodity rather than a precious resource'.

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with pharma

ments' with CCGs, which would only pay full price for drugs if targets on clinical outcomes were met, and the new document aims to expand on this. It lists a number of joint projects between drug companies and the NHS, including review of patients with COPD, a GP-led angina clinic and provision of care managers for patients with CVD.

A spokesperson for the ABPI said it wanted to ensure collaborations like these could continue after CCGs were authorised: 'We would encourage CCGs to engage with local pharmaceutical representatives and highlight areas where patients could benefit from combining the skills and resources of the NHS and pharmaceutical industry.'

A DH spokesperson said: 'We have worked with the ABPI for a number of years to promote joint working between the NHS and industry. It is up to each project to establish governance arrangements.'

But Dr Richard Vautrey, GPC deputy chair, said there was a clear conflict of interest when involving drug companies in planning care: '[CCGs] should not use this as a way to make short-term savings, as the long-term adverse effects might be greater.'

Dr Des Spence, a GP in Glasgow whose *BMJ* column is often critical of the pharmaceutical industry, said: 'If there is underdiagnosis it should be judged by someone who has no vested interest. CCGs are naive if they can't see this is bad idea.'

@nigelpraities

offering private services

Health said it would not accept the changes if brought forward, with the GPC also appearing reluctant to act on the vote.

The motion, proposed by Dr Nimish Shah, a GP in Bridgend and member of Morgannwg LMC, said: 'Conference urges GPC to negotiate a change to the GMS contract that would allow patients to receive treatment not funded by the NHS from their own GP on a private basis.

He added: 'The perceived conflict of interest is nonsense.'

Dr Chaand Nagpaul, GPC negotiator, said: 'This issue raises a Pandora's box of questions. It is fiendishly complex.'

▶ Full LMC coverage, page 4

RCGP tries to ban half its candidates for president

Three of the six leading GPs standing in the RCGP presidential election were originally barred from standing and were only reinstated after legal advice, Pulse can reveal.

Dr Una Coales, an RCGP Council member and one of the six candidates standing, claimed on her blog last week that the college's nominations committee banned half of the candidates now in the race from standing last month, with one candidate told they were 'not fit and proper' for the role.

The RCGP would not comment on the reasons for the bans, or confirm the names of the three candidates concerned, whom Pulse has decided not to identify.

This year's tightly contested race includes former GPC chair Dr John Chisholm, Dr Coales, North West Deanery postgraduate dean Professor Jacky Hayden, Bristol GP Dr Terry Kemple, Department of Health QIPP lead Sir John Oldham and former RCGP chair Professor Mike Pringle.

Dr Coales said the three candidates were initially told they would not be put forward for the ballot in an email on 16 April.

But following an appeal from two of the three candidates, RCGP chief executive Neil Hunt decided to reinstate all three.

PENSIONS

LMCs back reforms boycott over pensions

Narrow vote supports extension of pension action to hit commissioning

By Gareth Iacobucci

Say No to 30%

The BMA is to consider including a boycott of commissioning as part of future industrial action over the Government's pension reforms, after a key vote at the annual LMC conference in Liverpool.

In a passionate debate, LMCs overwhelmingly supported industrial action as a means of registering the profession's anger at ministers' raid on GPs' pensions.

But in a narrow 48% to 37% vote, LMC representatives also backed a motion recommending 'the disengagement of GPs from clinical commissioning be included in any industrial action'.

The vote comes as a boost for Pulse's *Say No to 30%* campaign, a key strand of which calls on the BMA to follow up on its proposed 'day of action' by balloting on a boycott of non-clinical work.

GPC leaders said the BMA would take account of the vote if planning any potential industrial action, but said the issue was complicated by the fact that the ballot taking place was UK-wide, while the possibility of withdrawing from commissioning was limited to England.

Dr Terry John, chair of Waltham Forest LMC, who proposed the motion, said: 'It is important for this conference to send a message. We need to take a stand.'

Dr Anthony O'Brien, a member of Devon LMC, said: 'Disengaging temporarily from clinical commissioning would have a dramatic effect. We have a massively powerful tool. We should use it.'

Dr Fay Wilson, BMA Council member and a member of Birmingham LMC, also backed industrial action, and issued a rallying cry to LMCs: 'If we are not prepared to stand up and be counted, they'll be back next year. We are being blackmailed because of our devotion to patients. Grit your teeth and walk the walk.'

The boycott vote was carried despite the GPC warning that withdrawing from commissioning would work against the profession.

GPC negotiator Dr David Bailey said withdrawal could 'leave the door open for enthusiasts – the 5% of our profession who think clinical commissioning is a way of controlling the rest of us'.

Following the vote, GPC negotiator Dr Chaand Nagpaul told Pulse the BMA would consider the vote when planning any future industrial action.

But he cautioned: 'It's a UK-wide ballot, and GPs withdrawing from commissioning is an English issue.'

In a separate motion, GPs called on the Government to reconsider its controversial pension reforms and return to negotiations with the profession, and warned there was 'a danger of workers of all ages leaving the NHS' because of the changes.

@garethiacobucci

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LMC leaders met in Liverpool for the first time

LMC conference videos

GPC chair Dr Laurence Buckman's keynote speech

Dr Fay Wilson on pensions: 'It's time to stand up and be counted'

Dr John Crompton on whether GPs could strike

pulsetoday.co.uk/videos

KEYNOTE SPEECH

'Tough times' for GPs

GPs' efforts to navigate an NHS heading towards 'financial and operational meltdown' are being hampered by 'regulation, bullying micromanagement and dissipated effort', GPC chair Dr Laurence Buckman has warned.

In a defiant keynote speech to representatives – his fifth as GPC chair – Dr Buckman took aim at a raft of Government policies, including pension reforms, revalidation and the removal of practice boundaries, and warned GPs' working lives were becoming unsustainable.

He said the extension of GP training and the 100th anniversary of the GPC had represented some 'rays of light' in the past year, but said GPs were operating in 'tough, uncertain and not very happy times'.

'All of us can see that workloads are rising back to 1999 levels, and most of us are back to 12-hour days,' he said.

'If we are continually ignored, we are going to be forced to walk away as our practices, our health and our solvency fail. This is not a threat – merely recognising reality.'

Dr Buckman also warned CCGs were developing without the involvement of many grassroots GPs, and said they must be made to work with LMCs.

REVALIDATION

GMC under fire over revalidation plans

By Gareth Iacobucci

LMCs have heaped pressure on the GMC by voting unanimously that revalidation must not go ahead without adequate arrangements for remediation that fully cover all types of GP.

Representatives at the annual LMC conference also poured scorn on the GMC for its 'total lack of leadership' on the policy, as GPs made their feelings known ahead of its planned introduction next year.

The motion insisted revalidation 'must not go ahead without proper arrangements for remediation, which are no more burdensome for GPs than for other doctors', and 'proper arrangements for all types of GPs, including sessional and prison GPs'.

It also called for any process to be 'simple, sensible and non-threatening', and 'not result in any increase in GMC fees for GPs'.

The vote came after Professor Malcolm Lewis, a GMC council member and a GP in Swansea, told the conference disagreements over remediation 'shouldn't be a delaying factor' for revalidation, as the majority of GPs would not need it.

GPs also expressed their anger at the GMC's policy of offering private medical insurance to its staff, as first revealed by Pulse back in January.

Dr Andrew Green, chair of East Yorkshire LMC, who proposed the revalidation motion, said: 'There has been a total lack of leadership by the GMC, and shocking complacency shown in front of us to say remediation and revalidation are not the same thing.

'Revalidation needs to work for all of us. If it isn't fair for all doctors, it isn't fit for purpose.'

The vote came after the GPC had encouraged GPs to back the motion, with GPC negotiator Dr Dean Marshall saying it was 'completely unacceptable' to push ahead when arrangements were not in place for all doctors, including sessional GPs.

Dr Marshall said: 'The GMC are shirking their responsibility to sort this out. They are clearly not getting the message. It was an incredibly unfortunate comment that it will only apply to a few doctors.

'The GMC has made a complete and utter hash of this.'

@garethiacobucci

Professor Malcolm Lewis (right) is introduced to the LMC bear pit

IN BRIEF

CQC registration

GPs demanded that practices should not incur any expense from CQC registration, unanimously backing a motion condemning current plans as 'a bridge too far'.

NHS 111

LMCs voted in favour of a motion warning the Government's rushed imposition of NHS 111 would compromise patient safety, and endanger existing GP out-of-hours services.

Work assessments

Representatives also backed a call for the work capability assessments run by private firm Atos to 'end with immediate effect', and be replaced with 'a rigorous and safe system that does not cause avoidable harm to some of the weakest and most vulnerable in society'.

HEALTH ACT

BMA faces down LMCs

BMA leaders have faced down a rebellion by LMCs over their policy of 'constructive engagement' with the NHS reforms.

A motion proposed by Dr Paul Hobday, a GP in Maidstone, Kent, asked LMCs to reprimand the BMA leadership for 'taking so long to wake up to the malignant effect of the Health and Social Care Act'. But representatives rejected the motion after a heated debate, in which BMA chair Dr Hamish Meldrum and GPC chair Dr Laurence Buckman defended their stance.

Dr Hobday questioned why the BMA had refused to ballot members on possible industrial action over the health act, and criticised its failure to lead an effective public campaign.

Dr David Wrigley, a GPC member and a GP in Carnforth, Lancashire, said he backed the motion. 'This bill wasn't a curate's egg – it was a very badly smelling egg,' he said, quoting Dr Meldrum's original description of the reform package.

But Dr Ivor Camphor, medical secretary of Mid Mersey LMC, dismissed the motion as 'infighting and quarrelling.'

ANALYSIS

A sense of moderation

Gareth Iacobucci
Chief reporter

The annual LMC conference is probably the most reliable barometer of grassroots GP opinion there is. So with the profession facing unprecedented challenges from all sides, what did this year's summit tell us?

Pensions is by far the most pressing issue on GPs' minds, with leaders fizzing with anger over the Government's raid on their retirement pots. In fact, the almost placid consensus on many other issues suggested GPs are saving most of their fight for the proposed industrial action.

That's not to say there weren't other flashpoints - anger at the NHS reforms still burns, although the debate has moved from principle to concerns over implementation. GPC chair Dr Laurence Buckman warned of CCGs shutting out the rank and file.

The GMC took a battering over its handling of revalidation, as did the Government for its hurried rollout of NHS 111, and hospitals for the seemingly never-ending amount of unresourced work being dumped on primary care.

But despite all this, a sense of reasoned moderation hung in the air, as the BMA escaped censure for its handling of the NHS reforms, and calls for Andrew Lansley and David Cameron to resign were dismissed as 'gesture politics'.

With the ballot on industrial action over pensions closing this week, GPs are perhaps keeping their eyes on the bigger prize.

Benefits remain if drugs are stopped after three years

OSTEOPOROSIS

Bisphosphonate benefits fade

By David Swan

GPs can discontinue bisphosphonate treatment in postmenopausal women after three to five years without substantially increasing their risk of a subsequent fracture, say experts after a major review of recent evidence into the drugs.

The review by the US Food and Drugs Administration found fracture rates were 'remarkably similar' in postmenopausal women taking bisphosphonates for over nine years, and those who switched to placebo after three to five years of continuous bisphosphonate therapy.

The advice comes after a major study linked bisphosphonate treatment with an increased risk of atypical femoral fractures, compounding concerns over long-term use of the drugs to prevent osteoporosis.

The FDA pooled data from three trials involving 2,496 women who took bisphosphonates for three to five years. Some of the women continued taking the treatments for six or more years, while others switched to placebo.

Those who continued treatment had mean fracture rates of 9.3-10.6% while those switched to placebo had rates of 8.0-8.8%.

Key findings

Group	Mean fracture rates over six years (%)
Women remaining on bisphosphonates	9.3-10.6
Women switched to placebo	8.0-8.8

Source: *N Eng J Med* 2012, online 9 May

Stopping bisphosphonates does not increase fracture risk

The analysis concluded: 'Statistical limitations preclude inferring any meaningful association between long-term treatment and increased risk of fracture.'

In an editorial discussing the FDA's analysis, experts from the University of California recommended that GPs consider discontinuing bisphosphonate treatment after three to five years in the light of 'safety concerns' over atypical fractures with long-term use: 'The available data do suggest that bisphosphonates may be safely discontinued in some patients without compromising therapeutic gains, but no adequate clinical trials have yet delineated how long the drugs' benefits are maintained after cessation.'

The advice comes as a new case-control study looked at 477 patients hospitalised with a subtrochanteric or femoral fracture.

They found 82% of patients treated for atypical fractures had been treated with bisphosphonates, compared with just 6.4% of patients with classic fractures. There was also an increased risk of atypical fracture in those patients who had a longer duration of bisphosphonate treatment.

Dr Pam Brown, a GP in Swansea and clinical assistant in osteoporosis, said the FDA recommendations should encourage GPs to review all bisphosphonate patients after three years and discontinue alendronate or zoledronate 'in those without previous vertebral fractures'.

***N Eng J Med* 2012, online 9 May**
***Arch Intern Med* 2012, online 21 May**
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OBSTETRICS

Diets in pregnancy 'improve outcomes'

A change of diet can significantly reduce weight gain in pregnancy and improve outcomes for newborn babies, according to UK researchers.

Their meta-analysis of 44 randomised trials involving 7,300 women found dietary interventions reduced weight gain during pregnancy by 3.84kg, compared with those who underwent no intervention.

A physical activity intervention resulted in a mean reduction in weight gain of 0.72kg, compared with those not undergoing the intervention, and combining the two approaches reduced weight gain by 1.06kg.

Dietary interventions were also associated with a 70% reduction in risk of gestational hypertension – compared with an 8% increase with a mixed intervention – and a reduction of 61% in the risk of gestational diabetes.

Study leader Dr Shakila Thangaratinam, consultant in obstetrics and maternal medicine at Barts and the London School of Medicine and Dentistry, said: 'With the clear benefit in gestational weight gain with dietary interventions in pregnancy, there is a potential for this strategy to be cost-effective compared with other methods.'

***BMJ* 2012, online 17 May**

OSTEOPOROSIS

Calcium pills up heart attack risk

By Madlen Davies

GPs are being encouraged to manage patients at risk of osteoporosis with dietary advice rather than calcium supplements, after a new study found supplements almost doubled the risk of heart attack.

The study of 24,000 people showed those taking vitamin and mineral supplements which included calcium had an 86% increased risk of a heart attack, and those taking calcium-only supplements had a 139% increased risk, compared with those taking no supplements at all.

The evidence adds to previous studies casting doubt on NICE guidance that GPs should consider calcium supplements in all postmenopausal women at risk of osteoporosis.

The study by German and Swiss researchers looked at men and women aged between 35 and 64 years, with no history of cardiovascular problems, and followed them for 11 years.

They found increasing dietary calcium intake reduced the risk of heart attacks.

Women in the third quartile of calcium intake had a 57% lower risk of heart attacks than the first quartile, although no significant effect was seen in men.

Calcium supplements can raise women's risk of heart attack

Study leader Professor Kuanrong Li, lead researcher in cancer epidemiology at the German Cancer Research Centre, said: 'Calcium supplements, which might raise myocardial infarction risk, should be taken with caution.'

