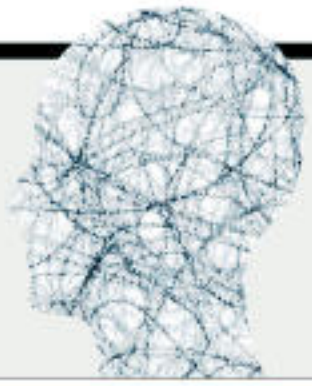

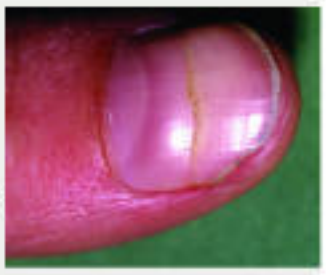

PULSE

02.05.12
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BriefingMedia

At the heart of general practice since 1960

GP pay hit as patients shun extended hours

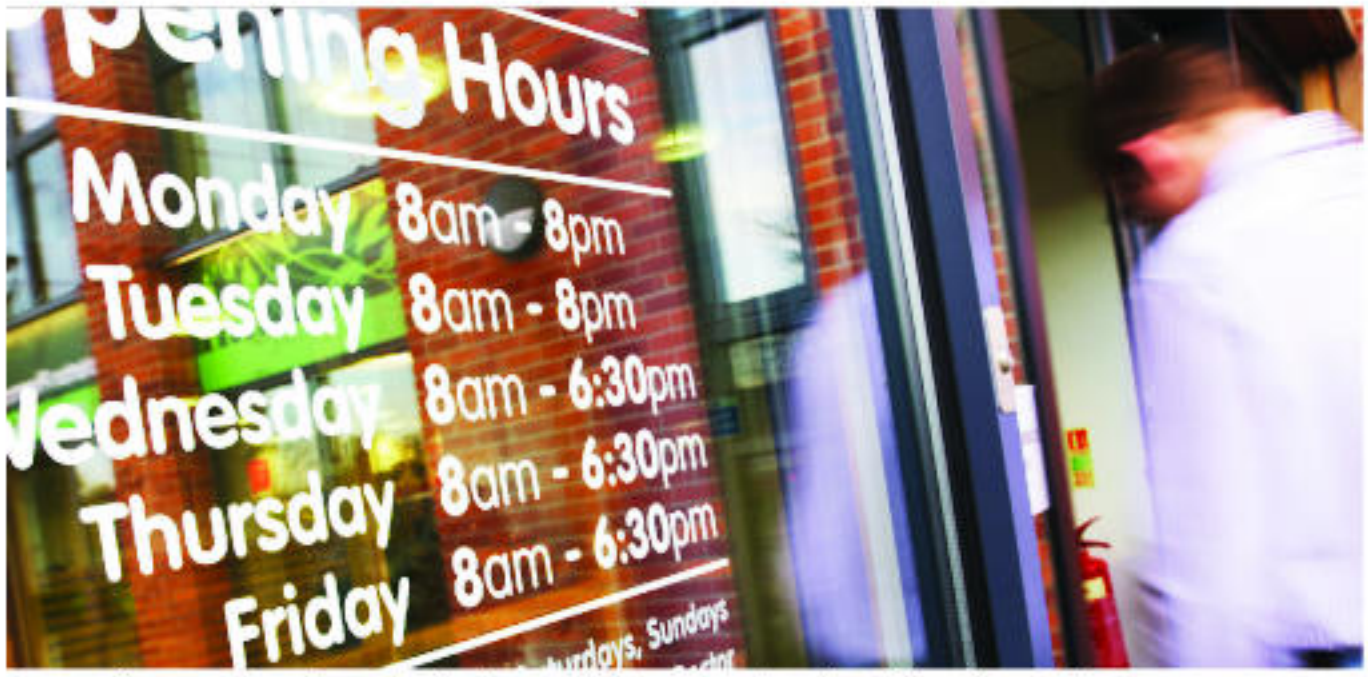
NHS managers rewrite LES contracts to claw back cash from GPs who can't fill surgeries

EXCLUSIVE
By Gareth Iacobucci

GPs who fail to fill extended-hours surgeries are to have their pay docked by NHS managers, after a series of PCT audits found many patients are shunning evening and weekend appointments.

A Pulse investigation reveals PCTs across England are writing 'utilisation' clauses into extended hours LESs, to withhold payments from practices if they fail to fill surgeries above a certain threshold.

EDITORIAL ▶
GPs made to pay for a failed policy 12



Many practices now offer evening and weekend surgeries - but some are struggling to fill appointment slots

The controversial move has been opposed by LMCs and described as 'wholly inappropriate' by the GPC, which said it was unacceptable for trusts to be offering LESs at worse terms than the national DES - which does not have any utilisation requirements.

At least three trusts have so far rewritten LES agreements to require practices to meet certain utilisation targets, while a series of others have ramped up their scrutiny of GP performance.

NHS Berkshire cluster, which covers Berkshire East and Berkshire West PCTs, has rewritten its 2012/13 LES to include a 70% utilisation target, which practices must achieve to receive full payment, after identifying a number of practices running largely empty extended-hours surgeries. The PCT said in 2011/12 two practices had a utilisation rate of between 50% and 70%, one between 30% and 50%, and three practices 30% or lower.

A spokesperson said: 'While the majority of practices across Berkshire are reaching the 70% target, both PCTs are closely monitoring uptake over the coming year. We'll provide assistance to practices not reaching the target before considering reclaiming funding.'

NHS Trafford inserted a clause into its 2011/12 LES agreement last June demanding practices achieve 75% utilisation to get paid, while other LMCs in the North West have resisted an SHA-led attempt to set a 75% threshold.

Falls in extended hours funding

2008 £158m recycled from Access and Choice and Booking DESs to create Extended Hours Access DES

2011 DES payments cut from £3.01 to £1.90 per patient - but some flexibilities added

2012 PCTs insert clauses in LESs to allow them to reclaim funding for unfilled appointments

Peter Higgins, chief executive of Lancashire and Cumbria consortium of LMCs, said: 'They attempted to talk to us about it but we wouldn't go there.'

Other trusts are increasingly scrutinising utilisation rates amid mounting evidence that extended-hours surgeries, first rolled out under the Labour government in 2008, are not being heavily used by patients.

NHS Sheffield has collected regular audit data from 68 practices signed up to its LES, and reported that two practices had utilisation rates of just 50%. NHS Bristol said it aspired to 80% utilisation, and practices failing to achieve this over a three-month period would be required to establish an action plan, while NHS North Lincolnshire said one practice had stopped providing extended hours after a PCT review of utilisation.

NHS North Somerset said it had analysed extended hours take-up during 2010/11, and found utilisation improved at some practices when opening times were rescheduled. It added: 'It was not always workers or commuters who wanted early morning or late afternoon slots. Elderly and retired [patients] used the early slots too as they could get relatives to transport them before work.'

GPC negotiator Dr Chaand Nagpaul said: 'It would be wholly inappropriate to put a requirement in a LES that was less favourable than the DES. No practice should have to provide data or be scrutinised in a way that goes beyond the core DES.'

Dr Paul Roblin, chief executive of Berks, Bucks and Oxon LMCs, said: 'If practices have done all they should to advertise the availability of extended hours and it's all due to low patient demand, I don't think any clawbacks should occur.'

@garethiacobucci

CPD in this issue: 4 hours
Earn CPD for our Key questions, What's new in and feature on occupational medicine

The week in general practice

INSIDE

Dr Louise Irvine

ONLINE
pulsetoday.co.uk/news

A GMC report has urged greater use of pharmacists, after a study found errors in one prescription in 20 issued by GPs
▶ pulsetoday.co.uk/clinicalnews

GPs working at the London Olympics have been forced to attend training on prescribing paracetamol
▶ pulsetoday.co.uk/practicenews

Resource of the week
Is your practice one of those due more than £10,000 for the Department of Health fees windfall? Find out here
▶ pulsetoday.co.uk/windfall

PULSENEWS

CCGs lobby for tougher scrutiny of GPs

Leaders push for stronger role in performance management as they gain responsibility for access

EXCLUSIVE
By Gareth Iacobucci

CCG leaders have been lobbying the NHS demanding a toughened-up system for managing the performance of practices, as they were handed responsibility for monitoring GP access.

One GP leader of a CCG angered LMCs across London after calling for a 'less light-touch' approach on a practice-rating dashboard being introduced across the capital.

The move came as CCG leaders in Manchester began employing mystery shoppers to scrutinise GP access at their practices.

Pulse has learned that NHS London has already added new indicators to its GP Outcome Standards - originally developed in conjunction with Londonwide LMCs - tightening scrutiny on practices and strengthening the role of CCGs.

Dr Michelle Drage, chief executive of Londonwide LMCs, accused CCGs of 'undermining agreements made by their parent organisations' over moves to toughen the framework.

> 'The way [the framework] is unfolding is far beyond the original idea'
> **Dr Chaand Nagpaul**

But the National Association of Primary Care fuelled the row, with chair Dr Charles Alessi describing moves to tighten the framework as 'very positive'.

The GP Outcome Standards were initially launched last year to hold 6,000 GPs across London and their CCGs to account on 22 performance indicators.