In an editorial, Professor Ian Reid and Professor Mark Bolland, deputy dean and senior research fellow respectively at the Faculty of Medical Sciences, University of Auckland, said the study showed supplementation was 'not natural'.

They added: 'We should return to seeing calcium as an important component of a balanced diet and not as a low-cost panacea to postmenopausal bone loss.'

Dr Christopher Arden, a GPSI in cardiology in Eastleigh, Hampshire, said the study's results showed regular exercise and a balanced diet might be more beneficial than supplements.

'The bottom line is that as GPs we have to look at approaches optimising lifestyles,' he added.

A spokesperson for the MHRA said it would 'carefully evaluate' the new study: 'We will provide updated advice if necessary.'

***Heart* 2012, online 24 May**

@madlendavies

PSORIASIS

Vigorous exercise cuts psoriasis risk in women

Vigorous physical activity in women at risk of psoriasis is associated with a reduced likelihood of the condition developing later in life, according to new research.

The authors analysed a cohort of 86,665 women without psoriasis over a decade. They found the most active women had a 29% decreased risk of psoriasis later in life, compared with the least active women. For the women in subgroups of activity levels between these two, there was a significant trend towards decreased risk as activity level increased.

When analysing the type of activity, women who undertook vigorous physical activity were 34% less likely to develop psoriasis when compared with less vigorously active women.

Study leader Dr Hillary Frankel, lecturer in dermatology at Harvard Medical School, said: 'Our results suggest vigorous exercise is associated with a 25-30% reduced risk of psoriasis.'

***Arch Dermatol* 2012, online 21 May**

COPD

Acupuncture benefit in COPD

Acupuncture for patients with COPD can have a comparable effect on dyspnoea and exercise capacity to pulmonary rehabilitation, a trial has found.

Japanese researchers looked at 68 patients with COPD and randomised them to receive either acupuncture or placebo acupuncture using blunt needles. Participants had no history of COPD exacerbations and had not undergone pulmonary rehabilitation in the last six months.

After 12 weeks, breathlessness after a six-minute walk, as measured using the Borg scale, had improved from 5.5 to 1.9 in the real acupuncture group, compared with no improvement in the placebo group – a difference that was statistically significant. Oxygen saturation was also significantly improved in the real acupuncture group.

Study leader Dr Masao Suzuki, lecturer in respiratory medicine at Kyoto University, said: 'Our results are comparable with standard care such as rehabilitation or exercise.'

***Arch Intern Med* 2012, online 14 May**

CPD TIP OF THE WEEK

Scoring tools good for finding alcohol misuse

Abbreviated alcohol scoring tools – such as CAGE, AUDIT and FAST – are useful for screening for potential alcohol misuse in newly registered patients and as part of chronic disease management, according to a new case-based learning module. Research into the CAGE tool found its sensitivity was greatly enhanced by an open-ended introduction, but greatly reduced when patients were asked about the quantity and frequency of their drinking beforehand.

ONLINE CPD

See the Hot topics in alcohol misuse module at pulse-learning.co.uk

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Size, geography and running costs of the 212 CCGs to be considered for authorisation announced

AUTHORISATION

Final CCGs vary in size 13-fold

By Gareth Iacobucci

The Government has revealed the final names and configurations of the 212 CCGs that will be considered for authorisation, in a move hailed as a 'landmark moment' in the transition to clinical commissioning.

The NHS Commissioning Board last week announced details of the sizes, geography and management allowances of the new organisations that will replace PCTs in England, signalling an end to the recent rush of mergers and reconfigurations.

The 212 CCGs, which must all carry the 'NHS' prefix, cover populations ranging from 68,000 (NHS Corby CCG) to 901,000 (NHS North, East, West Devon CCG), with most somewhere between 150,000 and 300,000.

Some 86 CCGs will match their local authority boundary, with four matching the boundaries of more than one local authority taken together, and a further 95 sitting wholly within a local authority.

Some 27 CCGs will cross local authority boundaries, with around half of these crossing at the margins, and the other half crossing boundaries 'in a more substantial way'.

The list also revealed the additional interim management allowance each CCG will receive, calculated according to how many unregistered patients are in each locality, and where patients are likely to access emergency care.

Details of proposed applicants for waves two, three and four of authorisation were also disclosed, ahead of the deadline for submissions from the 35 CCGs in wave one on 1 July.

Dr Michael Dixon, chair of the NHS Alliance and a GP in Cullompton, Devon, said the news provided 'welcome stability' to CCGs.

But he warned: 'This does look dangerously close to the number of PCTs. In terms of leadership they'll look different, but in terms of contact with local practices, the jury's out.'

But Dame Barbara Hakin, national director of commissioning development at the NHS Commissioning Board, said although many CCGs would resemble PCTs in geography, there would be 'enormous differences' in how they operated.

She said: 'The differences are more in how they are formed rather than the geographies they cover. This is a real landmark moment.'

@garethiacobucci

Dame Barbara Hakin: a 'landmark moment' for commissioning

CCGs by numbers

212
number of CCGs being authorised

68,000
number of patients covered by smallest CCG

901,000
number of patients covered by largest CCG

Source: NHS Commissioning Board

INTERACTIVE MAP
See all 212 CCGs
pulsetoday.co.uk/commissioning

COMMISSIONING SUPPORT

Charities to support CCGs

A group of leading charities has been selected to spearhead a Government pilot to offer commissioning support to CCGs, in a move that could pave the way for greater involvement from the voluntary sector in commissioning.

The Rheumatology Commissioning Support Alliance, a partnership between the British Society of Rheumatology, the National Rheumatoid Arthritis Society and Arthritis Care, has been chosen to take part in a new Department of Health pilot.

The move comes despite Pulse revealing in January that the Stroke Association had pulled out of plans to provide commissioning support, having decided it did not have the capacity to cope with the complexities of the process.

The group of charities pledged to provide 'professional, expert commissioning support services' to GP commissioners, and said specialist knowledge was 'urgently needed' to ensure services were commissioned more effectively.

Dr Michael Dixon, chair of the NHS Alliance, said: 'Charities will be very useful for commissioners as long as we know where they're coming from. There's a risk that they could upset priorities set by the CCG as they're only interested in their area and might want to slant budgets in that direction.

'But they have more detailed knowledge of one area and can offer innovative commissioning.'

PRIMARY CARE

Local focus for GP services

GP services are to be commissioned by local teams of managers after the NHS Commissioning Board delegated responsibility to them.

Minutes from the NHS Commissioning Board's May meeting reveal it plans to discharge some £22bn worth of direct commissioning responsibilities, with 'all local area teams taking on direct commissioning responsibilities for GP services, dental services and pharmacy services'.

It said the new structure would result in a 'significant reduction' from the 50 local offices of the board initially proposed, to a smaller number of local teams that would each oversee a handful of CCGs.

The board revealed a third of local area teams across England would lead on specialised commissioning, with a smaller number carrying out the direct commissioning of optometric services, military health services and offender health services.

The smaller teams will also commission public health services and interventions, with 'some most likely commissioned on a larger geography than individual local teams (such as screening programmes) and others possibly at individual local area team level (such as public health and under-fives)'.

All the latest in neurological medicine with this week's PulsePlus
▶ pages 18-23

Ca effect to beef up aspirin role

DH consults with NICE and MHRA over how to use aspirin to reduce cancer risk

By Nigel Praities

The Department of Health is looking at the 'next steps' for beefing up the role of aspirin in clinical guidelines, after an analysis showed 'clinically meaningful' reductions in cancer mortality after just four years of taking the drug.

The move comes after several studies showed aspirin use was associated with a reduction in cancer deaths, and raises the prospect of a surprising about-turn for the drug, which is in the process of being written out of many cardiovascular guidelines.

The DH said it was working with the MHRA, NICE and leading cancer charity Cancer Research UK in drawing up its response to the mounting positive data for aspirin.

NICE is currently reviewing its recommendation of low-dose aspirin for primary prevention in diabetes, with some experts suggesting the effect on cancer risk should be taken into account when treating people at high cardiovascular risk.

Aspirin was found to reduce deaths from cancer by 23%

The new meta-analysis - published in June's *American Journal of Medicine* - found a 23% reduction in cancer mortality in patients taking aspirin, compared with controls not taking the treatment. Researchers showed for the first time that significant protective effects could be observed after an average of just four years of follow-up.

They pooled data from 21 randomised studies and 16,000 patients, and found 162 cancer deaths in the group taking aspirin (2%), compared with 210 in controls (3.6%).

Study leader Professor Edward Mills, global health research chair for the Canadian government, said: 'These findings should be useful for counselling low- and high-risk patients with cardiovascular disease. It seems likely aspirin will now be the backbone of cancer prevention strategies.'

A DH spokesperson said: 'We are working with the MHRA, NICE and Cancer Research UK to consider the next steps on the benefits of aspirin on preventing cancer.'

NICE said: 'Use of aspirin for primary prevention of cardiovascular events will be considered in light of new evidence.'

In contrast, the European Society of Cardiology this month removed aspirin from its guidelines as an option for primary prevention of cardiovascular events, following a similar move in Scotland in 2010.

Dr Willie Hamilton, senior research fellow in primary healthcare at the University of Bristol and a GP in the city, said: 'There seems little doubt aspirin reduces cancer incidence, and some suggestion it reduces metastasis. However, the downside of haemorrhage is real. I don't think it's quite ready for GP recommendation yet, though I suspect it will be in time.'

@nigelpraities

Reduction in cancer mortality with aspirin

Months on aspirin	Cancer mortality risk
36	0.82
42	0.78
52	0.79
72	0.76
80	0.77

Source: *Am J Med* 2012;125:560-7

Trial of HPV tests before smears

The Department of Health is to test plans to replace smear tests as the primary screening method for cervical cancer, after its advisers said HPV testing might be a better indicator of risk.

The move comes after studies showed using HPV testing as the initial screen detected more women with potentially cancerous lesions than using smear tests.

If successful, the pilot would reverse the approach to screening currently being rolled out in England, as cytology would only be conducted if a sample tested positive for HPV.

The National Screening Committee said: 'The pilot will look at whether this leads to better outcomes for women, while minimising over-treatment and anxiety, and whether it is practical to roll out nationally.'

Dr Anne Mackie, director of the committee, said: 'HPV testing may better indicate which women are at risk of cervical cancer.'

IN BRIEF

QOF smoking errors

GPs have uncovered a series of errors in the business rules on QOF smoking indicators.

Full story ▶ pulsetoday.co.uk/clinicalnews

College's HQ unveiled

The RCGP has unveiled its £34m glass-enclosed headquarters near Euston station in London in a ceremony for members and fellows.

Full story ▶ pulsetoday.co.uk/practicenews

NICE advice on opioids

NICE has produced guidelines to tackle GPs' reluctance to prescribe opioids as part of palliative care.

Full story ▶ pulsetoday.co.uk/clinicalnews

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A tangle of IT contradictions

It's been a week when ministers finally flicked the off-switch on one troubled IT project, and appeared to accept another was being superseded by something sleeker and more modern. The previous government's flagship HealthSpace site became an early casualty of the coalition's information strategy. Ministers are just as keen as their predecessors to see online access to medical records and email access to practices – but it's going to be done at a pace, and to a specification, that fits GP needs. And the needs are there – some GPs are already exploring use of Skype for online consultations, outside the auspices of any Government IT project.

Then there's the Summary Care Record – the 100-million pound IT project to eat them all. It officially continues to hum along, like some giant, room-sized prototype computer. But the care record was mysteriously absent from the information strategy, and IT enthusiasts and sceptics alike are declaring it has been rendered largely redundant by the rampaging technological advances of the private EMIS Web system.

Richard Hoey
Editor

All this is consistent with the Government's ideological acceptance that a series of independent providers of IT systems are far more likely to quickly and effectively meet the needs of users than a giant, centrally dictated programme. So have we seen the end of health IT systems being imposed upon general practice from on high? Sadly, not just yet.

Over the last few months, Pulse has been tracking the slow decline of another unwieldy Government IT system – Choose and Book. GPs made perfectly plain their distaste for Choose and Book right from the start, so it should hardly have come as a surprise that once payments for its use disappeared, so did referrals through it – down from 57% in 2010 to just 50% now. The Government's response, according to its new doctrine of 'user knows best', should surely have been to open up the market to new providers of choice-based referral systems, that maybe were user-friendly enough not to need delegating to the receptionist. Instead, in the same week the Government released its information strategy, it put out a new document on choice – threatening that GPs who did not use Choose and Book would be forced to phone round providers individually to check appointment availability.

'Where Choose and Book is not being used, formal requirements to support greater choice for patients will have to be met by alternative – potentially labour-intensive – methods,' the document stated, ominously.

So one moment GPs are sufficiently IT-literate to make informed choices over systems for electronic records and online consultations – the next they are the recipients of blunt threats over Choose and Book. The Government's IT policy remains a tangle of logical contradictions.

Saying goodbye

I leave Pulse this week after eight years here, the last three as editor. It has been an immense privilege to put together a publication for general practice, and to have the chance to meet and speak to so many of those GPs who make it the great profession it is. I have found general practice to be warm, funny, passionate and never short of an opinion, and I shall miss it enormously.

Let us know your views by emailing Pulse at editor@pulsetoday.co.uk

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NORGINE

XIF/2620/SEP/11. Date of preparation: September 2011.

Yes, it *might* be lung cancer

If we got every minor symptom looked at, we'd spend our lives in our GP's surgery, **Phil** says

If you have a cough for more than three weeks, you might have lung cancer and so you should see your GP. So says a current advertising campaign, funded by the NHS, which appears on most websites I visit.

'If you've been coughing for over three weeks, it might not be "only a cough". So tell your doctor,' it says. Then you get a picture of Dr Ian Watson, who may or may not be real and who may or may not be the author of those words, but who is certainly in the 'chiselled jaw and stethoscope round the neck' class with Dr Hilary Jones and his ilk. The type who divide their time between the surgery, the sofa on breakfast TV, and having daily handsome lessons.

Of course, he could be right. It *might* be lung cancer. It just probably isn't. More probably for some than for others – this week I had to reassure the mother of an eight-year-old that his three-week cough might need some treatment, but not an X-ray at this stage and certainly not chemotherapy. I think she was already picturing him bald, at Disneyland.

Don't get me wrong, I'm not knocking this campaign. We are not good, in the UK, at picking up lung cancer while it is still in the operable phase – which is odd when you think about how much industrial lung disease we have suffered, as a nation. Perhaps subconsciously we feel that a bit of 'inflammation o' t'lungs' is just one of those manly things that working-class blokes get. Blood-stained phlegm? Just spit it into the coal fire and make it sizzle.

While looking up a bit of background on this campaign, however, I got a sobering insight into what can potentially happen if we follow every minor symptom to its logical conclusion. The Benenden Healthcare Society (and I should point out here that Benenden exists purely to sell private health insurance) has surveyed 2,000 people and discovered that we will each suffer an average of 9,762 ailments or injuries in our lifetimes. As we're each attending our GP's surgery about 400 times during our lives, it seems difficult to comprehend how we might fit them all in. That's over 24 complaints per consultation, which seems excessive even in those surgeries that offer 15-minute appointments. Perhaps not all are worthy of a doctor's appointment.