But last week, NHS London revealed it was adding six new indicators following discussions with CCGs, including greater scrutiny at practices of care for alcohol misuse, mental illness and the dying, and a new indicator for the effectiveness of CCGs at monitoring GP access.

A board paper from NHS Central London revealed Islington CCG had asked NHS London to make the process 'less light touch'.

The paper said CCG member Dr Karen Sennett warned the new tool 'doesn't encourage higher-rated practices to excel', and that Anne Whateley, deputy director of primary care, contracts and performance, 'agreed to feed back to NHS London the opinion of one CCG leader that it would be beneficial to have a less light-touch approach'.

NHS North Central London described this as an 'individual opinion'.

But Dr Charles Alessi, NAPC chair and board member of Kingston CCG, said: 'The view of the doctors from north London is welcome. If [the framework] remains as it is, perhaps it doesn't demonstrate quality as much as it could do. It's very

Magnesium tests urged with PPIs

The UK drug regulator has called for GPs to check the magnesium levels of all patients on proton pump inhibitors, in advice GPs have warned represents a 'massive undertaking' for primary care.

The MHRA said magnesium levels should be tested on initiation and 'periodically' thereafter, following reports to regulatory authorities in Europe that PPIs could cause hypomagnesaemia, with most cases occurring a year after treatment.

The MHRA said the symptoms of hypomagnesaemia could be easily overlooked and urged GPs to ensure they tested patients on prolonged treatment and anyone who might be at greater risk.

It also urged GPs to 'take account' of PPIs that were obtained over the counter.

The MHRA's *Drug Safety Bulletin* for April said: 'Severe hypomagnesaemia has been reported infrequently in patients treated with PPIs, although the exact incidence is unknown.

'For patients expected to be on prolonged treatment, and especially for those who take PPIs with digoxin or drugs that may cause hypomagnesaemia such as diuretics, healthcare professionals should consider measuring magnesium levels before starting PPI treatment and repeat measurements periodically during treatment.'

But Dr John O'Malley, a hospital practitioner in gastroenterology in the Wirral, former GP and secretary of the Primary Care Gastroenterology Society, said: 'If you are asking for a couple of hundred people to have their magnesium levels done once a year, it is crazy.'

BIG Question Should CCGs have a role in performance-managing practices? ▶ pulsetoday.co.uk/poll

DH to review student places

By Gareth Iacobucci

The Government is to carry out its largest review of the number of medical school places in England for six years, to assess whether it needs to increase the number of doctors being trained.

The review, launched jointly by the Department of Health and the Higher Education Funding Council for England (HEFCE), has been commissioned to ensure an 'adequate and affordable supply of good-quality trained doctors'.

It comes after a recent report from the Centre for Workforce Intelligence (CfWI) recommended the number of entry-level GP training posts should increase by 450 over the next four years, to around 3,250.

The DH's review, which is also being carried out by the CfWI, will focus purely on medical school numbers. But Sir Graeme Catto, former president of the GMC and co-chair of the review with NHS medical director Sir Bruce Keogh, told Pulse the findings would be considered in the context of the recommendation for an increase in GPs.

It will lead to a review of where medical students should be placed
Sir Graeme Catto

The review, described by the DH as a 'system-wide analysis of long-term supply and demand', will assess changing roles in the health workforce, and the evolving nature of care, including the greater emphasis on shifting services into the community.

The report, expected in autumn 2012, will make recommendations in time to determine the intake to medical and dental schools in England in 2013/14 and beyond.

Health minister Anne Milton said in the Commons: 'HEFCE and the DH have agreed this is an opportune time for a further review of the number of places.'

Sir Graeme said the review would have to consider a 'hugely complex' set of factors, including a higher proportion of women in the workforce, the EU working time directive, case mix and funding.

'It will lead into a review of where medical students ought to be placed,' he said. 'Independent of the group I'm co-chairing, there will be a move to try and improve the educational background for all doctors.'

Dr Clare Gerada, RCGP chair, said: 'We are underproducing GPs, but overproducing doctors.'
@garethiacobucci

Dr Charles Alessi: lobbying from CCGs 'very positive'

Where CCGs are cracking down on practices

Referrals
Clampdown on high-referring practices

Access
Tight scrutiny of patient satisfaction and opening hours

Prescribing
Close monitoring of practice spend on prescribing

positive that people are looking to refine it.'

Dr Drage said: 'What really worries me are comments that this isn't robust enough. These have been developed collaboratively - it's not about heavy-handed management. It's not CCGs' job to performance-manage the GMS contract. Who the hell do they think they are?'

Dr Chaand Nagpaul, a GPC negotiator and vice chair of Harrow LMC, said: 'The way [the framework] is unfolding is far beyond the original idea. It is taking on a life of its own.'

Meanwhile, North Manchester CCG has begun mystery shopping its GPs to measure same-day access.
@garethiacobucci

Health tourists owe UK £40m

Hospitals are owed as much as £40m in outstanding fees for treatment of foreign nationals, a Pulse investigation reveals.

The findings are set to reignite the debate over health tourism, and follow cases where GPs have been under pressure to register foreign nationals not entitled to secondary care.

Responses from 35 acute trusts under the Freedom of Information Act showed they were owed an average of £230k from foreign nationals who were not entitled to free NHS care.

St George's Healthcare Trust had the largest outstanding debts, totalling £2m from £3.55m invoiced to foreign nationals for health treatment from April 2009. Barnet and Chase Farm was next, with £488k outstanding from invoices worth £934k.

The most inefficient trust in collecting money was Royal Wolverhampton, which collected only 24% of the £419k owed, followed by Newcastle-upon-Tyne, which collected 36%.

Extrapolating the findings across all 168 trusts in England estimates total debt at £40m.

A spokesperson for St George's said: 'A high percentage of our patients require life-saving trauma, neuroscience, cardiovascular or paediatric care. We're working hard to improve the way we record overseas patients and the debt recovery rate.'

Dr Richard Vautrey, a GP in Leeds and deputy chair of the GPC, said it was important that hospital trusts put in place arrangements to ensure people could not exploit the system.

But he added: 'We need to be careful we are not putting barriers in place that prevent people getting access to healthcare.'

Call for radical reshape of QOF

Advisers to NICE find GPs overloaded with work on indicators that have 'relatively low health benefit'

By Nigel Praities

Advisers to NICE are calling for a radical reshaping of the QOF after conducting a review finding current indicators are 'not aligned' with health benefits.

Researchers warned the QOF was burdening GPs with workload on indicators that had a 'relatively low benefit to health', and risked 'skewing' the priorities of primary care.

The researchers included Dr Nicholas Steel, a member of NICE's QOF indicator advisory committee, and Professor Amanda Howe, honorary secretary of the RCGP. Their study, published online by *BMC Health Services Research*, found 28 indicators – representing about 40% of total payments – showed evidence of lives saved or quality-adjusted life years (QALYs) gained. Indicators such as those for flu vaccination in patients with diabetes and cardiovascular disease had a relatively high health gain, with a maximum of more than four lives saved per year in the average practice.

But other indicators had a relatively low health gain, with an indicator for prescribing ACE inhibitors or angiotensin receptor blockers in patients with diabetes and proteinuria saving a maximum of 0.2 lives over a year.

The study recommended removing badly performing indicators and paying GPs in proportion with health benefit, saying indicators such as those for use of ß-blockers in heart failure should get more money, and those for smoking cessation less.

Dr Ismat Nasiruddin: much of the QOF is a 'tick-box exercise'

It found 'no obvious relationship' between the size of the financial incentive for indicators and their health gain, and 'could not reject the null hypothesis of no relationship between incentive pay and health gain for all areas in both the 2004 and 2006 GMS contract'.

Study leader Dr Robert Fleetcroft, clinical lecturer in general practice at the University of East Anglia and a former adviser to NICE on its methods review, said: 'Our findings suggest incentives are not aligned with maximising health outcomes, which is an explicit aim of the Department of Health.' He said decisions on indicators should be made by taking into account 'the achievable health gain'.

NICE said the study looked at indicators introduced before it took over the framework, and stressed that QALYs were not the only measure of outcomes.

But Dr Ismat Nasiruddin, a GP in Balham, south London, said: 'Ridiculous arbitrary indicators are set which have no bearing on good practice.'

@nigelpraities

How the QOF measures up

High health gain
(maximum lives saved >3)
- DM18. Flu immunisation in patients with diabetes
- CHD12. Flu immunisation in patients with CHD
- BP5. Patients with BP of 150/90mmHg or less

Low health gain
(maximum lives saved <1)
- DM15. ACE inhibitor treatment in diabetes with proteinuria/microalbuminuria
- CHD6. CHD patients with BP of 150/90mmHg or less
- DM12. Diabetes patients with BP of 145/85mmHg or less

MORE ONLINE
See full details of how the indicators performed
pulsetoday.co.uk/qof

Reforms spark vaccination fears

The Government's expert advisers on vaccination and immunisation have written to the chief medical officer to highlight a series of potential risks to patient care posed by the NHS reforms.

The Joint Committee on Vaccination and Immunisation wrote to Dame Sally Davies warning about the effect of a period of transition on the national immunisation programme.

The Department of Health would not release the letter or Dame Sally's reply.

But minutes from the committee's February meeting reveal numerous concerns over the impact of the reforms, which will see immunisation programmes commissioned by the NHS Commissioning Board to a specification developed by Public Health England, informed by JCVI advice.

The minutes state: 'Under proposed arrangements directors of public health appear to lack robust levers to influence public health measures. While they may advise the NHS Commissioning Board, it was unclear if the board would know when it needed advice. There may soon be a shortage of qualified directors of public health. It was also unclear how schools-based programmes would be resourced and supported.'

Revalidation unlikely to get frank GP feedback

GPs are unlikely to give full and frank feedback on colleagues if their comments are included in assessments for revalidation, according to a GMC-funded study that raises serious concerns about the use of multi-source feedback to assess the performance of doctors.

The survey – published in this month's *British Journal of General Practice* – reveals some appraisers are already advising GPs to omit certain information from their appraisals ahead of the scheduled start of revalidation in seven months' time. Researchers interviewed 24 GPs and 24 appraisers, and found support for using colleague feedback to guide development in appraisals, but said most felt extending this to revalidation would compromise the value of appraisal.

Professor John Campbell, professor of general practice at the Peninsula College of Medicine and Dentistry in Exeter, said: 'Some doctors and appraisers may become more guarded regarding what is openly discussed and formally recorded in appraisal.' The study quoted one appraiser who was already advising GPs to censor their appraisal feedback.

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

NASONEX 50 micrograms/actuation Nasal Spray, Suspension (Phenylethyl alcohol-free formulation)

PRESCRIBING INFORMATION

Refer to Summary of Product Characteristics (SPC) before prescribing

Please refer to the full SPC text before prescribing this product. Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard. Adverse events with this product should also be reported to MSD Drug Safety Department on +44 (0)1767 353773

Presentations: Nasal spray suspension containing mometasone furoate (as monohydrate) 50 micrograms/actuation, a synthetic topical corticosteroid. **Uses:** *Adults and children aged 18 and over:* Treatment of nasal polyps. *Adults and children over the age of 12 years:* For the treatment of the symptoms of seasonal allergic rhinitis or perennial rhinitis. *Children 6 to 11 years of age:* For the treatment of the symptoms of seasonal allergic rhinitis or perennial allergic rhinitis. In patients who have a history of moderate to severe symptoms of seasonal allergic rhinitis, prophylactic treatment with Nasonex may be initiated up to four weeks prior to the anticipated start of the pollen season. **Dosage:** Nasal Polyposis: *Adults and children aged 18 and over:* The usual recommended starting dose for polyposis is two actuations (50 micrograms/actuation) in each nostril once daily (total daily dose of 200 micrograms). If after 5 to 6 weeks symptoms are inadequately controlled, the dose may be increased to a daily dose of two sprays in each nostril twice daily (total daily dose of 400 micrograms). The dose should be reduced following control of symptoms. If no improvement in symptoms is seen after 5 to 6 weeks of twice daily administration, alternative therapies should be considered. Efficacy and safety studies of Nasonex Nasal Spray for the treatment of nasal polyposis were four months in duration. Seasonal or Perennial Allergic Rhinitis: *Adults and children over the age of 12 years:* Two sprays (50 micrograms/spray) in each nostril once daily (total dose 200 micrograms). Once symptoms are controlled, dose reduction to one spray in each nostril (total dose 100 micrograms) may be effective for maintenance. If symptoms are inadequately controlled, the dose may be increased to a maximum daily dose of four sprays in each nostril (total dose 400 micrograms). Dose reduction is recommended following control of symptoms. *Children 6 to 11 years of age:* One spray (50 micrograms/spray) in each nostril once daily (total dose 100 micrograms). Clinically significant onset of action occurs in some patients within 12 hours after the first dose. Full benefit of treatment may not be achieved in the first 48 hours. Regular use is recommended to achieve full therapeutic benefit. **Contraindications:** Hypersensitivity to any of the ingredients. Do not use in the presence of untreated localized infection involving the nasal mucosa. Patients who have experienced recent nasal surgery or trauma should not use a nasal corticosteroid until healing has occurred. **Precautions and Warnings:** Use with caution, if at all, in patients with active or quiescent tuberculous infections of the respiratory tract, or in untreated fungal, bacterial, systemic viral infections or ocular herpes simplex. There was no evidence of atrophy of the nasal mucosa following 12 months of treatment. Patients using Nasonex over several months or longer should be examined periodically for changes in the nasal mucosa. If localised fungal infection of the nose or pharynx develops, discontinuance of Nasonex therapy or appropriate treatment may be required. Persistence of nasopharyngeal irritation may be an indication for discontinuing Nasonex. The concomitant use of additional therapy may provide additional relief particularly of ocular symptoms. There is no evidence of HPA axis suppression following prolonged treatment with Nasonex. Patients who are transferred from long-term administration of systemically active corticosteroids to Nasonex require careful attention. The safety and efficacy of Nasonex has not been studied for use in the treatment of unilateral polyps, polyps associated with cystic fibrosis, or polyps that completely obstruct the nasal cavities. Unilateral polyps that are unusual or irregular in appearance, especially if ulcerating or bleeding, should be further evaluated. Patients who are potentially immunosuppressed should be warned of the risk of exposure to certain infections. Very rarely, nasal septum perforation or increased intraocular pressure have been reported following the use of intranasal corticosteroids. Systemic effects of nasal corticosteroids may occur, particularly at high doses prescribed for long periods. These may include Cushing's syndrome, Cushingoid features, adrenal suppression, growth retardation in children and adolescents, cataract, glaucoma and more rarely, a range of psychological or behavioural effects including psychomotor hyperactivity, sleep disorders, anxiety, depression or aggression (particularly in children). Nasonex should only be used in pregnant women, nursing mothers or women of child-bearing age if the potential benefit justifies the potential risk to the mother, foetus or infant. It is recommended that the height of children receiving prolonged treatment with nasal corticosteroids is regularly monitored. If growth is slowed, therapy should be reviewed with the aim of reducing the dose of nasal corticosteroid, if possible, to the lowest dose at which effective control of symptoms is maintained. In addition, consideration should be given to referring patient to a paediatric specialist. Safety and efficacy of Nasonex Nasal Spray for the treatment of nasal polyposis in children and adolescents under 18 years of age have not been studied. Treatment with higher than recommended doses may result in clinically significant adrenal suppression. If there is evidence for higher than recommended doses being used, then additional systemic corticosteroid cover should be considered during periods of stress or elective surgery. In a placebo-controlled clinical trial in which paediatric patients (n=48/group) were administered Nasonex 100 micrograms daily for one year, no reduction in growth velocity was observed. **Interactions:** A clinical interaction study was conducted with ketotadine. No interactions were observed. **Side Effects:** Adverse effects commonly reported in clinical trials in adult and adolescent patients include headache, epistaxis, pharyngitis, nasal burning, nasal irritation and nasal ulceration. Other less common and rarely reported side effects are listed in the SPC. **Package Quantities:** 18g per bottle, supplied with a metered-dose manual spray pump actuator which delivers 50 micrograms per actuation. **NHS Price:** £7.68 **Legal Category:** Prescription Only Medicine. **Marketing Authorisation Number:** PL 00025/0587 **Marketing Authorisation Holder:** Merck Sharp & Dohme Limited, Hertford Road, Hoddesdon, Hertfordshire, EN11 9BU, UK. **Date of Revision of Text:** January 2012

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Reference: 1. IMS Health, MIDAS RDTA, November 2010 - October 2011

02-14 NSN-1027562-0002

Date of preparation: February 2012

Risk higher than with other statins and raised 12-fold for 80mg dose

CVD

Alert on simvastatin rhabdomyolysis risk

By David Swan

GPs have called for an urgent review of 'outdated' NICE guidelines on hyperlipidaemia after an analysis showed a 12-fold increased risk of severe muscle damage with simvastatin 80mg.

Researchers showed patients taking simvastatin across its doses were 2.6 times more likely to suffer rhabdomyolysis than patients taking other statins, in the first indication of a potential raised incidence of rhabdomyolysis in the community with simvastatin.

The findings follow the results of the UK SEARCH trial in 2010, which found a rate of rhabdomyolysis of 0.2% in patients taking simvastatin 80mg, compared with 0% in the simvastatin 20mg group.

Following this study, the MHRA warned GPs to avoid prescribing the highest dose of simvastatin, using the 80mg dose only in patients with severe hypercholesterolaemia, or a high risk of complications where the benefits were expected to outweigh the risks.

But the 80mg dose continues to be recommended in NICE guidance for patients who are not controlled on lower doses, and latest prescribing figures from the NHS Information Centre reveal over 550,000 prescriptions of simvastatin 80mg were made in primary care in England last year.

The US researchers compared estimated statin prescribing rates from pharmacy data in the Group Health Co-operative in Washington state over four years.

They found 29 validated cases of rhabdomyolysis and 18 cases of myopathy, equating to an overall statin-related incidence

Incidence rate ratio with simvastatin

Simvastatin (all doses)	2.61
Simvastatin (80mg)	12.2

*compared with other statins. **compared with 20-39mg of simvastatin
JAMA 2012, online 18 April

Simvastatin 80mg increases the risk of rhabdomyolysis by 12-fold, a new study finds

HYPOTHYROIDISM

Treating hypothyroidism cuts CVD risk in under-70s

Treating subclinical hypothyroidism dramatically reduces the risk of CVD in the under-70s, but may increase the risk of events in older patients, say UK researchers.