I think she was picturing him bald, at Disneyland

Deeper analysis makes this look more likely. You'll have 2,808 bumps or bruises during your time on this earth. You'll have blocked sinuses 312 times, and heartburn exactly the same number of times. Someone else appears to be having all my sinus trouble, but I'm shouldering at least four of my fellow citizen's acid reflux.

You'll suffer 234 shaving cuts, which seems excessive. I've done it twice, so the rest of you please shave only when sober and not during parachute jumps. You'll also crick your neck 318 times, have 468 'stomach upsets' (different from heartburn, then) and an astonishing 78 eye infections. I'll put my reputation on the line and call that one a lie.

One quarter of us admit to having stepped on an electric plug and hurt their foot. Presumably the rest of us were too pissed to remember, because *everyone* has done that. Only a bit of discarded Lego is more painful in the dark.

The spokesperson from Benenden advises us that the human body takes a terrible daily bashing, and his advice is 'washing hands regularly, maintaining good posture, eating healthily and exercising to stay fit and well'.

Thanks for that, spokesperson. Another finding of your survey, although one that you did not publish, is that the number of average deaths suffered by humans remains at one, and is not likely to change any time soon, no matter how good our posture might become.

Dr Phil Peverley is a GP in Sunderland

MargaretMcCartney

Wake up to perils of awareness

Most awareness campaigns can prove only that people have become more aware of the campaign, **Margaret** warns

I can't be the only GP who has noticed an awful lot of coughing. There is a new urgency and a new concern, though – cancer. True, we've always known that a persistent cough can be a sign of serious underlying disease. And certainly, a chronic cough needs medical attention. But is a new NHS awareness campaign – 'Be clear on cough' – going to do us any favours?

The '3 week cough' campaign has a website, which starts off by asking: 'Has someone you love had a cough for three weeks or more?' (It doesn't say what to do if they're not very lovable.) 'It might be something more serious,' it says, followed by: 'Don't take any excuses – they may need a chest X-ray, even if they've had one before... Help stop their cough and put an end to their worry.'[1]

That's curious, because no one seemed to be worried before they were told to get to the doctor with no excuses. Even more curious is the assertion that 'a chest X-ray is a quick and easy way to find out if everything is okay'.

So what's based in evidence? Do we know, first of all, that awareness campaigns work? When asked, most campaigns will deliver evidence that shortly after the money was spent on advertising, more people had heard of the campaign. But what's really needed is evidence that the campaign led to meaningful improvements in quality and quantity of life, for instance through better interventions for easier-to-treat cancer.

The evidence provided by the Department of Health for this campaign rests on a pilot scheme that showed more people had heard of the campaign and that there were 'extra' attendances for cough eight weeks after the advertising.[2]

The number of chest X-rays ordered went up – but did this help detect cancers earlier? A pilot in Doncaster suggests more lung cancers can be picked up in areas subjected to an awareness campaign.[4] Before the campaign, the rate of lung cancer detection in the control group was 108 per 100,000; the intervention group's was 88 per 100,000. The rate after the campaign was 97 in the control group and 112 in the intervention group. The abstract proclaimed a '27% increase in lung cancer diagnoses in the intervention area compared with a fall in the control areas', but the variable base rates, I think, mean it is difficult to make a definite conclusion about the value of it. We must also account for lead time bias when trying to assess how useful campaigns like this are – we might only be detecting cancers a matter of weeks earlier. Indeed, so far the Doncaster data has shown that more lung cancers are being diagnosed at stages III and IV. Not the earlier diagnosis that was hoped for.

Money spent on campaigns comes from somewhere

How frequently does a cough mean lung cancer? Not often: a 2005 study from Bristol suggested just over half the presentations of lung cancer involve a cough.[4] However, when people are sent questionnaires, around 12% of the population say they have a chronic cough,[5] and less than 2% of people seeing their doctors about a chronic cough will be diagnosed with lung cancer.[5]

As for chest X-rays, they will miss lung cancers around a quarter of the time.[6] So with the sizable false negative rate, is this marketing campaign and all the effort attached to it – including prerecorded coughs as part of adverts in bus shelters – really the best we can do to reduce the suffering caused by lung cancer? I don't think so – and of course money spent on awareness campaigns has to come from somewhere. I'm concerned that only the least ill will pay attention to them. When it comes to awareness campaigns, we need better evidence than this.

Dr Margaret McCartney is a GP in Glasgow

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Pharmacist interventions won't solve script errors

A flawed analysis of prescribing errors has damaged the reputation of general practice, says **Dr Mark Ironmonger**

On 2 May, the national headlines wallowed in how bad we GPs are at prescribing. According to the BBC, GPs were 'making too many errors prescribing drugs'. The *Daily Mail* said our drug mistakes had hit 40% of the elderly, and the *Daily Express* put one in six patients at risk from our 'blunders'. Little wonder GPs took a pasting, given the responses from our professional representatives about the need for 'improvement' (from the GMC) and 'more GP training' (from the RCGP). But are the 'errors' really errors?

Many of the moderate errors recorded in the PRACTICE study were actually a result of poor medicine at a minority of practices leading to bad prescribing rather than systematic prescribing errors. This was particularly apparent in the list of scenarios subject to a root cause analysis.[1]

Of the 11 serious errors found, there were two obvious allergies that should have been flagged up by an effective use of IT. The other nine were down to inadequate INR monitoring, with eight of these from one practice involving three patients who clearly did not wish to comply with the district general hospital-run INR clinic. The study rightly stated that warfarin prescribing without access to INR test results was 'the most important problem identified' - but failed to highlight that this was largely at one practice.

The study failed to say that most warfarin errors were at one practice

Some 69% of errors were down to 'failure to request monitoring', which is not a black and white issue, and is subject to change. For example, simvastatin was cited as responsible for 10.5% of prescribing errors and 18.2% of monitoring errors. We don't know if these errors were due to a lack of biochemical monitoring - even though 'fire and forget' is considered a legitimate strategy by NICE once efficacy and two sets of normal LFTs have been established - or whether the errors were due to a failure to specify 'use at night', which some consider of limited significance anyway, and does not apply to some other statins. There is a legitimate argument to say it is more important that the patient takes the medication when they remember.

As a dispensing doctor, I have a natural interest in the prescribing and dispensing accuracy of dispensing practices. Of the report's 227 pages, unfortunately, only one discusses dispensing practice.

This concluded well-trained practice dispensers are a useful defensive strategy against prescribing errors. Dispensers are described as mitigating 'the loss of the safety barrier [of a pharmacist]'. As well as screening prescriptions for errors, dispensers play a useful role in converting Latin prescription instructions into English for patients, and in identifying patients who need monitoring or medication review. A key contribution to patient safety is the dispenser's ability to make annotated changes on the practice computer system.

GP as well as pharmacy representatives leapt on the report's conclusions that pharmacist-led interventions, particularly medication review, have value in preventing prescribing errors.

Yet the report's own update of a systematic review of primary care interventions found pharmacist-led interventions were not effective at reducing hospital admissions and suspected adverse drug events. It added that because community pharmacists' interventions were not routinely documented on the patient's medical record, this could lead to errors being propagated to subsequent prescriptions.

Collaborative working with pharmacists brings benefits to patients. But before we embark on initiatives that may cost the NHS more than they save, we must be sure of the evidence base - and that must include a study of dispensing errors made by pharmacists. This report hands the press another stick with which to beat general practice. If the three patients from one practice who would not comply with INR monitoring are taken out of the equation, we are left with three serious errors, and none that caused harm to patients, out of 6,048 GP-issued prescriptions.

Our representative bodies should re-examine this paper and support the excellent service that GPs provide. But I fear on this occasion, the damage has already been done.

Dr Mark Ironmonger is a GP in Brenchley, west Kent, and a board member of the Dispensing Doctors' Association

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Golf jibe is par for the course

LETTER OF THE WEEK

From Dr John Derounian
Glenlivet, Aberdeenshire
via pulsetoday.co.uk

Professor Malcolm Grant's jibe about GPs being 'out playing golf' is just based on the crass ignorance of an individual who clearly has the knowledge and insight of a cow pat ('Commissioning board chair makes GPs "playing golf" jibe', pulsetoday.co.uk/news).

Playing golf? If only I had time for such recreation. It's clear that the bureaucrats have no insight as to how pissed off we really are.

Like many other GPs I spend 55 hours minimum clinical contact with patients a week, and a further 20 hours on administrative work.

What more do people want? Phrases like 'flogging a dead horse' and 'getting blood out of a stone' spring to mind.

Golf comment was a 'cheap jibe, made for easy laughs'

● **From Dr San Sumathipala**
Gloucester
via pulsetoday.co.uk

The professor, as far as I know, is not medically qualified. He appears to hold law degrees.

Whatever insight he has into GP work is limited by that setback, and although he is entitled to his opinion, it does not does allow for an *ex cathedra* statement about the GP golf-player stereotype. I am sure he means well, but where is his evidence?

Surely, his august role chairing the NHS Commissioning Board must dictate that he chooses his words carefully?

The professor needs to venture into the GP community, and speak to us. We are available 8am to 6.30pm, give or take extended and out-of-hours work – unless, of course, he is too busy playing golf.

● **From Dr Jonathan Harte**
Nottingham
via pulsetoday.co.uk

Professor Grant is out of touch. Ill-timed jibes like his will do nothing to help healthcare providers collaborate to develop an NHS that works for patients as a whole, rather than being split into a series of individual commodities.

● **From Dr Richard Page**
Audley, Staffordshire
via pulsetoday.co.uk

I wish I had time to play golf! My clubs have been in the loft for 21 years (incidentally, the same length of time I have been out of hospital practice).

I know many more health service managers and hospital consultants than GPs that play golf, but I don't hear any jibes about them.

● **From Dr Tom Inskip**
Bedford
via pulsetoday.co.uk

I work five days a week as well as weekends and evenings for our local out-of-hours service, so my average working week is 55 hours long.

Playing golf less than once a week is my way of staying sane. Does Professor Grant want me to burn out even earlier?

His was a cheap jibe, made for easy laughs from an uninformed audience.

GPs should stand for election

From Dr Giles Wynne
North Hykeham, Lincolnshire

There will be doctors thinking about their duty to defend the NHS by standing as independents against coalition MPs at the next general election, and there are voters willing to support them.

The history of doctors standing in their locality is impressive, and even more so when standing on a single-issue campaign.

However, so shocking is the attack by the coalition on welfare benefits and pensioners that any campaign on the NHS would inevitably take on board these issues too.

There are constituencies where Labour expect to overturn an opposition majority, but other areas including my own in Sleaford and North Hykeham where the sitting Tory has a large majority.

He voted for the health bill without insisting on the publication of the NHS risk register first.

This is an MP who needs opposing, and if a GP was willing to stand there would be financial and physical support.

We must hit Government in the pocket

From Dr Jess Oldroyd
Blaydon, Newcastle

I agree entirely with Dr Malcolm Foulds who suggested that we stop being gatekeepers for a day ('Day of action will only create work', pulsetoday.co.uk/letters).

This would not irritate patients, but it would send a very strong message to the Government. No one ever gets to hear the real reason behind days of action and we will not get any sympathy if we adversely affect patient care.

If we have a financial impact it would be more difficult to ignore, especially if we grit our teeth and kept it going. It seems a hugely wasted opportunity that this was not the subject of the ballot rather than a day of reducing patient care.

For the record

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

Apparently, judges give more to UK

From Dr Simon Ruffle
Twyford, Berkshire

Mr Cameron was questioned last week on why judges only pay 2% of their income to pensions. His reply was astonishing – he said it was in reflection for what they do for the country.

Every public-sector worker should be outraged, especially those of us who pay employers and employees pension payments of 21.5% and rising.

I think it may be time for all of us to withdraw from the Ponzi scheme we are effectively in and watch it collapse.

There is a solution that is Tory in the extreme. Freeze public-sector pensions and promised benefits tomorrow and hand over provision of pensions to one of their mate's financial companies to give us a pension on the same basis as the private sector.

I suspect judges would then want to pay more than 2%.

Ignorance doesn't listen to experience

From Dr Nicholas Ford
Croydon, south London

I have just had one of my most unpleasant experiences since becoming a GP in 1988.

An infrequent surgery attender appeared on a booked 10-minute slot incandescent with rage. He perceived me to be an uncaring, incompetent doctor who had failed to diagnose that his elderly, asthmatic mother was seriously ill with pneumonia, claiming that 'anybody could have known' and that her life had been put at risk.

The actual sequence of events was that a home visit had been made to assess severe neck pain and general malaise in a 78-year-old, asthmatic woman with two previous spinal operations and pneumonia in 1991, four days into a course of clarithromycin.

An assessment including vital signs, full examination and pulse oximetry was carried out, and after 20 minutes it was agreed this woman – who was speaking in full sentences and did not want to go to hospital – would remain at home under the care of her live-in daughter and be reviewed in the light of a pending chest X-ray result.

Advice was given to call again should there be vomiting, difficulty breathing or carer worry.

A script was issued for additional analgesia for the neck pain. Six hours later the daughter called out-of-hours, channelled through 111. The telephone triage flagged up possible 'crushing or severe aching/pain in the chest, upper back or upper abdomen' and an ambulance was despatched. The subsequent diagnosis was bi-basal pneumonia not apparent on chest X-ray but revealed on CT scan, in the face of persistent fever and very elevated CRP.

The son had no time for any explanation, either of the difference between an experienced GP's home visit and a protocol-driven telephone triage service, nor of the fact that diseases evolve, and left grimly shaking his head.

He was not planning a formal complaint because of the ability of the medical establishment to close ranks and cover things up. Dr Roger Neighbour would have lamented lack of 'housekeeping' and that the remaining patients were kept waiting for over half an hour.

Where are applicants for new places?

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

If the deaneries had to reduce training places by 7% because of a lack of 'quality applicants', how will increasing training places help ('Lansley agrees 20% rise in GP training places in radical workforce overhaul', pulsetoday.co.uk/news)? And is there any mention of extra funding?

My impression was that young GPs now find being a sessional GP more attractive than either a GP partnership or a salaried option.

If you are contemplating a career in medicine, who in their right senses would enter a branch where the future is uncertain? What is certain is that politicians of all parties are determined to denigrate GPs.

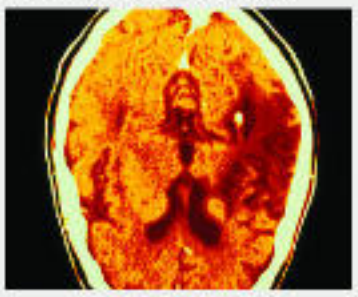
Does it matter how many training places are available if the job has been made so unattractive nobody wants to apply?