Their study looked at data from the GP records of 4,735 patients with serum thyroid-stimulating hormone levels of 5.01-10mIU/l over almost eight years. It evaluated the effect of synthetic thyroid hormone treatment, and found those aged 40-70 years treated with levothyroxine had a 37% decrease in the risk of ischaemic heart disease compared with those who were not.

This effect disappeared in patients aged over 70, with a 6% increase in risk, compared with those not taking levothyroxine.

Study leader Dr Salman Razvi, consultant endocrinologist at Queen Elizabeth Hospital in Gateshead, said: 'The benefits of treatment in older persons may be offset by an increased risk of adverse cardiovascular events.'

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

UTIs

Some antibiotics better than others for UTIs

There are 'clear efficacy differences' between antibiotics for uncomplicated urinary tract infections, with ciprofloxacin and gatifloxacin the best options in most women, concludes a new analysis.

The meta-analysis of 12 randomised controlled trials looked at the treatment of UTI symptoms in 5,514 female patients aged 12 or over, using ciprofloxacin as the reference antibiotic, and found a wide range of outcomes with different antibiotics. Gatifloxacin was the most effective, with a 6% greater likelihood of short-term bacteriological cure than ciprofloxacin.

Amoxicillin-clavulanate was the least effective, with a 83% reduced likelihood of bacterial cure than ciprofloxacin.

Study leader Dr Bart Knottnerus, lecturer at the department of general practice at the University of Amsterdam, said: 'Our results show clear efficacy differences between different antibiotic treatments for UTI.'

***Family Practice* 2012, online 19 April**

MIGRAINE

Botox injections can help prevent migraines

Botox injections show 'small to modest' benefits in preventing migraine and headache, say US researchers.

This meta-analysis looked at 315 randomised controlled trials that evaluated the effect of botulinum toxin A injections on the reduction in frequency or severity of headaches.

Botox injections were associated with a reduction of 2.06 headaches per month for patients with chronic daily headaches and 2.30 per month for those with chronic migraine, compared with placebo.

They were not associated with a significant reduction in headache frequency when compared with topiramate and amitriptyline for prophylaxis against chronic migraine headaches.

Study leader Dr Jeffrey Jackson, professor of medicine at the Medical College of Wisconsin in Milwaukee, said botox injections had only a 'small to modest effect' compared with placebo.

***JAMA* 2012;307:1736-45.**

CPD TIP OF THE WEEK

Carbamazepine still first line for epilepsy and pregnancy

Carbamazepine remains the anti-epileptic drug of choice in pregnancy, a case-based learning module recommends.

Women taking this, or any other anti-epileptic, should be encouraged to breastfeed. While anti-epileptic drugs may be found in breast milk, they usually only occur in small amounts and are not harmful to the baby.

Mothers should monitor their children for drowsiness and feeding difficulties, and if they are present you should consider switching them to another formula to see if these resolve.

ONLINE CPD
Hot topics in epilepsy
pulse-learning.co.uk

rate of 10.1 people and 6.3 people per 100,000 person-years, respectively.

Simvastatin overall had an incidence of 13.5 per 100,000 person-years.

At a dose of 80mg, it was associated with an rhabdomyolysis incidence of 64.8 per 100,000 person-years, a 12.2-fold increase in risk compared with lower doses of 20-39mg.

Study leader Dr James Floyd, a lecturer in epidemiology at the University of Washington, said: 'Most of the risk of high-dose simvastatin is up front, within the first year.'

Dr Rubin Minhas, clinical director of the BMJ Clinical Evidence Centre and a GP in Hoo, Kent, said future NICE guidance should be changed in line with the evidence: 'The risk of muscle damage adds to the evidence for considering atorvastatin at higher doses.'

Dr Ahmet Fuat, a cardiology GPSI in Darlington, said: 'This study highlights the folly of the "fire and forget" approach to monitoring bloods in statin takers suggested by outdated NICE guidelines.'

***JAMA* 2012, online 18 April**

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Strike by BMA staff threatens GP ballot

By Gareth Iacobucci

The BMA's plans to ballot its members on industrial action over the Government's changes to doctors' pensions could be jeopardised by strikes by its own staff, Pulse can reveal.

The association is set to ballot doctors from 14 to 29 May over potential action, with doctors due to vote on whether to provide only urgent and emergency care for a 24-hour period.

But Pulse has learned that BMA staff are to be balloted on the possibility of strike or 'work to rule' action over the management's pay offer of 1.5%.

The GMB union, which represents more than half of the association's 600 staff, is hoping to time the possible action to clash with the association's own ballot.

Anna Meyer, GMB regional organiser, said: 'We will look to go down the route of coinciding with the BMA ballot.'

Asked whether this would affect the BMA's ballot, she said: 'Clearly there would be an issue. The BMA staff would be carrying out the balloting process for the doctors. Our consultative ballot has said it is industrial action including strike action or short of strike action. This would also mean working to rule, which would affect the ballot.'

The BMA ballot could be disrupted by a strike from its own staff

The GMB requested a 5% pay rise. The BMA originally offered 1%, later increasing this to 1.5% as well as a 0.5% 'performance pot'.

The GMB added: 'The BMA rightly expects the Government to negotiate in good faith, yet it seems it doesn't wish to practise what it preaches and is treating its own staff with contempt.'

Tony Bourne, BMA chief executive, said staff had been offered a 'fair' deal given the 'challenging economic environment': 'The BMA provides secure employment, competitive salaries and a generous pension. To continue to do that and to serve our members effectively, we have to manage our costs sensibly.'

But Dr Louise Irvine, a GP in Lewisham, south London, who was elected to BMA Council last week, said: 'All working people should have a right to pay rises that at least keep up with inflation.'

@garethiacobucci

CONFERENCE ROUND-UP

Stroke prevention

Primary prevention measures for stroke should be targeted at ethnic minorities in the UK, say researchers. While admissions for Caucasians decreased, statistics from the Hospital Activity Analysis show an increase in admissions for stroke in Afro-Caribbeans during the period 1997-2006 – from 1.88 to 3.11 per 1,000 admissions.

World Congress of Cardiology 2012, abstract number P678

Antiplatelet bleeds

Patients over 65 treated for acute coronary syndrome with dual antiplatelet therapy are more likely to suffer from gastrointestinal bleeding as a complication than those younger than 65.

A study examined patient records of 180 admissions and found 7.2% of patients over 65 were re-admitted with gastrointestinal bleeding, compared with 3.6% of those under 65.

World Congress of Cardiology 2012, abstract number P543

Full-dose polypill

A full-strength polypill gives greater drops in blood pressure and cholesterol than a previously studied half-dose version. The TIPS 2 trial showed the pill reduced systolic blood pressure by an additional 2.82mmHg.

World Congress of Cardiology 2012, abstract number P282

Diabetes advice toughened

GPs are being urged to ramp up diabetes treatment within just three months if they do not reach their glycaemic goals on metformin alone, under a radical update of guidelines issued by European and American diabetes societies.

The new approach advises GPs to step up treatment by choosing between a range of diabetes therapies currently reserved for third or even fourth line, such as gliptins, exenatide or basal insulin.

It urges a move to three-drug therapy if patients are not achieving their goals within six months of initiating treatment, and to multiple daily doses of insulin within nine months if goals are still not achieved.

The position statement – co-authored by Department of Health diabetes tsar Professor Rowan Hillson – said guidelines should be 'less prescriptive' as there was very little evidence to distinguish between options for diabetes, after metformin.

Current NICE guidelines for diabetes recommend sulphonylureas are used second line, with new oral therapies reserved for when there is a particular risk of hypoglycaemia or the patient does not tolerate, or has a contraindication to, sulphonylureas. The statement – published last month – said the choice should be based on factors such as lifestyle, the need to reduce cardiovascular risk and preventing weight gain.

They do look very different from the previous guidelines

Dr Roger Gadsby

Professor Philip Home, professor of diabetes medicine at Newcastle University and an author of NICE guidelines on diabetes, said the statement would be 'widely read' but was sceptical its recommendations would be included in NICE guidelines.

Dr Roger Gadsby, primary care lead for NHS Diabetes and a GP in Nuneaton, Warwickshire, said the approach was 'very different' and stressed the patient as an individual.

GPs told share of £10m cash windfall

Hundreds of GP practices across England will be paid more than £10,000 each and thousands more will receive a cash windfall under an agreement to resolve underpayments in dispensing and personally administered fees.

The £10m one-off payment to GP practices was agreed by the GPC and Department of Health to resolve underspends in 2010/11 and 2011/12, and will be paid according to the proportion of dispensing and personally administered fees earned by each practice in 2010/11.

The one-off payment was first announced last month, but the DH last week published a detailed breakdown of exactly how much each practice would receive.

One practice in Cornwall will receive over £30,000 in compensation, and more than 260 practices will receive in excess of £10,000 each, while a further 832 practices will receive between £1,000 and £10,000.

Personally administered fees include those charged for immunisations, and fitting long-term contraceptive devices and sutures, and the vast majority of practices are owed at least a small rebate.

Any practice that is due a payment of less than £2.50 will not be paid, but this only applies to 49 practices nationwide.

A letter from Richard Armstrong, head of primary care at the DH, said PCTs would be allocated the money and that payments should be made 'as soon as possible' this financial year.