Pulse Plus

Our monthly CPD section provides an in-depth update on a clinical area, allowing you to earn credits for appraisal by answering questions online

In this issue

Neurology



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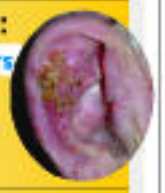

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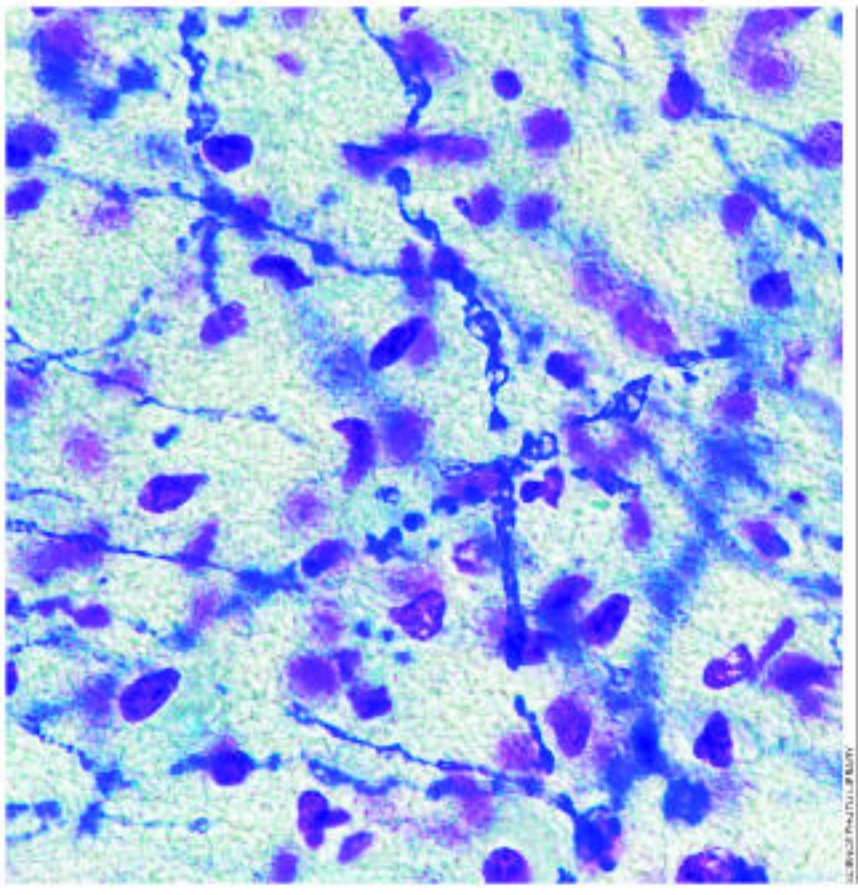
Resource of the week
The European Association for the Study of the Liver have launched a smartphone app

Neurology

Key questions

Multiple sclerosis

Neurologist **Professor Nikos Evangelou** answers questions from GP **Dr Melanie Wynne-Jones** on investigations, disease-modifying drugs, managing fatigue and diet



Demyelination of nerve fibres can cause symptoms such as numbness and tingling

1 What are the common and less common presenting symptoms of multiple sclerosis? When should we refer?

The presenting symptoms of MS are notoriously variable. Some symptoms, such as tingling or fatigue, are seen daily in general practice in patients with no identifiable disease. So it is not surprising that patients often complain of delayed diagnosis. A third of newly presenting patients complain of weakness, and one in five report numbness or tingling. Some 20% also present with loss of vision because of optic neuritis. Sensory symptoms are often reported at the beginning of the disease. A common pattern is for tingling to start in part of a limb, and then – within a few days – spread to the whole limb.

Less common, but not infrequent, symptoms include vertigo, double vision and sometimes bladder symptoms accompanying leg tingling and numbness.

If you suspect a diagnosis of MS you should refer. Specifically, symptoms with discrete attacks lasting weeks or months are very suggestive of MS and should trigger a referral. Although it is uncommon to initiate treatment after the first attack of MS, many patients report diagnostic delays and wish they had been diagnosed earlier.

2 As MS is said to be a clinical diagnosis, what investigations should be carried out?

In the right clinical scenario the diagnosis can be made without any tests – but I don't think that any patient will have been diagnosed recently without an MRI of the brain. MRI is non-invasive and in most cases of MS the scan shows white-matter lesions in a typical distribution. The lesions are usually periventricular, but can affect the brain stem and the cerebellum. Subcortical lesions are present in two-thirds of patients with MS, and the corpus callosum is also frequently affected.

Other diseases such as small vessel cerebral disease can cause white-matter lesions indistinguishable from MS lesions, but in these patients it is unusual for the spinal cord to be affected. So usually a combination of brain and cervical – or whole cord – MRI is requested in the initial evaluation.

In many cases a lumbar puncture is performed which looks for oligoclonal bands, and this is of great help when the diagnosis is in doubt. Evoked potentials are used less frequently, but the visual evoked potentials appear to be most helpful in identifying subclinical attacks of optic nerve involvement. Blood tests may exclude a systemic disease such as B12 deficiency, which can manifest with neurological symptoms.

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3 Should GPs manage relapses by prescribing oral steroids or by referral for specialist care?

Sometimes it is difficult to diagnose a relapse – many MS symptoms will recur in the context of an infection, excessive tiredness or stress. These 'pseudo relapses' should not be treated with steroids. But a patient who experiences many relapses is likely to require escalation of treatment. It can be difficult to draw the line between what is a significant disabling relapse and what is a mild sensory attack, so all relapses should be discussed with, or referred to, the MS team. No patient with MS should be on long-term oral steroids. The MS team won't treat all relapses with steroids, and if they do decide to use steroids, an explanation of the risks and benefits of these in the context of an acute relapse will be given.

4 Depression is common in patients with MS, and fatigue and pain can also be debilitating. What can GPs suggest?

Depression, fatigue and pain can be extremely debilitating, and the lack of visible manifestations means that their

importance may not be appreciated.

GPs know better than anyone how depression can cause fatigue. Identifying and treating depression is one of the most effective steps we can take to reduce MS fatigue. The general principles of the use of antidepressants apply to patients with MS. But I would bear in mind that sedation can worsen fatigue caused by MS. It is a fine balance between treating depression in MS – which is very common – and not causing too many side-effects.

Tricyclics with their anticholinergic action at a low dose can help patients with bladder symptoms and are also very helpful in treating pain. Fluoxetine has been shown to reduce fatigue, even in non-depressed patients. Amitriptyline and fluoxetine have also been shown in small studies to reduce the uncontrollable laughing and crying (pseudobulbar symptoms) that we occasionally see in MS patients.

Poor sleep because of leg spasms can also cause terrible fatigue. Treating sleep difficulties is very important and it is worth asking about night pain, cramps and anxiety. Often 10-20mg of baclofen or 300-600mg of gabapentin before bed can reduce the pain and spasms without any side-effects. Review medication frequently, as many drugs can cause fatigue.

Amantadine 200mg daily has shown a benefit in some patients with fatigue in a small study, so when all else fails it is worth trialling a patient on this for a month or two. Musculoskeletal pain will benefit from exercise, physiotherapy and NSAIDs. And neuropathic pain often responds to gabapentin, pregabalin and tricyclics.

Opiates have a role to play in MS, especially for exacerbations of of pain. But given their side-effects and cost, it is best to follow local guidelines on use of opiates in treating non-cancer pain. Sometimes it is necessary to get the input of the local pain team.

5 When and how would you use disease-modifying drugs? Are there any new medications in the pipeline?

Not all patients with MS benefit from disease-modifying drugs – they are only useful in the early inflammatory, relapsing-remitting stage of the disease.[1] Unfortunately, our current drugs are of no benefit in progressive disease.

The current recommendations[2] advise using disease-modifying drugs when patients have experienced at least two relapses causing significant disability over two years. Interferons and glatiramer are injections given at home. These drugs are partially effective and reduce the risk of relapses by a third. If the disease is more active, natalizumab – a monthly hospital infusion – can be initiated after consideration of risks and benefits. A new oral drug, fingolimod, has become available in the UK in the last few weeks for patients with the most active MS. This is the first oral MS drug, but it is aimed at more aggressive MS not controlled with first-line treatments. A couple more oral drugs are expected to become available in the coming years. More powerful drugs given in hospital are at the stage of being assessed by the authorities.

6 Do you recommend dietary modification or supplements?

Diet plays an important role in many diseases, and since we do not know what causes MS, it is understandable that many have suggested diet could be a key factor. The evidence for this is thin, but playing an active role in diet selection and exercising is important in helping patients to take control of their disease.

I promote healthy eating and encourage patients to keep an eye on their weight, because overweight patients with MS experience more walking difficulties.

There is some evidence from trials in animals that eating fish may protect against demyelination,[3] and as fish is a part of a healthy diet, I suggest to patients with MS who like fish that they could probably eat more.

Vitamin D supplementation has not been proven conclusively to reduce relapses or to have an impact on disability, but the evidence is getting stronger all the time.[4] So I mention to patients that I would take vitamin D if I had MS – though not all MS neurologists would do the same. The 'MS-specific' diets which are currently in vogue have not been tested, can be restrictive and include lots of supplementation, so I do not recommend them.

7 How should we advise a woman with MS who wishes to become pregnant?

Having MS should not stop a patient having a baby – MS does not affect fertility and pregnancy does not have a long-term effect on the progression of MS – but there are important issues to consider. I would review all medications and make sure the patient balances the potential risks and benefits during pregnancy. At this stage, I would ask the patient to get in touch with her MS team because the decision to discontinue treatments is not straightforward – especially if patients are on disease-modifying drugs.

Fatigue and any help needed after delivery are important issues to consider. If a parent has MS, there is also a small increased risk of the child getting MS – the general population risk is one in 800 and that increases to one in 50 when a parent has MS. Although this is considered an acceptable risk by most, it is important to discuss it with any patient with MS who wants to become a parent.

Professor Nikos Evangelou is a clinical associate professor of neurology at Nottingham University Hospital

Dr Melanie Wynne-Jones is a GP trainer in Stockport, Cheshire

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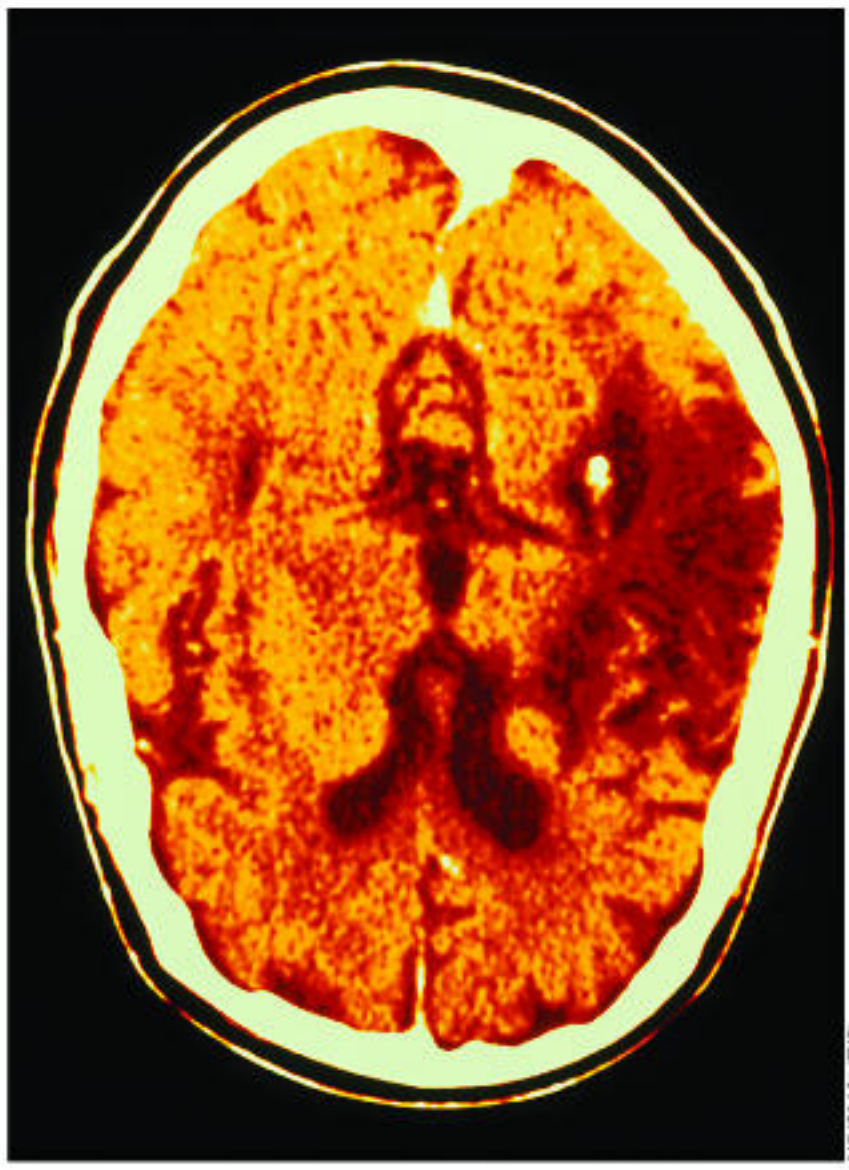
Update on stroke management

Dr Geoff Cloud, consultant stroke physician, gives an update on stroke management in primary care



Patients must have a CT scan to exclude haemorrhage before thrombolysis is given

CHADS2 remains the first choice for assessing stroke risk in atrial fibrillation.

The CHADS2 is a clinical prediction tool to assess the risk of stroke in patients with atrial fibrillation. It uses the presence or absence of five factors – congestive heart failure (scores 1), hypertension (1), age 75 years or greater (1), diabetes (1) and prior stroke/TIA (2) – to produce a score of 0 to 6. It has been thoroughly validated and corresponds to a range of annual stroke risk from 1.9% for a score of 0 to 18.2% for a score of 6.

Anyone who scores more than 1 should be considered for anticoagulation. This tool is simple, has universal validation and is widely used.

You can download a version of CHADS2 from pulsetoday.co.uk/tools-and-resources.

Recently, a modified version – CHA2DS2-VASc – has been developed which includes additional risk factors including vascular disease. It has been added as an option in the 2010 European Society of Cardiology guidelines for the management of AF. But as CHADS2 is the score used in the QOF AF indicators for 2012/13, this is likely to be the score used most widely in general practice.

NICE changes guidance on secondary prevention after a stroke.

The optimum antithrombotic regime for secondary prevention of stroke is either aspirin 75mg OD in combination with dipyridamole MR 200mg BD or alternatively clopidogrel 75mg OD. On the basis of ease of compliance and cost – since clopidogrel has now come off patent – most stroke physicians are currently recommending clopidogrel.

Very occasionally we would use aspirin and clopidogrel in combination – for instance, in patients with symptomatic intracranial stenosis – but we wouldn't advocate doing this long term because of the increased bleeding risk.

The NICE guidance is not helpful here because it distinguishes between TIA and stroke[1] and recommends they be treated differently. Dipyridamole MR plus aspirin is still recommended first line for people who have had a TIA. The guidance says no recommendations are made about the use of clopidogrel after a TIA because it is not licensed for this indication. But as the causes of TIA and stroke are exactly the same, it seems odd to treat them differently.

Stroke units reduce mortality and length of stay.

Randomised controlled trials demonstrated the benefit of stroke units over general medical care over 20 years ago. This has been shown to be the case in clinical practice in the NHS in the National Sentinel Stroke Audit, which since 1998 has demonstrated that as access to specialist stroke units has increased, mortality and morbidity due to stroke have reduced.

The most recent report has shown that 30-day mortality has reduced from 20% in 2008 to 17% in 2010.[2] Stroke units also reduce the length of time patients spend in secondary care – patients admitted to a stroke unit within four hours have a median length of stay of nine days compared with 12 days for those who were not directly admitted to a stroke unit.

Every acute hospital in Britain has a stroke unit, and patients who have a stroke in 2012 should expect to be treated in one, rather than in a general medical or geriatric ward.

The Stroke Improvement National Audit Programme publishes results on key indicators of acute care and reviews local services, so you may find it useful to look at this – particularly if there are several providers close by, so that you can decide which to refer your patients to.[3]

Thrombolysis after acute stroke can only be given by a specialist.

Any patient with ischaemic stroke should be given thrombolysis within four and a half hours of symptom onset if their clinical symptoms are not improving, and as long as they do not have any contraindications to thrombolysis. The licence has recently changed from three hours to four and a half hours, following a study of the efficacy and safety of this.[4]

Although there have been studies suggesting suitably trained paramedics can safely administer thrombolysis to patients with an acute myocardial infarction, the situation with stroke is far more complex. It is crucial that the patient has a CT scan to exclude a brain haemorrhage before thrombolysis is given, and this is why thrombolysis is currently not given before the patient's arrival at hospital.

Throughout the NHS, patients should have access to thrombolysis 24 hours per day. This may be in the local hospital or by a networked approach of one hospital among a group providing a 24/7 stroke thrombolysis service for a region. The important issue here is that patients do not have excessive delays to access specialist opinion and brain imaging.

The clinician administering the thrombolysis should be trained in stroke clinical decision making and using thrombolysis – for example, a neurologist or stroke physician. The British Association of Stroke Physicians has a training scheme and there are now deanery subspeciality training programmes in stroke available for trainees in parent specialties such as neurology, and acute and geriatric medicine.[5]

Carotid surgery is only necessary in patients with symptoms of carotid stenosis.

People with symptoms of acute non-disabling stroke or TIA who have a relevant carotid stenosis of 70% or more should have carotid surgery within two weeks of symptom onset. There is some evidence that carotid surgery may be beneficial for patients with symptomatic stenosis from 50% to 69%. The absolute benefit in such patients, however, seems only to be present if they are operated on within two weeks of symptom onset. A randomised controlled trial this year will look at randomising such cases between best medical treatment and surgery.

There are very few indications for carotid surgery in patients with asymptomatic carotid artery stenosis – the risks and costs of surgery generally outweigh any benefit.

Dabigatran is a new option for patients having difficulties with warfarin.

In AF, anticoagulants are far better at preventing recurrent stroke than anything else. Dabigatran has good randomised controlled trial data and this has all been looked at by NICE.

For secondary stroke prevention, dabigatran can be considered in people who have difficulty keeping within the therapeutic INR range, or those who are at increased risk of bleeding complications on warfarin.

There is often reluctance in primary care to anticoagulate patients, but all patients with ischaemic stroke in AF should be considered for anticoagulation and a clear reason should be documented where a decision is made not to treat.

Warfarin is economically a good choice, but the new oral anticoagulant agents will have an increasing role to play, I am sure, as they come off patent. The total of 39% of patients with AF on warfarin after stroke in the 2010 *National Sentinel Stroke Audit* is some way short of the 60% aspiration set by the Department of Health.

Lowering blood pressure is key in reducing risk of recurrent stroke.

Patients who have had ischaemic strokes caused by AF should be prescribed anticoagulants. Otherwise antiplatelet treatment should be instigated as described above. These patients should also be considered for statins – aiming to reduce total cholesterol below 4mmol/l and LDL cholesterol below 2mmol/l.

There is a strong association between lowering blood pressure and reducing the risk of recurrent stroke. I would suggest trying to lower blood pressure to 130/80mmHg or less as a target, but however much it is lowered there will be a relative reduction in the risk of recurrent stroke.

Giving patients the usual advice about lifestyle modifications is also very important – for example, stopping smoking, moderating alcohol intake and exercising.

Patients with a stroke due to brain haemorrhage should be followed up to look for an underlying structural reason for the haemorrhage. For example, MRI may pick up tumours and some arterio-venous malformations.

Overall, the key to secondary prevention after haemorrhagic stroke is lowering blood pressure. There is no strong evidence for lipid lowering after haemorrhagic stroke compared with ischaemic stroke.

I would usually avoid anticoagulants or antiplatelets because of the risk of recurrent haemorrhage in such patients.

Dr Geoff Cloud is a consultant stroke physician, honorary senior lecturer in the department of clinical neurosciences at St George's Hospital, London, and associate director for the Royal College of Physicians' stroke programme

This May has been Action on Stroke month, and the Stroke Association has launched its Life After Stroke campaign to challenge the barriers that prevent stroke survivors from making their best possible recovery. To find out more visit stroke.org.uk/campaigns.

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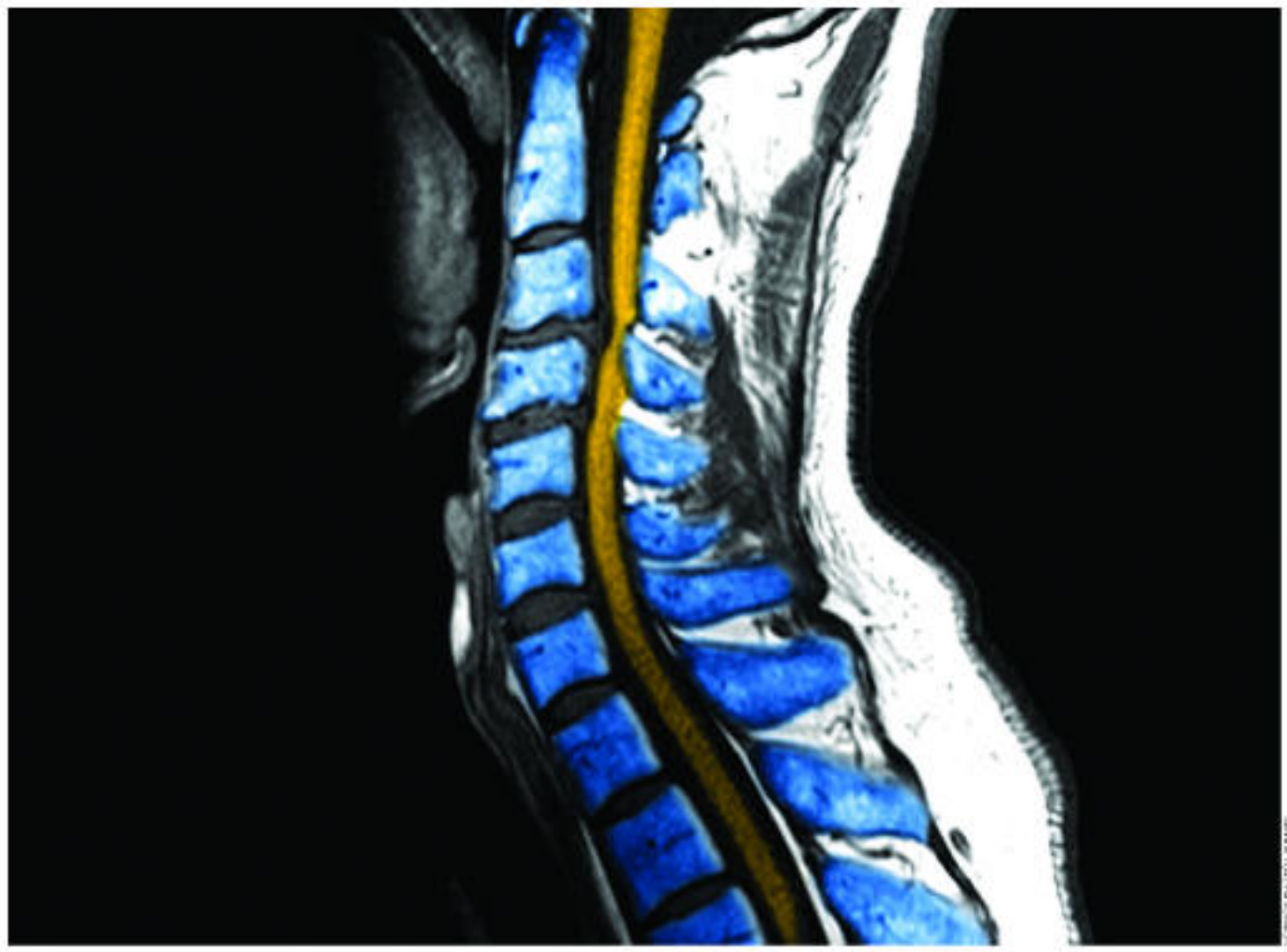
Further reading

● Department of Health. *National stroke strategy*. 2007.

Urgent neurological problems

Consultants **Dr Chris Taylor** and **Mr George Samandouras** advise on how to identify and manage urgent neurological and neurosurgical problems



Degenerative disc disease can cause spinal cord compression

TIA and ischaemic stroke

A transient ischaemic attack is a transient episode of neurological dysfunction caused by focal brain, spinal cord or retinal ischaemia, without infarction.[1] Ischaemic stroke involves evidence of infarction and is a major cause of morbidity and mortality.

The annual UK incidence of ischaemic stroke is 1.5-2 per 1,000. Risk factors include old age, hypertension, obesity, TIAs, diabetes, high cholesterol, cigarette smoking and atrial fibrillation.

The risk of stroke during the first seven days after a TIA can be predicted from the ABCD2 scoring system:

- A: age – older than 60 years (scores 1)
- B: raised blood pressure – systolic blood pressure greater than 140mmHg or diastolic blood pressure greater than or equal to 90mmHg (1)
- C: clinical features – unilateral weakness (2) or slurred speech (1)
- D: duration in minutes – at least 60 minutes (2), 10-59 minutes (1) or less than 10 minutes (0)
- D: presence of diabetes (1).

Patients should be referred immediately if they have:

- two or more TIAs in a week
- TIA while on warfarin
- an ABCD2 score of more than 4.

Everyone else should be referred for urgent outpatient assessment.

Ischaemic stroke may require aggressive management of haemodynamic instability with adequate fluid resuscitation and inotropes, ensuring end-organ perfusion.

Thrombolysis with tissue-type plasminogen activator should be given intravenously within four and a half hours, or intra-arterially within six hours, of symptom onset. Patients with large, non-dominant hemisphere infarction and raised intracranial pressure may benefit from decompressive craniectomy.

Secondary prevention involves anticoagulation for non-valvular atrial fibrillation, antihypertensives and antiplatelets – aspirin and dipyridamole or clopidogrel started 24 hours after thrombolysis can reduce stroke recurrence by 25%.

Exacerbations of multiple sclerosis

The prevalence of multiple sclerosis is 50-90 per 100,000 in the UK, and around 80% of patients have the relapsing-remitting form of the disease.

Relapses or exacerbations are episodes of focal neurological disturbance lasting more than 24 hours, without an alternative explanation, and with a preceding period of clinical stability lasting at least 30 days.

Management is focused on aggressively treating severe exacerbations, in order to shorten the duration and intensity of neurological dysfunction.

Urgent discussion with, or referral to, a neurologist is recommended – a short course of high-dose steroids (methyl prednisolone) orally or intravenously as advised may be helpful. Adrenocorticotrophic hormone is an alternative in patients unable to cope with the side-effects of steroids.

All patients with relapsing-remitting MS should begin one of the disease-modifying therapies – an interferon, glatiramer acetate or nataizumab/retuximab.

Guillain-Barré syndrome

Guillain-Barré syndrome is an acute inflammatory polyneuropathy. The annual incidence is one in 100,000 in the UK population.

It affects more men than women, and is most common between ages 15 to 35 and 50 to 70 years.

Guillain-Barré syndrome is usually preceeded by an infective illness such as a URTI or gastroenteritis. It can also follow a vaccination or a new drug, or can be triggered by chronic illness or infection such as lymphoma or HIV.

The classic presentation is paraesthesia, progressive (less than four weeks) ascending neuropathic weakness of more than one limb and areflexia, and it is often associated with autonomic dysfunction and neuropathic pain.

It may involve the cranial nerves, causing swallowing problems and respiratory muscle failure.

Diagnosis is based on clinical features, neurophysiological studies and examination of cerebral spinal fluid. All patients require urgent hospital admission and monitoring until the disease has reached a plateau.

Specific treatment consists of high-dose intravenous immunoglobulin or plasma exchange. Mortality is between 5-10%, but 85% of patients make a full recovery within one year.

Status epilepticus

Recent guidelines[2] define status epilepticus as five minutes or more of continuous clinical or electrographic seizure activity, or recurrent seizure activity without recovery between seizures.

Status epilepticus has an annual incidence of 25 per 100,000 in the UK population. It affects men and women equally, and in a third of cases it is the first presentation of epilepsy. Emergency assessment of the airway and cardiopulmonary function may be necessary. Oxygen may be needed and potential causes – including hypoglycaemia, alcohol withdrawal, toxins, CNS infections and brain injury – should be treated.

Status epilepticus requires urgent transfer to A&E for drug therapy.

In early status epilepticus, use buccal midazolam as an 'out-of-hospital' option.

Mortality is high, at 20%, and depends on the patient's age, duration of seizure and underlying cause.

Subarachnoid haemorrhage

Subarachnoid haemorrhage, the acute release of blood in the subarachnoid space, usually results from a ruptured intracranial aneurysm. In post-mortems, one in 20 people are found to have intracranial aneurysms, but the incidence of subarachnoid haemorrhage is only 10.5 per 100,000 people per year.

The clinical hallmark of subarachnoid haemorrhage is sudden onset of very severe headache – often described by patients as the worst of their life. Half of patients have a period of unresponsiveness and a third of patients have focal signs.

Subarachnoid haemorrhage is often misdiagnosed as migraine, influenza, viral syndrome, arrhythmia or syncope, especially in patients who are fully conscious and have no focal deficits.

Any patient suspected of having a subarachnoid haemorrhage should be immediately referred to the local hospital for a non-enhanced CT scan, and if this is normal, a lumbar puncture.

On confirmation of a subarachnoid haemorrhage, the patient should be urgently referred to a neurosurgical unit for a catheter angiogram and endovascular coiling of the identified aneurysm.

In the UK, more than 90% of aneurysms are coiled and the remaining are clipped surgically.

Brain tumours

More than 100 types of brain tumour have been described by the World Health Organisation. Symptoms and signs depend on the location of the tumour and the rate of its growth:

- The presence of any mass within the confines of the skull produces headache and, rarely, nausea and projectile vomiting.
- Irritation of the cortex can produce seizures, common in meningiomas growing in the convexity of the brain or low-grade gliomas of the temporal lobe.
- Tumours growing near to, or at, the sensorimotor or language cortex produce weakness, sensory deficits and expressive or receptive dysphasia.
- Some tumours produce visual symptoms or endocrine abnormalities – the classic example is pituitary tumours.

The diagnosis of a brain tumour can be difficult in patients presenting with headaches only. Such cases should be discussed – preferably – with neurology or neurosurgery on-call teams. Patients with focal neurological deficits, confusion or seizures should be referred urgently to A&E for a brain scan and onward referral to a neurosurgical unit. In contrast with other types of tumours, the terms 'benign' and 'malignant' do not apply as literally in the brain. A slow-growing and histologically benign tumour can have devastating effects if it grows in an area such as the brain stem or the sensorimotor or language cortex.

The most common intrinsic brain tumour is the glioblastoma – a malignant astrocytoma, arising from the astrocytes – which occurs at a frequency of three to four new cases every 100,000 population every year.