MORE ONLINE

Find out how much your practice is due

pulsetoday.co.uk/windfall

Can you identify what this florid rash is?
▶ page 19

Private firms to bid for LTC care

Radical Government 'year of care' scheme would make providers responsible for whole care package

By Jaimie Kaffash

Private companies will be able to bid for contracts to run every aspect of the care of patients with long-term conditions at a series of pilot sites, under a radical new Government scheme.

Ministers are to put out to tender contracts for six 'year of care' schemes intended to incentivise major providers to keep people out of hospital by making them responsible for patients' entire package of care, under a single budget tariff.

A supporting document for applications from aspiring providers of the schemes gives a list of four potential funding models, including one under which a principal contract holder would then subcontract aspects of care to other providers.

This contractual model could 'attract new providers that are able to offer cost-effective, high-quality care', and allow providers to focus on prevention and primary care ahead of expensive emergency treatment, the Department of Health said.

But it admitted there were potential risks to the model too, including providers making short-term decisions because of their one-year contracts, which would dilute the emphasis on prevention.

Private providers of care packages will not bear the financial risk if there is an overspend, and any savings on the planned budget will be ploughed back into the local NHS rather than being kept as a profit share by companies.

Dr Louise Irvine: 'concerned' about the initiative

Dr Oliver Bernath, managing director of Integrated Health Partners, said his company would be bidding to run care at one of the pilot sites, adding that the 'year of care' model was one IHP had been 'pushing for a number of years'.

He said: 'Current financial arrangements are not conducive to working on the efficiency of a total year of care. There are no payment mechanisms that encourage providers to avoid complications. If the holder of this year of care tariff also has to pay for emergency treatment, they will be incentivised to make sure the patient stays well.'

But Dr Louise Irvine, a GP in Lewisham, south-east London, said she was 'concerned' about the initiative: 'There is a lot of cause for concern when we see private firms running services for vulnerable people. We see how they can cut costs and standards.'

The deadline for applications is 25 May, and the DH said it would give each pilot site financial support of £95,000 between April 2012 and March 2013.

feedback@pulsetoday.co.uk

Benefits and risks of pilots

Benefits

- Subcontracting could yield a better price
- Might attract new providers
- Principal provider has greater autonomy

Risks

- Local politicians may challenge implementation
- One-year time frame could discourage the subcontracting of 'prevention' services
- No direct relationship between commissioners and 'significant' parts of the service

Source: Department of Health

MORE ONLINE
Read the document
pulsetoday.co.uk/news-analysis

Warning over CCG outsourcing abroad

NHS managers have raised concerns that financial services to be used by every CCG in England could be outsourced to India.

The warning emerged amid the fallout from the NHS Commissioning Board's controversial decision to force CCGs to use NHS Shared Business Services (NHS SBS) for their finance management.

NHS Greater Manchester's chair Professor Eileen Fairhurst has written to the Department of Health expressing her concern about potential outsourcing overseas, including its effects on local employment.

And a board meeting heard that Dr Mike Burrows, chief executive of NHS Greater Manchester, had 'made representations' over the potential for outsourcing abroad - given NHS SBS has a facility in India where it is understood parts of the system will be managed.

The NHS Commissioning Board made using NHS SBS – a joint venture between the Department of Health and private firm Steria – a condition of authorisation for CCGs earlier this month, after signing a £15.8m deal for its financial services.

The GPC voiced 'serious concerns' about the decision after a series of GP payment delays and administrative errors.

A spokesperson from NHS Greater Manchester said: 'Board members raised concerns about any potential outsourcing of functions overseas. It was agreed the chair would write to the DH.'

IN BRIEF

BMA Council elections

A number of prominent critics of the health bill have been elected to BMA Council.

Full story ▶ pulsetoday.co.uk/politicalnews

Flu vaccine meeting

DH advisers are to meet to discuss a possible extension to the flu vaccination programme.

Full story ▶ pulsetoday.co.uk/clinicalnews

Reforms data fears

NHS reforms could have 'severe implications' for monitoring health needs, a study claims.

Full story ▶ pulsetoday.co.uk/politicalnews

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Four CCGs back down after challenge from local GPs

INTER-PRACTICE AGREEMENTS

LMC victory on inter-practice agreements

By Alisdair Stirling

An LMC has claimed a major victory in the fight against imposition of draconian inter-practice agreements on GP practices, after winning a series of key amendments to proposed local contracts.

GPs across four CCGs on Humberside were asked to sign agreements that would have allowed the expulsion of practices without appeal and could have forced them to identify sick or failing GPs to all CCG members.

The row follows a warning by lawyers last month that a series of CCGs are now requiring practice staff to sign inter-practice agreements committing them to follow CCG policy.

Dr Russell Walshaw, chief executive of East Yorkshire and Lincolnshire LMC, told Pulse agreements proposed by four CCGs contained the phrase 'It is expected that practices will...' followed by a list of bullet-points on performance management.

Dr Walshaw said: 'The inter-practice agreements were addendums to the constitution. As it was, they could expel practices and there was no question they could defend themselves.

'Where such practices had sick or failing doctors, the way they were to be handled would mean their identities would have been exposed to the whole council of members. They were totally unacceptable.

Dr Nigel Watson: some CCG leaders have 'gone native'

'However after representations, they have made amendments to the agreements. Practices need to know they can have these agreements looked at - this sort of thing will be happening all over the country.'

Dr Nigel Watson, chair of the GPC's commissioning and service development subcommittee, said: 'Some CCGs seem to think they can just write what they want. CCGs are not the police and they haven't got the sanctions. There are lots of really good CCGs around but some people involved in them seem to go native.'

A spokesperson for North Lincolnshire CCG said: 'The Humber cluster developed an interim constitution to support the aims of the four CCGs. The four CCG councils of members each made significant changes to their own draft document producing separate versions.'

East Riding CCG, Hull CCG and North Lincolnshire CCG said agreements had now been signed after amendments, while North East Lincolnshire CCG said it was in the process of developing a separate constitution.

feedback@pulsetoday.co.uk

The GPC view

- **No requirement for CCGs to use inter-practice agreements**
- **Would be conflict of interest for a CCG to take action against a practice**
- **No requirement for practices to engage on the CCG with work related to commissioning**

Source: Birmingham LMC

AUTHORISATION

All CCGs set for April 2013 lift-off

Health secretary Andrew Lansley has revealed he expects all CCGs to be authorised by next April, as the chair of the NHS Commissioning Board predicted there would be around 220 CCGs in place once the shake-up is complete.

He told the NHS Alliance and National Association of Primary Care Clinical Commissioning Coalition's conference for CCG leaders last week that it was time to move away from the 'big burst of politics' that surrounded the passing of the Government's controversial Health and Social Care Act.

CCG leaders at the event voiced a list of complaints to Mr Lansley and Professor Malcolm Grant, chair of the NHS Commissioning Board, over their perceived lack of control of commissioning support, any qualified provider, 111 and telehealth.

But Mr Lansley told them 'the autonomy you have is real', and vowed they would be granted freedom to decide whether to use competition when commissioning and where to acquire their commissioning support.

CCG REPRESENTATION

NHS Alliance and NAPC form CCG body

The NHS Alliance and National Association of Primary Care have formed a single membership organisation for CCGs in conjunction with the NHS Confederation that will represent GP commissioners' interests in the revamped NHS.

The formation of the new organisation - NHS Clinical Commissioners - was announced at the Alliance and NAPC's joint conference last week.

The leaders of the respective organisations said the move would ensure that CCGs had the 'firepower' to succeed in the new world. It comes after Pulse reported last October that the organisations were considering a full merger within two years.

Dr Charles Alessi, chair of the NAPC, said the new organisation represented a 'broad church' to champion commissioners: 'We weren't the best of friends for many, many years and now the relationship is quite cordial.

Dr Michael Dixon, chair of the NHS Alliance, said: 'The reason we're doing this is that you said you wanted a strong representative organisation.'

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* At NHS list price and licensed posology
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Made to pay for a failed policy

Richard Hoey
Editor

The imposition of extended hours was one of the bloodiest episodes in the recent history of general practice.

Ministers steamrollered GPs into accepting a DES funded only with recycled money from Choose and Book and access by threatening to otherwise slash 135 points from the QOF and deliberately delay payments to practices.

Negotiations had been so fraught that at one point the GPC raised the serious prospect of the profession quitting the NHS en masse.

The saga caused GP leaders lasting psychological damage, which has to some extent shaped their response to more recent crises, and continues to be a sore point for many GPs.

So the news that GP practices are now facing financial penalties over extended hours is likely to infuriate the profession.

We reveal this week that PCTs across the country are auditing 'utilisation rates' of practices' extended-hours surgeries, and in some cases planning to dock pay if too few patients come through the door.

It is in vogue to hold GPs to account for matters far outside their control

Some GP surgeries appear to have been left with little choice but to quit offering the service, sacrificing their slice of that recycled cash, because new PCT requirements for surgeries made them simply too onerous to run.

It is apparently in vogue to hold GPs to account for matters far outside of their sphere of control.

First practices were set QOF points that penalise them if too many patients turn up to A&E; now they face deductions in their pay if those same patients fail to turn up during extended hours.

The Government is convinced that there is a right and a wrong way for patients to access care, and if they get it wrong GPs get the blame.