22

21 The standard treatment is aggressive surgical resection followed by radiotherapy and chemotherapy.

Spinal cord compression

Spinal cord compression can be catastrophic if not recognised and treated urgently.

Patients often present with established deficits such as weakness or paralysis with or without bladder and bowel symptoms. Any patient who presents with new onset of weakness of legs, or arms and legs, should be presumed to have spinal cord compression until proven otherwise.

Patients often have myelopathic signs – brisk reflexes, increased tone, up-going plantars and positive Babinski sign.

Patients suspected of having spinal cord compression should be referred urgently to their local hospital or to a neurosurgical unit for an MRI scan of the spine.

The sooner the spine is decompressed and stabilised – ideally within 24 hours – the higher the chances of preserving remaining function and occasionally reversing established deficits.

By far the most common cause of spinal cord compression is metastatic tumours to the spine (80-90%), followed by intradural spinal tumours such as meningiomas, neurofibromas, and schwannomas, trauma, haematomas, abscesses and degenerative disc disease such as large prolapsed cervical or thoracic disc disease.

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Dr Chris Taylor trained at University College London Hospitals. He is an examiner at the Royal College of Anaesthetists and his clinical interests include neuromedical critical care, anaesthesia for myasthenia gravis, functional neurosurgery and neuroradiological procedures.

Mr George Samandouras (georgesamandouras@gmail.com) was trained in Oxford and completed a fellowship in Paris. He is editor of the best-selling book *The neurosurgeon's handbook*. His clinical interests include advanced techniques for the surgery of brain tumours, minimally invasive surgery and spinal surgery.

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Five misconceptions in neurology

GP and epilepsy specialist **Dr Jane Williamson** on five common misconceptions

1 Headache is a useful predictor of a brain tumour

Patients who present in primary care with a headache often have one of three possibilities in mind: they need glasses, they have high blood pressure or they have a brain tumour.

GPs see a lot of headache, but do a great job in managing it themselves – only 3% of patients are referred to secondary care for further assessment.[1] It's true that headache is a very common symptom of brain tumour – 70% of patients will experience a headache during their illness at some time. But the risk of headache being associated with a brain tumour is very low and is estimated to be around 0.09%.[2]

It is easy to understand how an overzealous or inexperienced GP might want to err on the side of caution, especially as some of the non-headache symptoms of brain tumour are subtle.

The latest guidance from the Department of Health on direct access to diagnostic tests for cancer recognises that selecting patients for investigation of a possible brain tumour is particularly dependent on a GP's experience and intuition.[3] The criteria for urgent referral for suspected brain or CNS cancer are clearly set out in a document available to download at pulsetoday.co.uk/downloads.

And finally – headache rarely warrants an immediate referral, but the exception is a sudden-onset headache which is maximal immediately or within a few minutes and lasts longer than an hour, which should ring alarm bells of a subarachnoid haemorrhage.

2 Anyone who's had an episode of unexplained loss of consciousness should be referred to a neurologist

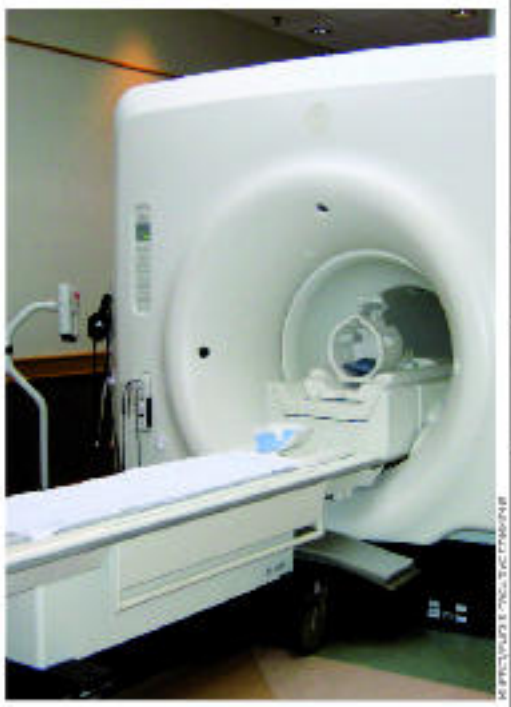
In our fast-track epilepsy clinic, only about 50% of referrals actually have epilepsy. Most of the rest are faints or vasovagal attacks. There are a few with other physical problems, such as cardiac dysrhythmia. And about a fifth of those referred have psychogenic pseudoseizures of one kind or another – what we used to call pseudofits, but are now termed non-epileptic attack disorder (NEAD).

The best way to decide who to refer to neurology is to take a careful history, both from the individual and also from any reliable witness to the episodes.

Witnesses can often give a pretty good description of a classic seizure, and if the patient recalls having some sort of aura-like experience before the episode it's clear they had a seizure.

Feeling light-headed with a sound of drumming in the ears is usually a sign of a vasovagal attack, especially if there's a witness description along the lines of 'he went pale and then sort of crumpled'.

Features that are common in NEAD but rarer in epilepsy include: biting the tongue, seizures lasting more than two minutes, seizures having a gradual onset, a fluctuating course of disease severity, the eyes being closed during a seizure and side-to-side head movements.



As with all somatoform disorders, it is important to recognise it as early as possible – and hopefully before the patient starts taking antiepileptic drugs.

3 Self-referred brain scans are pointless, but harmless

What should we tell patients who insist they need a brain MRI and are willing to pay around £250 to go private? Should we tell them to go ahead as it won't do any harm?

The answer is probably 'no' – for a couple of reasons.

There's a one in 37 chance of finding an abnormality that may well never bother the patient.

A UK meta-analysis looked at the number of incidental findings in 19,559 asymptomatic people who underwent MRI brain scans. These were defined as apparently asymptomatic intracranial abnormalities that were clinically significant because of their potential to cause symptoms.

They found a 2.7% prevalence and a number needed to scan of one in 37.[4] The major dilemma – and this affects asymptomatic volunteers who undergo a brain MRI as part of a research study – is whether to treat incidental brain findings and, if so, how.

In fact, most of the abnormalities were meningiomas, which grow slowly and remain asymptomatic, and surgery on this type of tumour comes with a significant risk of morbidity.

Similarly, aneurysms affect about 2-3% of the population, but treating an aneurysm invasively carries a 5-10% risk of stroke-related death.

The second problem with brain scans is the the detection of incidental findings carries implications for some patients' driving licences, life insurance policies or even their jobs.

So – rather than being relieved to get a nagging patient off our backs – we should stick to the principle of *primum non nocere* and refuse to lend any credibility to a pointless and potentially harmful private enterprise.

4 Cervical radiculopathy is caused by a trapped nerve

Nerves do not simply get trapped and untrapped and this certainly is not the case in cervical radiculopathy – neck pain that radiates into the arm.

This is generally caused by irritation of the lower cervical roots (usually C5-T1) from a herniated disc or degenerative disc disease.

While surgical decompression provides rapid and substantive relief, it is not without complications and the long-term outcomes are unclear.

Degenerative cervical radiculopathy with a subacute onset generally settles, and a wait-and-see policy is recommended for the first six weeks. Patients should be referred if symptoms persist after this.

A recent study published in the *BMJ* explored whether using immobilisation with a semi-hard collar or physiotherapy could improve symptoms faster than a simple wait-and-see strategy.[5]

Pain improved substantially in both the physiotherapy and immobilisation groups compared with those assigned to the wait-and-see approach, making the simpler option – collar and relative rest – the most preferable.

You can learn more about cervical radiculopathy – including the red flags – in the Hot topics in musculoskeletal medicine CPD module at pulse-learning.co.uk.

5 Parkinson's disease with dementia and dementia with Lewy bodies are different diseases

It's quite common for patients who have had Parkinson's disease for some time to be referred to psychiatry because they have started to become forgetful and even experience hallucinations – with Lewy body dementia as the chief suspect.

In fact, both conditions are two presentations of a single underlying disease process – Lewy body disease – which these patients have probably had for some time.

Other than age of onset and possibly response to levodopa, there are no major differences between dementia with Lewy bodies and Parkinson's disease, and the management aims are essentially the same – to treat motor, cognitive, psychiatric and autonomic dysfunction using the same drugs and non-pharmacological strategies.

There are revised diagnostic criteria for dementia with Lewy bodies and for dementia in Parkinson's disease, and neurologists should be using an agreed terminology, which would certainly help patients understand what is happening to them.[6]

Dr Jane Williamson is a GP in Birmingham and associate specialist in epilepsy

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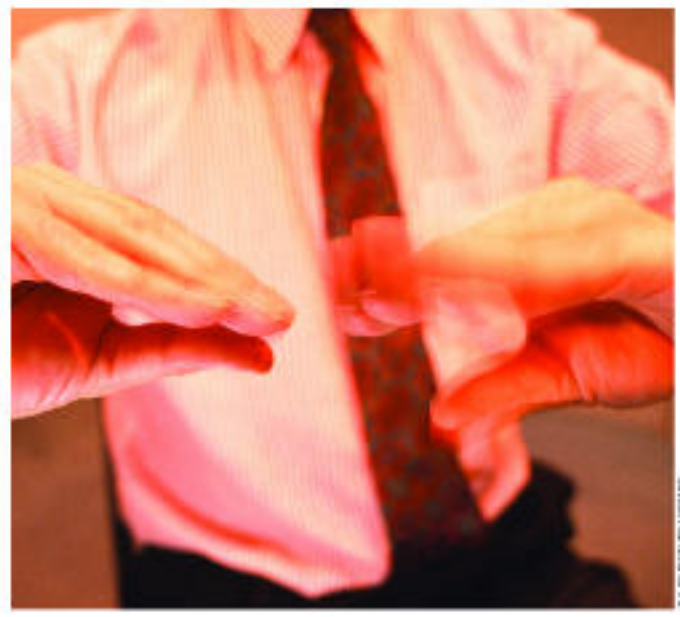
Ten top tips
Parkinson's disease

Dr Alistair Church, GP and associate specialist in neurology, offers his tips on managing patients with Parkinson's disease



1 Patients don't always present with a tremor.
Up to 20% of patients, particularly those with early-onset disease, never develop a tremor. For a diagnosis of Parkinson's disease the patient must have bradykinesia. A good way of identifying this is to ask the patient to tap their thumb and first fingers together as fast, and with as big an amplitude, as they can. Watching a patient walk down the corridor can also be helpful – reduced arm swing on one side can be an early sign.

2 Consider Parkinson's in younger patients.
With a prevalence of one in 500 and an annual incidence of one in 8,000, the average GP looks after three or four patients with Parkinson's at any time.[1] The mean age of onset is 60, but 15% of patients present before the age of 45. Younger patients often present with stiffness, slowness or dystonia rather than tremor.

3 Non-motor symptoms can be an early sign.
Parkinson's causes non-motor problems which can predate the motor symptoms, sometimes by years. Loss of sense of smell and thrashing about when asleep – 'living out their dreams' – can be early signs. These are non-dopamine-related complications, so do not respond to dopamine replacement therapy.

4 Be aware of sleep problems.
Patients with Parkinson's can find it difficult to sleep because of restless legs, painful 'off medication' dystonia and urinary frequency. Periodic limb movements may also disturb their partner – this may respond to a low dose of clonazepam. Daytime somnolence can result, and may be compounded by dopamine agonists.

5 Audit patients on dopamine-depleting drugs.
Antipsychotics and some anti-emetics deplete dopamine, so think carefully before putting patients on these long term. A good practice audit would be to review all patients on repeat prescription of these, before symptoms start – because drug withdrawal once extrapyramidal problems have emerged doesn't always lead to resolution.

6 Think again if there are atypical features.
Diagnosing atypical Parkinsonism can be challenging. Features such as a rapid time course, early falls, difficulty swallowing, early autonomic features, ataxia, marked early cognitive impairment and eye movement disorders may suggest an alternative diagnosis, such as progressive supranuclear palsy, multiple-system atropy or corticobasal degeneration. If patients do not respond to dopamine replacement therapy, review the diagnosis – and if the issues persist, refer.

7 Treatment should be started when the patient becomes functionally disabled.
Medical treatment should be started when patients become functionally disabled or they are unable to perform tasks that are important them. This is something that the specialist will need to discuss with the patient. We can currently only treat the symptoms of Parkinson's and not the progression of the condition. Dopamine replacement therapy – usually co-careldopa or co-beneldopa – is still our best symptomatic treatment option.

8 Be aware of the drawbacks of dopamine agonists.
Dopamine agonists are not as effective as levodopa and have more side-effects. But they do offer more continuous dopaminergic stimulation and are only taken once a day. Watch out for impulsive and compulsive behaviour, such as pathological gambling, hyper-sexuality and excessive shopping. These problems may occur in up to 17% of patients on these drugs, and can also arise in some patients (7%) taking levodopa.

9 Adjunctive treatments may help.
Other treatments for the motor complications of Parkinson's include catechol-O-methyltransferase inhibitors – such as entacapone or tolcapone – which increase the bioavailability of levodopa and prolong its effects. These must be taken with each levodopa dose. Monoamine-oxidase type-B inhibitors prevent dopamine breakdown at the synapse. They can be used as a monotherapy or as adjunctives and have a once-daily dosing regimen, but should not be used in patients on SSRIs as this could induce a serotoninergic crisis. Amantadine has minor benefits for motor symptoms, but is mainly used to reduce dyskinesia. It can cause hallucinations and confusion.

10 Get early input from other specialists.
Parkinson's nurse specialists are often the key to co-ordinating care and managing motor complications. Physiotherapists and occupational therapists can be invaluable in improving a patient's confidence in managing their symptoms. A speech and language therapist can enhance the volume and intelligibility of speech, and in the later stages of Parkinson's swallowing assessment can be important.

Dr Alistair Church is a GP and associate specialist in neurology, with a special interest in Parkinson's disease, in Newport, south Wales

Parkinson's UK offers support to all healthcare professionals working with people with the condition. For information, resources or to join the charity's professionals' network, visit parkinsons.org.uk/professionals.

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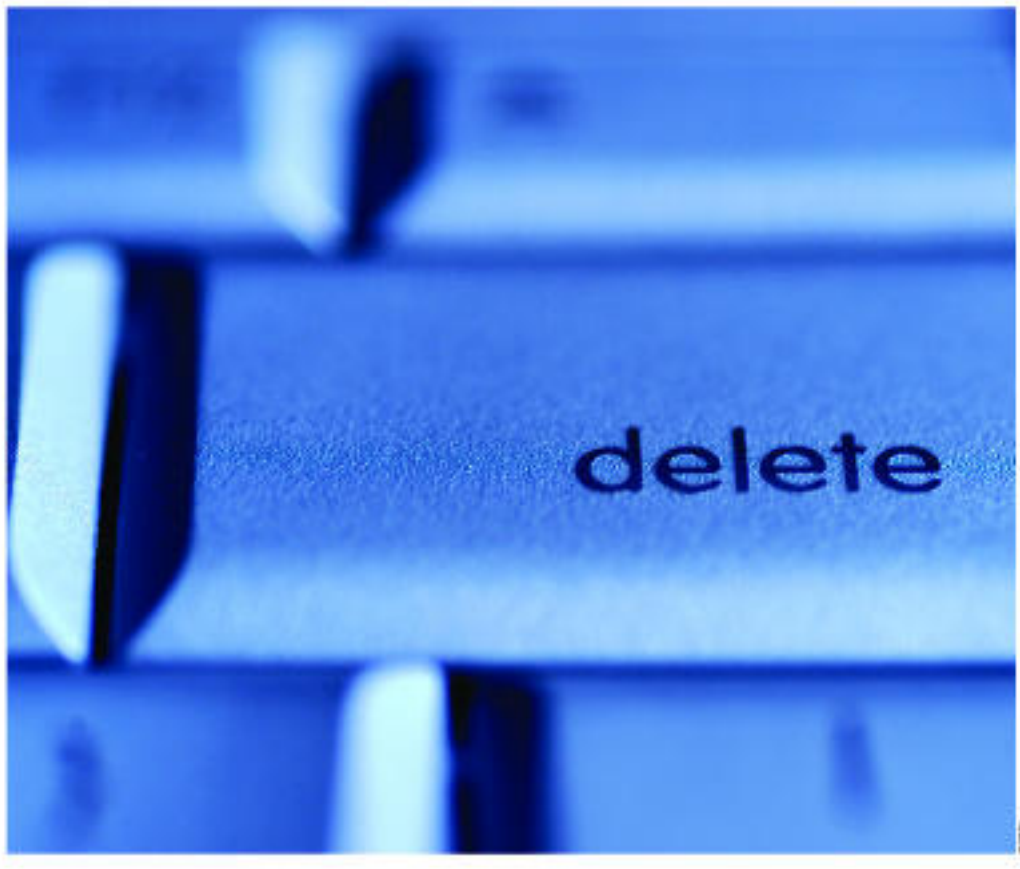
Nine ways to avoid costly data breaches

GPs will face increasing demands to share data – so it is essential to understand the regulations. **Dawn Monaghan** from the Information Commissioner's Office explains



Data protection is likely to become a hot topic as GPs enter the new world of clinical commissioning. Under CCGs, GPs are likely to be sharing more of their patient and other data with many other organisations – both within and outside the NHS.

Priorities for GPs are:

- to make sure they fully understand their obligations under the Data Protection Act and Freedom of Information Act
- to put practical systems in place to ensure they can meet those obligations.

GPs need to be sure that they fully understand that they can share data, but must identify the risks associated with that sharing and mitigate them. The following nine points will help GPs ensure practice data is protected and that they understand what information can and can't be shared.

1 Beware of information breaches

Activities that can risk data breaches include putting data onto memory sticks or sending data to work from home without using a secure network or encryption process. If any data is downloaded to a mobile device, it should be encrypted. There is guidance on the Information Commissioner's Office (ICO) website about suitable encryption packages. There are a number of different commercial options available and data controllers should ensure they meet the current standard, such as the recommended FIPS 140-2 (cryptographic modules, software and hardware) and FIPS – 197.

If GPs are working from home or sending information to somebody else, they should always use NHS.net and send data on a secure connection. This doesn't always happen, particularly in small organisations where people may send data to their hotmail account, for example.

We also see a lot of breaches involving faxes. Our guidance is not to use a fax machine as a secure means of transferring data. If you have no other option, there must be stringent policies in place and staff must be trained in how to use the policies – for example, staff should ring the recipient and make sure someone will be at the machine to collect it immediately, double-check the fax is being sent to the right number and ring back after the fax has been sent to make sure it has arrived.

There is also the issue of staff unlawfully accessing or using data. This is usually because of incompetence rather than for malicious reasons. Staff must be made aware that they only have access to data for certain purposes and are not allowed to use it in any other way.

Another common data breach is when someone – for example, a private detective – will pretend to be someone's relative to blag information over the phone. Practices could use security passwords or questions to ask enquirers before providing them with personal data.

2 Remember that the GP holds responsibility for the data

GPs have obligations under the Data Protection Act, but staff at the ICO often find they pass on their responsibility to the practice manager too readily. A GP is able to delegate the tasks, but not the responsibility – if something happens to data held by the practice, the GP is seen as the 'controller' of that data regardless of their involvement or otherwise with a breach.

GPs should make sure the people they are delegating to are fully aware of what the obligations are and how they must deliver them. It is also important that the person delegated to makes the GP aware of:

- how the data is being managed
- whether security measures are working
- what data monitoring systems are in place
- what agreements cover sharing arrangements if data is being shared.

GPs and their staff are already very aware of issues of confidentiality. What often needs more consideration is how data is stored, who has access, how it is shared and awareness of what GPs' responsibilities are.

3 Report data incidents

When you've had a breach – such as losing a memory stick with personal data on that you know is not encrypted – it's worthwhile reporting it. The ICO can help in ensuring the right questions are asked, such as: what was the data on the memory stick, was it encrypted and what has the GP done about it? We can make an assessment and recommend what systems to put in place to make sure it doesn't happen again. Practices can then handle the matter themselves with our support and assistance, which will cover the practice and the GP's reputation.

4 Put systems in place to avoid future breaches

You should know what personal data is held and how it is stored. Establish where the risks are and identify weak points in security measures. Monitor staff awareness of security and consider setting up a group to discuss 'what if?' issues. Data security is a role for the information governance lead rather than the information technology lead – although in general practice, the practice manager may cover both roles. It is not just to do with technical aspects – the data controller should have technical, such as encryption, and organisational measures in place. Most of the breaches we see are to do with human error, not technology.

5 Tailor training for your staff

It is important to tailor training to the needs of your staff. There is no point in sending staff to a conference on data protection to be subjected to a day of legalese. Staff need practical training in areas such as: what do GPs need to do? What is the role and responsibility of the practice manager? What is everyone else's role and to what level do they need training? GPs should contact the information governance manager at their PCT or CCG for advice about good local courses.

The Department of Health's *Information governance* online training toolkit is a good place to start to raise awareness when you have a new member of staff, or staff who have never been trained in data protection. However, beware of using it as a tick-box exercise – don't assume your staff are trained because they have done the toolkit.

6 Be clear about handling data access requests

There are currently two means of requesting access to information. Personal data can be accessed by the individual in question through the Data Protection Act, via a subject access request. If a practice receives a subject access request in writing, the data must be provided to the individual making the request within 40 days. Practices can charge a fee, but be careful that all the data the practice holds on them is provided – not just the patient's medical records, but also items such as emails or letters.

The Freedom of Information Act covers access to official, rather than personal, information – for instance, if someone asked the practice to provide them with their policy on chaperoning. If a patient wants information provided to the practice about themselves, that is more complicated. It might slip out of data covered under the Freedom of Information Act into data protection, as there might be personal information involved. There might also be third-party data that might be exempt.

If a patient is requesting their own personal data it needs to be provided, and if it's official information it needs to be provided unless it is exempt – for instance, if disclosure would be likely to prejudice a criminal investigation or someone's commercial interests. There is a list of exemptions on the ICO website.

7 Understand the regulations about data sharing

Data requests from sources such as the police, social services or the CCG can be complex. They are data sharing, rather than a request for information. Data sharing means the disclosure of data from one organisation or more to a third-party organisation or organisations, or the sharing of data between different parts of an organisation. Each situation is very dependent upon the circumstances.

A data controller cannot share information unless certain criteria are met. In the case of sensitive personal data, it must meet one of the criteria in both schedule 1 and 2 of the Data Protection Act (which cover areas such as whether the person the data relates to has consented to it being shared, how the data was obtained, how long it is kept, whether it is being transferred outside the European Economic Area and whether processing is necessary to protect the individual's 'vital interests'). If you get explicit consent from an individual to share their data with someone else that would be compliant, but often that is not practical or possible.

It is incumbent on the data controller to decide whether or not they share the data based on whether they think they have the grounds to do so. Information on data sharing can be found in the data sharing code at tinyurl.com/3fn5hj4. This includes a checklist covering such questions as whether sharing is justified, whether you have the power to share, key points to consider and recording your decision.

Specific legislation covers data sharing with certain organisations – the police, for instance, can obtain a court order to access information.

8 Check your marketing policies are ICO-compliant

Marketing communications fall under the *Privacy and electronic communications regulations*, which are stringent rules on what practices can and can't market to people. The key point to bear in mind is: what did you collect the data for in the first place? Would those people expect to receive information relating to that?

A patient knows their GP is collecting their data for the purposes of healthcare, so if the practice was marketing a Well Woman clinic to them that should be perfectly safe.

But if the practice were to share a patient's contact details with a company selling smoking patches, it could be in trouble as the information wasn't collected for that purpose.

9 Don't let information governance hold your practice back

GPs often think they can't do something that involves sharing data because of data protection legislation.

But not sharing data can be just as dangerous as sharing it – GPs just need to be confident that they are familiar with what can and cannot be done. It should be treated as any other business process. Ask yourself: what am I doing and why? What are the risks? Can I mitigate them?

Dawn Monaghan is the group manager for public services at the Information Commissioner's Office

MORE ONLINE

The ICO website

Offers guidance on obligations of data controllers, the *Data sharing code* and a template for a privacy impact assessment for your practice.

▶ ico.gov.uk

Connecting for Health

Has a guide to meeting obligations on data protection, as well as training materials for practice staff.

▶ connectingforhealth.nhs.uk/systemsandservices/infogov

Using volunteers to deliver healthcare

Volunteers can provide a low-cost source of labour for health schemes – and the act of volunteering has benefits too. Three GP commissioners give their own experiences

Dr Michael Dixon

Dr Sam Everington

Volunteering has long been a staple of the social care and charity sectors, but GPs have traditionally hesitated before using unpaid workers. Many would argue that there is little opportunity for patients to contribute to primary care because they lack a clinical background, but GPs are beginning to find opportunities to involve patients more in local healthcare services. The obvious benefit to GP commissioners is the low cost, but volunteer schemes can still be challenging to set up and time consuming to run given the low or non-existent levels of clinical skill among most volunteers.

Here, three GPs give their advice on how to use volunteers safely and effectively.

Volunteer counselling

Dr Michael Dixon *Cullompton, Devon*

At my practice, we employ volunteers according to their background. At the more experienced end, we have two counsellors with a community background – a former health visitor and primary school teacher. At the less experienced end, we have a gardener's group and a fundraising team. All the volunteers are overseen by our health facilitator Ruth Tucker, who is employed part-time by the practice.

We also offer patient groups for those with long-term conditions such as fibromyalgia and diabetes.

Social isolation can be a big problem, so to try to overcome this we have a café facility, which the gardeners' group produces vegetables for. The gardener's group also offers herbal remedies as alternatives to prescriptions where we GPs consider it appropriate.

Our costs are minimal, and there is even a cost benefit for schemes like our borrow-a-book service, where a per-book charge of £1 has added up to enough for us to buy an ECG.

We have had to pay for Criminal Records Bureau checks for our counsellors, but while there's no direct saving, having them working with our practice has taken the pressure off child and adult mental health referrals by providing an opportunity for low-cost early interventions. The counsellors pay for their own insurance.

Our greatest cost is employing the health facilitator

A project at our practice to promote gentle exercise in 2009 used volunteer-led activities such as walking, gardening and 'exercise on prescription', and found that participants managed to lose weight, stop blood pressure medicines and relieve depression symptoms.

We saw a small reduction in the number of clinical appointments booked in the six months following the intervention, especially among high-demand patients.

We've found the greatest cost of having volunteers is employing a health facilitator, but the role ensures that we have well-organised patient groups, good training and strong links to the wider local volunteering scene.

Volunteering as therapy

Dr Sam Everington *Bromley by Bow, east London*

The Bromley by Bow Centre (BBBC) has been offering people in a deprived area of east London support on their health, education and employment for over 20 years. My practice, the St Andrew's Centre, is located on site and offers support to the health centre based on four key aims – supporting

Dr Amit Bhargava

patients' education, creativity, employment and environment.

The BBBC accepts 3,500 referrals a year from the borough of Tower Hamlets. Dan Hopewell, director of strategies at the BBBC, estimates GPs at my practice make 20 to 30 referrals to them a month, often taking the patient from their GP consultation straight to the office of the person in the BBBC the patient is being referred to.

Many of our referrals send patients to the Time Bank scheme, where they are asked to assess their skills and needs and to join a skills exchange programme.

Rather than recruiting volunteers to work with patients, patients are often 'treated' by registering as volunteers. The scheme currently has around 100 members with 50-60% engagement in volunteering activities.

The BBBC also offers health projects for specific patient groups, such as Pollen – a horticulture therapy group for patients with mental health issues. Funding comes from outside the BBBC for this scheme, which has been specially commended by the charity Mind.

Vulnerable adults can attend a day centre at the BBBC, and we target patients for whom English is a second language through early intervention and cancer screening outreach among local students.

Queen Mary University is currently in discussions with the BBBC to develop a programme for volunteer and work experience medical students to work as health navigators in the reception area of our practice and the BBBC, and to pursue follow-ups after appointments.

The health navigators will then assess the patient's condition, recommend a good self-care programme and put them in touch with support groups where appropriate – for instance, for weight loss or diabetes.

The two main opportunities I see in volunteer schemes are encouraging patients to take more responsibility for their own health, and the big wins available through better lifestyle.

Many of the things GP commissioners aim to target – areas of health spend such as emergency admissions and disease areas such as diabetes – can be dramatically improved by giving patients better resources for dealing with their health problems and by changing their diet and exercise habits.

Volunteer schemes can be a good, low-cost way for us to reduce our workload by delegating healthcare back to patients.

The cost to the practice is hard to assess, but one of my partners dedicates one to two days a week to help manage the BBBC's activities. The integration extends both ways, with the chief executive of the BBBC working as a non-profit-sharing partner of our practice.

Carer support networks

Dr Amit Bhargava *Crawley*

Volunteer services make a strong contribution to our practice brand and help us maintain our rate of list growth – currently sitting at 85 to 100 new patient registrations a month. Neighbouring practices that offer similar volunteer-run services are also experiencing a comparable level of list development.

The main strategy for our volunteer schemes is to make them self-sustaining, so they create a zero-cost clinical benefit to GPs without requiring time or financial input from us.

We started with offering a general support network for carers, but as it grew we established more specific groups – for example, for Alzheimer's disease and back pain.

Initially we offered simple social meetings for carers in the networks, but we now provide health education sessions too.

We employ a co-ordinator for our volunteer schemes who works 12 hours a week, but managing the volunteer schemes is only part of her role and the groups mostly organise themselves.

The practice makes no financial input to volunteer groups and, as it doesn't charge rent even to private health providers using rooms on the site, there is no loss of income from providing volunteer-run groups with a place to meet.

Some successful programmes we participate in were suggested by our carer groups. So for example, we encourage people to use the 'This is me' scheme run by the Alzheimer's Society, in which patients or their carers fill in a questionnaire with photo ID, describing the patient and their health needs and medicines, and providing contact details for their main carer. It has been shown to help reduce the average length of hospital stay for participants.

We also have an armchair exercise group for the frail elderly, which is provided and run by the local branch of Age UK.

Early intervention is the main objective of our volunteer services, and our 8% reduction in unscheduled admissions since last year can be partly attributed to their introduction.

Since we introduced our volunteer services, demand for GP appointments and requests for home visits have also gone down.