Metropolitan elite

But it is particularly galling when GPs are held to account for low interest among patients in extended hours, because that was precisely the GPC's case against the scheme in the first place.

GPs have long criticised Government policy on access for being rigidly focused on the needs of the metropolitan and urban elite, without taking into account the very different needs of patients in small towns and rural areas across the UK.

Professionals in London, Birmingham and Manchester might well want extended surgeries, but was there ever a case that the good people of Buckingham or Wallingford wanted to see a GP at 7:30pm?

GPs raised just the same objections over the nationwide rollout of Darzi centres, arguing that they might fulfil a need in urban centres, but were always likely to be a waste of money in more rural areas.

As one by one Darzi centres close their doors, that argument looks won. But at least when unloved Darzi centres are forced to shut up shop, it is PCTs that pick up the tab.

When the punters shun extended hours, it is GPs who are being asked to pay the price.

That is more than just a cruel irony. It is grossly unfair, and must be resisted by LMCs. Otherwise, this most unpopular of policies will be allowed to further extend the pain.

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

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PULSE BriefingMedia recycle

Bring back co-ops to run OOH

Dr Krishna Korlipara started one of the first GP co-operatives for out-of-hours care, and argues they represent a far better model than failing out-of-hours companies

Pulse's recent front-page investigation highlighting low ratings by patients of care delivered by private out-of-hours providers in many parts of the country should come as no surprise.

Until 2004, nearly 27,000 GPs were members of not-for-profit GP co-operatives providing an excellent service to their patients. There was a network of more than 300 co-ops all over the country that provided care to nearly 30 million people.

It is worth recalling how GP co-ops evolved. Before 1977, most doctors had to be available to see their patients at any time of day or night, seven days a week. This was very stressful, so there were a few private firms providing an out-of-hours service in return for profits in some areas.

The standards of service were appalling, however, and most patients were seen by junior hospital doctors who had no previous experience in general practice. Not surprisingly, these patients had to be re-visited again by their own GP the following morning. It was an absolute shambles.

I wanted an alternative, and so turned to the idea of setting up a GP co-op. I called a meeting of local GPs in Bolton and shared my vision, explaining how the new service would relieve us of the need to be available 24 hours a day without being dependent on commercial providers driven by profit.

And so the first GP co-op in the UK was born in Bolton at midnight on 31 December 1976. On Call Ltd, the private provider, had to quit within a year as Bolton Medical Services became hugely successful.

Five years later, we set up the National Association of GP Co-operatives, which went on to become the biggest network of out-of-hours care providers in the NHS, eventually counting more than 300 co-ops as members.

But the 2004 GP contract changed everything. As GPs were relieved of the responsibility for out-of-hours care, many PCT managers invited private providers to step in rather than encouraging more co-ops to take over collective responsibility for out-of-hours care. These private providers cost the NHS a lot of money – and standards of care in some cases slipped to unacceptable levels.

There is no goodwill among GPs towards commercial organisations, and very few offer their services outside normal surgery hours. The way to improve out-of-hours care is to learn from the current debacle by inviting local GP communities to come up with a collaborative or co-operative model, which will be wholly owned and run by local GPs who know the area's population well.

Patients will be reassured to know that while their own GP may not be available, they will be seen by another local GP. Those who work out-of-hours will be paid handsomely as an incentive for others to offer their services, but the overall costs will still be less than in a commercial venture and the standards of care will be higher. In a co-op, we should never need to rely on foreign locums to provide cover out of hours – we now know it puts lives at risk.

Our patients deserve nothing less than personal care from local GPs, and the Government must act to restore co-ops and prevent any further calamities.

Dr Krishna Korlipara is a GP in Bolton and founder of the first GP co-op in the UK

An elder, but not a better

She may be pushing 100, but that's no excuse for being a malignant old bat, **Peverley** reckons

'I'm 98, you know!' I have literally not got the bloody door fully open yet. It's only about halfway ajar and already this malignant harpy is on my case.

'I know you're bloody 98,' I mutter to myself. I don't know why I keep it quiet. I could say it out loud because 1) she's deaf and 2) she wouldn't be sodding well listening even if she wasn't.

'You tell me at least four times on every visit, and last year you told me four times every visit that you were 97. I can trace a similar pattern back for 18 years now,' I add.

Why am I opening the door myself, anyway? When I have visitors to my house, I make it a point of principle to open the door to them, personally, with my own two hands. It seems only civil.

This old bat invariably sits in an armchair six feet away from her front door and commands us to make our own entrance. I wouldn't mind if she had some sort of disability that precludes her from getting up. But she doesn't.

'It's me legs.'

It's always her legs, so I don't recoil in any particular state of amazement. However, as usual, she soon loses focus on her legs.

'God, you're getting fat,' she advises me. 'Don't you ever stop eating?'

Occasionally I make stuff up or embellish things for the purposes of writing this column, but just at this moment I'm faithfully reporting literal events of three hours ago.

'Fat, am I?' I riposted. 'What the hell are you then?' I refrained from commenting that, aside from looking like a globe on legs, she also has a face out of one of the rougher Hieronymous Bosch paintings.

Expert as she is at avoiding linear conversations, she immediately moves on to my receptionist: 'I asked for a visit at 10 o'clock this morning! It's past two now! It wasn't like that in my day!'

I find myself wondering just how she thinks that she is not experiencing 'my day' right now.

Aside from someone arriving daily to wipe her arse (and this concept is not out of the question), I cannot conceive of why she thinks she could have more attention and support that she gets right now.

'Dr X used to look after me,' she informs me, again.

'I know. You told me. He's been dead for 40 years.'

'And Dr Y used to come and see me before you did!' she says.

'He's only been dead for 10 years. And I'm beginning to understand why.'

She has a face from a Hieronymous Bosch painting

We should respect our elders – I was going to write 'elders and betters' there, but I changed my mind – but maybe there should be a statute of limitations on this form of behaviour.

'I can't collect this prescription, I can't get out of the house.'

'Can one of your friends or family collect it for you?' I ask.

'I haven't got any friends or family,' she says.

'You amaze me,' I say.

Faintly I hear a cry of 'I'm 98 you know!' as I gently close the door behind me.

Dr Phil Peverley is a GP in Sunderland

More online

Copperfield returns next week, but if you can't wait until then you can now follow him on Twitter at @doccopperfield.

CKD stages no sort of progress

The kidney tsar thinks it's unethical not to give patients their exact diagnosis – but **Margaret** wonders what the benefits are in a label

This month's *British Journal of General Practice* contains a challenge. It's an editorial titled 'Telling the truth – why disclosure matters in chronic kidney disease' written by Dr Donal O'Donoghue, the renal 'tzar', and colleagues – none of whom, notably, are based in primary care. It begins: 'The dynamics of the doctor-patient relationship have evolved over recent decades from a model of benevolent paternalism to a framework centred around shared decision making for which patients' awareness of their diagnoses, and hence disclosure of diagnoses by healthcare professionals, are prerequisites.'

So far, so good. Of CKD diagnosis, they say that not telling patients is wrong: 'Such practice is divergent from a patient-centred approach to chronic disease management.' They conclude that 'we should not forget physicians have a duty, both morally and legally, to disclose truths that patients could reasonably be expected to be told in a sensitive way they would understand.'

This is a thoroughly ironic misplacement of ethics. It's absolutely necessary that patients should know what's in their notes. But it's also imperative patients are given the opportunity to decline testing when the results may give rise to unforeseen dilemmas and uncertainties.

Effectively, we have moved to CKD screening without adequate explanation or consent. We used to check renal function and get a urea and creatinine by return – now we have an eGFR and, if necessary, a stage of CKD from one to five. This is new, but have we done patients any favours?

Confusing advice

The new test has created a group of patients who have CKD 3 but who are already having their hypertension, cholesterol or other cardiovascular risk managed. They have been given a new diagnosis – they are told that their kidneys are not working perfectly. Is this useful?

This month, the US Preventive Services Task Force, a redoubtable organisation that demands evidence before action, published its systematic review on screening, monitoring and treatment of CKD, and concluded: 'The role of CKD screening or monitoring in improving clinical outcomes is uncertain. Evidence for treatment is strongest... in patients with albuminuria combined with diabetes or cardiovascular disease.' Which is what we've been doing anyway, whatever the grade of CKD.

It seems unfair that we concentrate on telling people the results of their CKD test without also informing them about the problems the test may create. I can't be the only GP who has noted the difficulties with holiday insurance this label has caused. Nor have we adequately studied the harms an additional diagnosis, which comes with limited opportunities to alter it, delivers to the patient. For some, being told they have something else wrong is upsetting and demoralising. I'm also troubled by the suggestion from O'Donoghue's editorial that patients with CKD will alter their lifestyles more effectively when given their diagnosis. It would be better if all people who had risk factors for CKD and cardiovascular disease could take up appropriate advice.

We are doing tests capable of a negative impact on patients without a the opportunity to reverse the results. Instead of fretting about patients having 'non-disclosure' of their diagnosis, it would be better to concentrate on the ethical and moral issues of testing without adequate informed consent.

Dr Margaret McCartney is a GP in Glasgow

We want to hear your views

Post your letters online at pulsetoday.co.uk/feedback. Email letters@pulsetoday.co.uk

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

Returner guidance is unfair to female GPs

LETTER OF THE WEEK

Will return to work guidelines disadvantage women doctors?

From Dr Maureen Baker
Lincoln
via pulsetoday.co.uk

As a long-standing member of RCGP Council, I am appalled at the new recommendations requiring returners to undergo assessment after short-term absences ('GPs should undergo "robust" assessment if away from work for more than three months, say royal colleges', pulsetoday.co.uk/news).

The RCGP should distance itself. There may be an issue with the length of time doctors can be absent from practice before their skills are affected, but the report itself says there is little evidence in this area.

I completed a thesis on medical workforce and ran the first Return to Practice course for doctors in the UK and I am not aware of any evidence that doctors returning from maternity leave, for instance, pose a danger to patients.

If implemented, these proposals will significantly disadvantage female GPs. Patient safety is of paramount importance, but safety is far more likely to be threatened by a shortage of doctors than by short absences. I will be calling on the RCGP to reject these ill-considered recommendations from the Academy of Royal Medical Colleges.

Our scheme's not 'flagging'

From Dr Will Haynes
Gloucester

I was disappointed to read your recent article portraying a misleading account of Gloucestershire's telehealth scheme ('GPs paid £70 a patient to boost flagging telehealth scheme', pulsetoday.co.uk/news).

Far from 'flagging', this is the most successful and largest GP programme in the UK, with 88% of GP practices – 74 out of 85 so far – actively referring patients. The rollout plan is designed to bring the number of patients in the county being supported by telehealth to 2,800.

GP training has been largely completed and the programme established within practices. With growing buy-in from GPs and increasing referral rates, we are on course to achieve real quality improvement and to have at least covered our costs by March 2013.

The standard LES payment of £70 for each patient referral was designed to free up initial clinical time to focus on appropriate referrals, and was supported by both clinicians and local commissioners.

Like other LESs, it supports the infrastructure for new clinical pathways and demonstrates good use of our existing mechanisms to improve patient care.

CQC must seek evidence, not anecdote

Name and address supplied

Thank you for requesting feedback on the plans for practices to be regulated by the Care Quality Commission ('GPs face inspection by CQC every two years', pulsetoday.co.uk/news).

I have a variety of concerns about the plans for practices to be regulated by the CQC, especially with the plan to interview patients and staff.

A report following the CQC's recent unannounced visit to a local hospital included quotes from both patients and staff.

It struck me how easy it must be to find disaffected examples of both and, when questions are leading, how easy it is to frame quotes as 'evidence'.

Several colleagues commented that the 'evidence' could be seen as little more than anecdote.

Dr Peter Holden's suggestion of mass non-compliance with the CQC is one that the profession should seriously consider.

How many calls to co-ops are 'urgent'?

From Andrew Gardner
Chief executive, Harmoni

Unlike some mutuals or GP co-operatives who refused to participate in this round of benchmarking, Harmoni welcomes the publication of comparative data ('Patients prefer co-ops to private OOH firms', pulsetoday.co.uk/news).

We continually strive to improve the quality of our services and have participated in all four rounds of the Primary Care Foundation benchmarking process.

We review the outcomes with our commissioners and agree with them any actions we need to take to raise standards further.

We are surprised that Pulse should focus on how ownership issues affect responsiveness to urgent calls without mentioning the variation in the number of calls identified as urgent.

The survey highlights a significant number of providers who have very low levels – some less than 10% and one as low as 0% – of 'urgent' case identification during the initial prioritisation of a call.

A normal service should be identifying between 15-25% of their calls as 'urgent', and not to do so would raise alarms in our clinical governance framework. Harmoni on average identifies 20% more 'urgent' calls than the average of other providers.

Harmoni does get asked to take over contracts from failing out-of-hours providers. Our national average performance is therefore dragged down until we raise the standards of these services.

Budgets under threat from pharma

From Dr Charlotte Ferriday
Plymouth
via pulsetoday.co.uk

I am horrified by your story revealing that GPs face a clampdown on their off-label prescribing after a pharma company challenge (pulsetoday.co.uk/news).

It shows how ridiculously powerful the drug companies are.

All trials should be published. The EU is also interfering too much and soon everything sensible, safe and cost-effective will be illegal in the NHS.

We need to be strong and fight this as a nation, and the GMC must stand up for the NHS's right to prescribe these tried and tested medications.

Otherwise every saving we try to make in primary and secondary care could be wiped out overnight.

For the record

In last week's issue, we listed NHS Kingston among a number of PCTs introducing schemes allowing access to the Pill without a GP prescription. In fact, it made initial moves to implement a scheme, but then decided against it.

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

Protect your over 50s patients against shingles

GPs able to prescribe and administer first shingles vaccine, Zostavax®▼ [shingles (herpes zoster) vaccine (live)], to patients in the United Kingdom by private prescription[1]

Did you know?

- 90% of adults raised in the UK are at risk of developing shingles as most will have contracted chickenpox in childhood[2]
- One in four people will develop shingles during their lifetime[3,4] due to reactivation of the chickenpox virus (varicella zoster virus), lying dormant since an earlier infection
- Shingles mainly affects people aged 50 years or older, as their immune system may weaken with age which could allow the virus to reactivate[5,6]
- Up to one in five people with shingles may develop severe and long-lasting pain, known as post-herpetic neuralgia (PHN)[4,7,8,9,10]
- The pain associated with PHN can be debilitating and lead to sleep disturbance, weight loss, chronic fatigue and depression accompanied by social isolation[9]
- Ophthalmic zoster develops in 10 to 20% of shingles cases which can lead to complications such as keratitis, iritis or in some cases, blindness in the involved eye[11,12]

The burden of shingles

Herpes zoster, more commonly known as shingles, is a viral disease characterised by a blistering rash. It is a mild disease for most people but some experience continuing pain and debilitating complications that can last for months. Even with timely anti-viral treatment, shingles and PHN can have a significant impact on patients' quality of life. A study showed that 42% of patients rated their worst shingles pain as 'horrible' or 'excruciating'.[13] Now for the first time in the UK, a vaccine for the prevention of shingles, called Zostavax®, is available on private prescription for adults aged 50 and over.[1]

What's the evidence?

Results from the Shingles Prevention Study involving more than 38,000 adults aged 60 and over showed that the shingles vaccine reduced shingles cases by 51%.[1,14] In those people who went on to develop shingles despite receiving the vaccine, being vaccinated reduced cases of 'shingles with severe pain' by 73%; reduced the incidence of PHN by 67%; and reduced pain and discomfort by 61%. Headache and injection site reactions are the most common side effects of shingles vaccination.[1,14]

Who may benefit from Zostavax®?

Adults over the age of 50 years who want to protect themselves from shingles are advised to talk to a healthcare professional about the risk of shingles, the treatments available, the benefits of vaccination and how to obtain a private prescription.[1]

How can patients obtain the shingles vaccine?

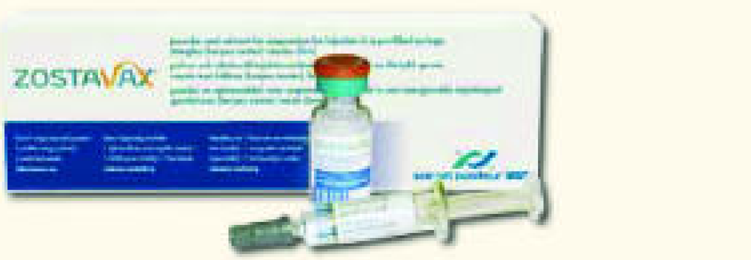
Any GP, including those who treat NHS-registered patients, can now prescribe shingles vaccine privately and administer it. GPs will not be able to prescribe this vaccine on an NHS prescription. GPs may not supply the vaccine nor charge NHS patients for either the private prescription or for administering the vaccine.

So how do patients pay for the vaccine?

Your patients can expect to pay the cost of the vaccine, plus an additional dispensing fee, to obtain the vaccine from a pharmacy. The one-dose shingles vaccine costs £99.96. Alternatively, patients may be directed to a private healthcare provider for shingles vaccination.

For more information, please contact Medical Information Department by telephone on 01628 587693, by e-mail at medinfo@spmsd.com, or visit www.shinglesaware.co.uk

To order supplies please contact Sanofi Pasteur MSD customer service on 0800 085 5511.



ZOSTAVAX▼
Shingles (herpes zoster) vaccine (live)

ABRIDGED PRESCRIBING INFORMATION

ZOSTAVAX® ▼ powder and solvent for suspension for injection [shingles (herpes zoster) vaccine (live)]

Refer to Summary of Product Characteristics for full product information.