MORE ONLINE
Go to pulsetoday.co.uk/tools-and-resources to download a copy of the 'This is me' form developed by the Alzheimer's Society for patients with dementia

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DOCTORS/GPS REQUIRED

College Health is a dynamic and innovative organisation; our ethos is putting patients first and delivering high quality locally based primary care services. We have been successful in being awarded primary care contracts in the Medway Towns and Essex.

We are seeking highly motivated, enthusiastic individuals who value working as part of a multi-disciplinary team and are committed to providing high quality clinical services which changes health outcomes for the better.

We have vacancies for 1 full time GP and a part time maternity cover Locum. We are a unique practice in that we have a registered patient list and also a busy walk in centre.

It is an exciting time to join as the centre is expanding its services in line with current commissioning intentions to provide more services within primary care.

We already have consultant led clinics in Cardiology (echo) and ultrasound and outreach clinics coming soon in dermatology, pain management and diabetes.

If you are interested in working in an exciting, progressive environment why not consider us?

Applicants should contact the Practice Manager, Anne Osbaldeston by email at anneosbaldeston@nhs.et or by calling 01375 899702.

Informal enquiries welcome

The Welby Practice

GP Partnership Opportunity

The Practice is looking for an enthusiastic, highly motivated GP to join our friendly rural dispensing practice in the beautiful Vale of Belvoir. The practice has five thousand patients is fully computerised and scores highly in QOF and patient surveys. The vacancy is for a full time and part time General Practitioner.

- *Emis clinical system moving to System One*
- *PMS practice*
- *Leicester Medical School Training Practice*
- *No OOH commitment*
- *Good Schools within the local area*

For more information or to arrange an informal visit
Contact Lisa Wild Practice Manager

Please apply in writing with your CV by 29th June 2012

Main surgery:
The Welby Practice
Walford Close
Bottesford
Nottinghamshire
NG13 0AN

Direct line to Practice Manager 01949 845366
Email: lisa.wild@lpct.nhs.uk

Salaried GP required
with a view to Partnership
Full time (8 sessions) or part-time considered

Werrington Village Surgery is a GMS Practice supporting c7879 patients, located in a modern purpose built surgery. We are a semi-rural practice, close to the Peak District, in an area with reasonably priced housing.

- 4 Progressive Partners (3.25 WTE)
- Active in Practice Based Commissioning
- High achiever of QOF points
- Excellent support team with low staff turnover
- Fully computerised Emis LV Practice (soon to be EMIS Web)
- Strong Nurse team; triage
- Strong Community support with integrated teams
- No requirement for out of hours cover

Apply in writing enclosing C.V. to
Peter Bailey, Practice Manager
Werrington Village Surgery
Ash Bank Road, Werrington
Stoke-on-Trent, ST9 0JS
peter.bailey@northstaffs.nhs.uk

Telephone for informal discussion or visit, 01782 304742
Closing date 22.6.2012 Interviews 12.7.2012

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**

SUMMERCRESTT SURGERY

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

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
ISoft 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.

End of Life Nutrition

Band 6 • £25,528 - £34,189
37.5 hours per week • 2 year fixed term contract

Are you an experienced nutrition support dietician looking for a challenge? This is an exciting new Macmillan sponsored post for a minimum of 2 years.

You will join an existing Band 7 working as part of a Specialist MDT. This will be a varied post with cover of a hospice in-patient/day hospice facility, together with community cover. There will also be scope for research, education sessions and audit.

You will need to bring knowledge, show empathy and commitment in this sensitive area. In return you will be well supported by the organisation, wider Birmingham Community Team and Macmillan.

For informal enquiries please contact
Sue Mackie - Clinical Specialist Dietician
on 0121 465 2002.
Closing date: 29 June 2012.

John Taylor Hospice

Waterloo – Merseyside
Partner Vacancy - due to retirement

We are looking for a GP partner to join our well organised, established, friendly small practice.

- List size 3200
- Emis Web
- GMS
- Excellent QOF achievement
- 7 sessions per week

We have a happy, efficient and supportive team and have very good links with the wider PHCT. We strive to provide the highest standards of modern primary care while maintaining the very best of traditional family general practice.
Apply in writing with covering letter, CV and two referees to Dr Duran, 20 Kingsway, Waterloo, Merseyside, L22 4RQ
Tel 0151 920 9000

Closing date for applications 16th June 2012.

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.

Dr Mughal and Dr Bhatti Partners are looking for a salaried GP for 6 sessions. Wages negotiable. High QOF achievement and friendly environment.

Contact Shirley Suker by e-mail shirley.suker@nhs.net or tel 0208 550 3740

DOCTORS/GPS REQUIRED

Full/Part time GP Required

Dallam Lane Medical Centre is looking for 1 full time or 2 part-time Salaried GP's with a view to partnership for the right person(s). We are offering a competitive package with the opportunity for professional development.

Dallam Lane Medical Centre is a well established, family orientated practice which has recently moved to new and modern premises in the busy town centre, with significant growth potential.

The practice is a high QOF achiever and prides itself in the high standard of clinical care provided to our list of 3,500 patients. The practice is EMIS PCS moving to EMIS web.

Please apply in writing to Angela Bonney, Practice Manager, Dallam Lane Medical Centre, Warrington, Cheshire, WA2 7NG.
Tel: 01925 572 334 or email warr-pct.dlmc@nhs.net
For further information please call Angela Bonney on 07811 768103.

Does your Practice currently include a Pharmacy?

Do you receive an annual rent from the Pharmacy?

If the answer to both these questions is 'Yes' then you might be able to sell the space that the pharmacy occupies for at least 10 times the current annual rental and in some cases even more than that. This means that the current Practice Partners can share in the value of the pharmacy premises now and unlock a sizeable amount of value.

For an informal discussion on your best options please email Conor Daly of Rushport Advisory LLP at conor.daly@rushport.co.uk

Rushport Advisory

Partnership Vacancy – September 2012

Llys Meddyg, Sway Road, Morriston SA6 6JA
Tel: 01792 771392.

We are hoping to attract you to join our team – preferably as a full time Partner but negotiable for the right candidate!

Percentage Share Premises Purchase Option
Well established Isoft Ganymede Practice
Excellent Support Team
8 weeks Annual Leave

Informal enquiries welcome.

Written applications together with your CV to Mrs Ceri Jenkins, Practice Manager at the above address or by e-mail to ceri.jenkins@gp-w98029.wales.nhs.uk

Closing Date: 22th June 2012

Sunnybank Heath Centre, Blackwood, Gwent.

PART-TIME SALARIED GP

Sessions negotiable

We require a part-time GP to work in a friendly Practice

- 4,700 patients
- High QOF achievements
- Vision clinical system, paperlight practice.
- Purpose built premise
- 2 Full-time partners

Please e-mail to meryl.thomas@gpw98014.wales.nhs.uk with your CV by the 30th June 2012.

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 319490. Email: sam.paul@nhs.net

Full Time GP

(probable future partnership)

Large forward-thinking practice seeks full time GP due to retirement.

Our ambition is to achieve, by an effective team approach, the highest quality of progressive family health care, in a happy and compassionate environment.

We care for 16,100 patients in the pleasant Weald of Kent area. We operate four buildings, two of which are purpose-built Medical Centres. We are part dispensing and currently have 3 GP Trainers. We have an excellent nursing, ancillary and PHC team.

Please write with full CV to Peter Nicholas, Managing Partner, Hildenborough & Tonbridge Medical Group, Westwood, Tonbridge Road, Hildenborough, Kent, TN11 9HL.

Closing date extended to 8th June 2012

Shortlisted candidates will be welcome to arrange an informal visit to the practice.

Foxhill Medical Centre, North Sheffield
Tel: 0114 2854 313

PART TIME PARTNER (salaried GP considered)

REQUIRED FROM SEPTEMBER 2012
5-7 sessions (negotiable)

We are a friendly, innovative practice with a reputation for providing good patient care, having major links with the local community and being a strong, supportive team that values a good sense of humour. Well established partnership with opportunities for teaching/mentoring.

• LIFT premises under construction • No buy in
• Six partners (4.5 WTE) • Highly skilled nurses
• Committed PHCT • 6,100 patients • Training practice
• Involved in PBC • High QOF achievers
• Complementary therapies (acupuncture, herbalism, massage)
• Practice Psychotherapist
• Many DESs including Substance Misuse.

Please contact Dr Amanda Rosario
or email mandy.neville@nhs.net

Closing Date: Thursday 5 July 2012, at 12 noon

FULL OR PART TIME DOCTORS REQUIRED FOR BRITISH CRUISE SHIP COMPANY

LOCATION - CRUISES SAIL WORLDWIDE
RECRUITER - NOT SPECIFIED
SALARY - NOT SPECIFIED

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• Excellent remuneration • Full administrative support

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

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

Tudor House and Rectory Road Medical Practice

GP LOCUM NEEDED

2-4 Sessions all day Tuesday and some Thursdays
Starting ASAP

Required for large friendly medical practice in Wokingham town centre

- 11 partners and 1 salaried doctor with 22,500 patients
- Full clinical team including triage nurse, nurse led clinics and HCA
- Emis-LV, moving to EMIS web in July 2012
- See our website for more details www.tudorhousesurgery.co.uk

Please apply by email with a copy of your CV and covering letter to:
tudor.house@nhs.net

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Due to expanding requirements, our client is seeking full time, part time and sessional GMC registered Doctors. These roles require at least three years of broad based experience, excellent communication and IT skills with full time training provided prior to starting.

Our client provides functional assessment services on behalf of the UK government.

Flexible opportunities for experienced Doctors are also available, from a minimum of 5 sessions per week to fit around current work commitments.

To get started email your CV and covering letter to:
jobs@sjbmedical.com or call 020 7832 1961

fb.com/sjbmedical @sjbmedicaldocs

BIRCHINGTON MEDICAL CENTRE

FULL TIME PARTNER (8 Sessions) REQUIRED

DUE TO RETIREMENT

We are a progressive team of 7 GPs (5.5 FTE) , 4 nurses, and excellent administrative staff. We are committed to upholding and continuously improving an excellent standard of patient care.

We operate from attractive purpose built premises overlooking farmland and located in a seaside village.

- *Paperless Emis LV (moving to EMIS web)*
- *High QOF achievement*
- *In house cardiology GPwSI Clinic*
- *Active in local commissioning group which expects early authorization*
- *Teaching practice*
- *Local attractions include sailing, water sports, and championship golf courses.*
- *45 minutes from channel tunnel*

Application and CV to Mrs Sarah Price, Birchington Medical Centre, Minnis Road, Birchington CT7 9HQ or Sarah.price@nhs.net
Telephone 01843 846818

SALARIED GP

ROTHSCHILD HOUSE SURGERY, TRING, HERTFORDSHIRE
(From October 2012)

We are GMS practice seeking a permanent salaried GP to join our friendly team.

- *Ideally 8 sessions a week working over 5 days however we would consider less for the right candidate*
- *Large semi-rural dispensing practice on the edge of the Chiltern Hills*
- *Purpose built premises in attractive market town*
- *Well organised management, clinical and administrative teams*
- *Paper-light practice, InPS "Vision" clinical software.*
- *Teaching practice*
- *Excellent local schools. Easy access to London, motorway and rail networks*

CVs will be accepted in support of an application form.
For an application pack please contact:

Dorothy Pluck on 01442 892465 or Jenny Stevens on 01442 892466
Email: dorothypluck@nhs.net or jennystevens@nhs.net

Closing date 22nd June 2012

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THREERIVERS MEDICAL

Full or Part-time Salaried GPs

To join Church Close Surgery, Madeley, Telford, which is a small friendly practice of approx 4700 patients. We are seeking 2 or more salaried GPs to cover between 12 – 14 sessions per week, some starting in Aug-Sept this year and more next April 2013. We are happy to consider job share or any other proposals. BMA Contract and salary scales.

We are EMIS paper lite, and the surgery has an excellent established telephone triage system in place. We run chronic disease clinics led by nurses, and achieve high QOF points. We will hopefully be moving to new practice premises in the next 18 months or so.

Successful applicants will practice evidence based medicine and prescribe cost-effectively, and be flexible in their role to meet the needs of the surgery. Minor op skills or willingness to train is desirable.

All informal enquiries to Julie Ellis (Nurse Partner/Managing Partner) 01952 586616 or apply in writing with CV to Julie Ellis, Church Close Surgery, Church Close, Madeley, Telford. TF7 5BP.
julie.ellis1@nhs.net

Closing date End June 2012.

LOCUM AGENCIES

COURSES & CONFERENCES

@pulsetoday The best of what's online this week at pulsetoday.co.uk

EDITOR'S CHOICE

A life without benefits

Patients refused disability living allowance should be offered counselling to help them focus on what they can do – not what they have lost, says Dr Stuart Berry

Dr Stuart Berry: provide CBT

A friend commented recently that she had walked past a billboard saying: 'One-legged man refused disability living allowance.' She initially felt sorry for the chap – why shouldn't he be able to claim when he had been left disabled by an accident? But this was quickly followed by some thoughts about what jobs remained open to him.

It's great that obvious benefits cheats don't always profit from their fraudulent ways – but what about the cases that are less clear-cut?

Patients who are refused DLA should be automatically offered counselling and advice about the reasons for their rejection and how that opinion has been reached. They should be offered cognitive behavioural therapy so they can start thinking more positively about the sorts of jobs they can do, instead of focusing on what they have lost.

Rejection from DLA can lead to patients considering suicide, as they feel they cannot ever find a job or income that will allow them to carry on. Offering a fast track into CBT or interview with an occupational therapist can prove beneficial to the patient – and their family – in the long term.

Dr Stuart Berry is a GP in Pendle, Lancashire, and communications lead for East Lancashire CCG

MORE ONLINE
Read the full article
pulsetoday.co.uk/opinion

VIDEO

LMCs enjoyed some comic relief, Scouse-style, with Dr Ivan Camphor and Dr Neville Bradley donning traditional outfits to argue the conference should return to Liverpool. Watch it and other videos from the LMC conference last week.

▶ pulsetoday.co.uk/videos

WHAT YOU'VE BEEN SAYING

▶ pulsetoday.co.uk/forum

> **GPs are beginning, at last, to see how the maths is adding up to a peach of a Copperfield article.**
>
> ... on how GPs' pay may be docked over pensions action

> **The BMA never gets its powder wet – we will be waiting till pigs start flying.**
>
> ... on GP opposition to revalidation

> **Faces look so lonely without their noses.**
>
> ... on LMCs demanding a commissioning boycott over pensions

MAP

CCGs' proposed running-cost allowance

Go online to see an interactive map showing the 212 proposed CCGs and their indicative running-cost allowance.

INTERACTIVE MAP
pulsetoday.co.uk/maps

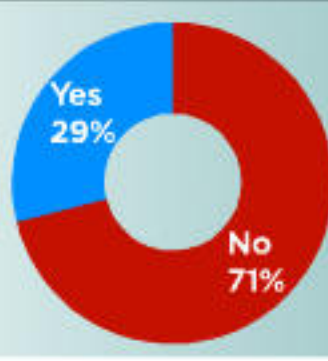
THIS WEEK'S POLL

Should drug firms help plan and manage NHS services?

Vote at ▶ pulsetoday.co.uk/polls

Last week's poll

Will online booking ease the '8am rush'?



Turn inside for this week's Phil Peverley and Margaret McCartney columns
▶ page 14