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

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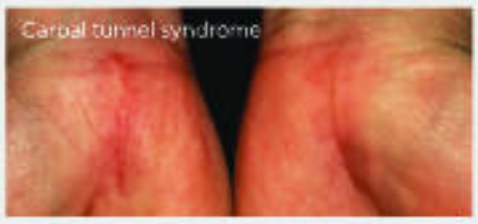

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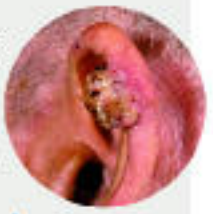

Squamous cell carcinoma on the left pinna A silver winner in the 2012 Institute of Medical Illustrators awards
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Resource of the week
A new tool to help patients with Parkinson's communicate their non-motor symptoms
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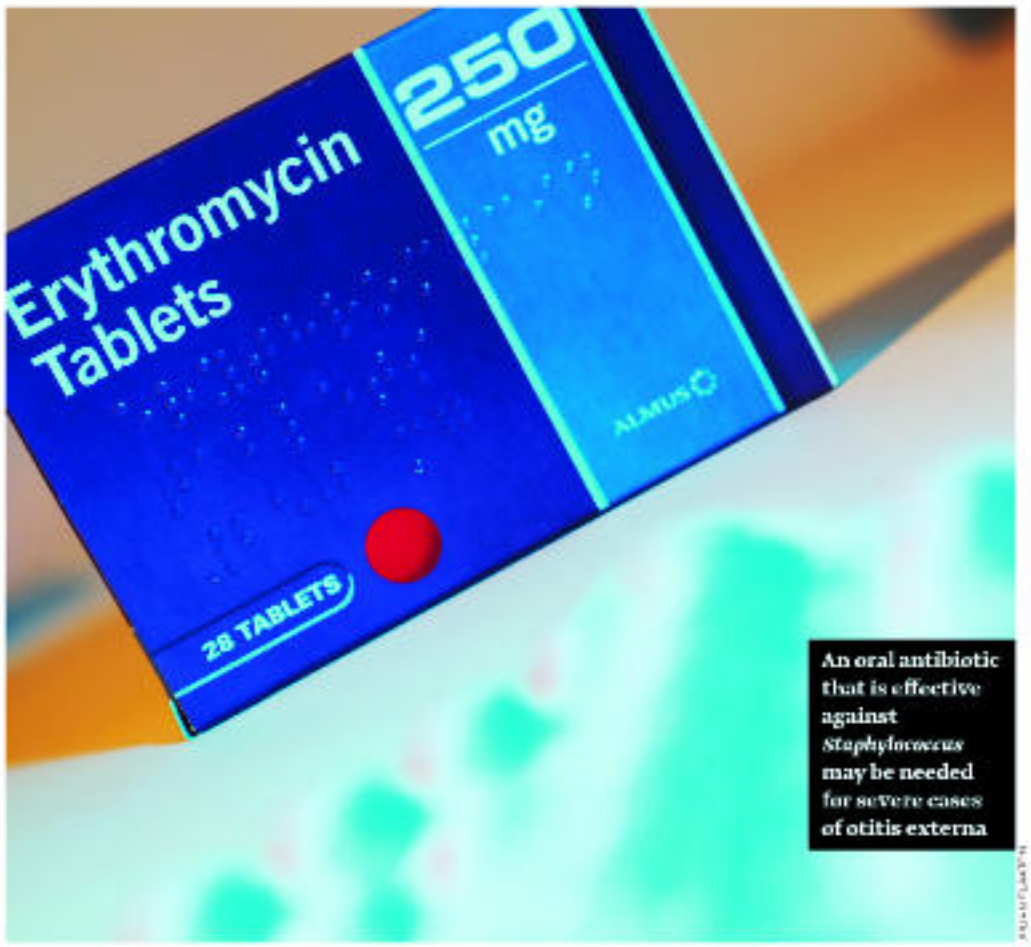
KEY QUESTIONS

Antibiotic use

GP and prescribing lead Dr Martin Duerden answers questions from GP Dr Pam Brown on appropriate antibiotic use for common primary care presentations



An oral antibiotic that is effective against *Staphylococcus* may be needed for severe cases of otitis externa

1 When should topical antibiotics be considered in preference to oral?

There is quite a controversy surrounding the use of topical versus oral antibiotics. Some argue that topical antibiotics have little place in managing infection – they can cause skin sensitisation and may have little benefit because of limited skin penetration, and they can lead to antibiotic resistance. Others argue that topical antibiotics can reduce the exposure to systemic antibiotics, are useful for localised skin infections and – if used carefully – antibiotic resistance is not an issue. It is probably best to look at this concern in the context of some common primary care scenarios.

Typical antibiotic preparations such as erythromycin and clindamycin certainly have a place in managing acne vulgaris, although the mechanism is probably mostly anti-inflammatory. However, the development of resistant proprionobacter – the micro-organism associated with acne – reduces their effectiveness in individuals over time. Other non-antibiotic antimicrobial preparations such as benzoyl peroxide are useful because resistance to these is not seen.

Limited and careful use of fusidic acid in localised impetigo is also generally accepted. But if the condition is severe or if there are diffuse or spreading lesions then a systemic anti-staphylococcal treatment with flucloxacillin – or erythromycin or clarithromycin if the patient has a penicillin allergy – is required.

The most controversial area for the use of topical antibiotics is probably in the case of infected eczema. Flare-ups of eczema are commonly associated with infection, usually due to *Staphylococcus*, and this is particularly likely where there are weeping or crusted lesions. Skin products containing combinations of steroids and antimicrobial agents are widely prescribed, but the role of these products is debatable – and patients often have atopy with susceptibility to skin sensitisation and allergy to the antimicrobial, so the British Association of Dermatologists advises not using them for more than a week.[1] Ideally – although impractical – these products wouldn't be used at all and instead we would use oral anti-staphloccocal antibiotics, such as flucloxacillin, alongside simple topical steroids.

2 What are the most common organisms in otitis externa? Are topical antibacterials appropriate, and are any topical treatments more effective than others?

Acute otitis externa is frequently caused by bacterial infections, most commonly *Pseudomonas aeruginosa* or *Staphylococcus aureus*. Many GPs recognise a flurry of cases in the summer when patients return from their holidays with ear infections caused by inadequately maintained swimming pools. In other patients the cause may be superficial fungal infection, which is usually due to *Candida albicans*, or occasionally *Aspergillus*.

Current guidance advises treatment with a topical ear preparation, usually for seven days. If the case is mild – with itching and soreness the predominant symptoms, and no significant pain, deafness or discharge – topical acetic acid 2% spray can be used, and is available over the counter.

In more severe cases – with pain, deafness or discharge – or if treatment with acetic acid has not been effective, a topical antibiotic, with or without a topical steroid, should be used.[2] There are several products available – in our area we advise flumetasone-clioquinol ear drops first line, as this has an antifungal agent. Commonly used alternatives contain gentamycin or neomycin. An ear swab can be useful in persistent infection, and if the swab shows fungal infection consider using clotrimazole 1% ear drops as an alternative.

For such a common condition there is surprisingly little evidence to show that one intervention is better than another.[3]

Remember that infection is also often confused or associated with contact dermatitis caused by local irritants or allergens, such as topical medications, hearing aids or earplugs. So if the patient's

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condition suddenly gets a lot worse when using topical antibiotics, you should suspect allergic contact dermatitis.

3 What oral antibiotic is most appropriate if the otitis externa fails to settle with topical treatment?

In very severe cases an oral antibiotic may be needed. Usually antibiotics are chosen which are effective against *Staphylococcus* – flucloxacillin, or erythromycin or clarithromycin – but sometimes other antibiotics are needed and an ear swab might be required to guide therapy.

Some cases where the ear is blocked may need ear cleaning and debriding. If you're not confident doing this yourself, referral may be needed. People with very swollen, blocked ears may also need referral, and in particularly severe cases parenteral antibiotics are required.

4 When should antibiotics be used in preference to topical wash-outs in patients with indwelling catheters and bacteriuria?

Unlike in pregnancy, asymptomatic bacteriuria is not an indication for antibiotic use in people with indwelling urinary catheters. Bacteriuria is the norm when there is a foreign body going into the bladder and treatment should only be considered based on clinical assessment. Careful clinical judgment is recommended because there is no good evidence that antibiotics are beneficial and repeated treatment of asymptomatic bacteriuria increases the risk of colonisation by drug-resistant bacteria.

Ask if the catheter is truly necessary and, if so, whether intermittent catheterisation is possible, as this is preferable. Consider whether the catheter is blocked and draining properly. There is limited evidence that a catheter change before starting treatment might improve outcomes. It's also important to consider if there could be another source of infection.

Current guidance is not to use bladder instillations, wash-outs or antiseptics as there is no evidence that these work.[4] If infection is suspected, treatment with antibiotics depends on the clinical situation and the severity of the problem.

If symptoms are particularly severe – for example, nausea and vomiting, confusion, tachypnoea, tachycardia, hypotension and reduced urine output – admission to hospital may be indicated for parenteral treatment.

If the symptoms are less severe – with fever and suprapubic or loin pain – then oral antibiotic therapy may need to be considered.[5] Ideally this should be guided by urine culture, but in many cases empirical initial therapy may be necessary.

Local guidelines should be followed, but nitrofurantoin or trimethoprim are often reasonable first-line options.

The catch with urine specimens in these circumstances is that several organisms may be grown and some may be contaminants. If the causative organism is not clear, it may be useful to have a discussion with your local microbiologist.

5 What should make us suspect bacterial superinfection following influenza?

Pneumonia is a common complication of influenza and may be indicated by lower respiratory tract distress – laboured breathing, shortness of breath, pleuritic chest pain and haemoptysis.

It may occur immediately, or up to two weeks after, initial symptoms of influenza and may be difficult to distinguish from community-acquired pneumonia that is not preceded by influenza.

The concern with post-influenza pneumonia is of lobar consolidation – or lobar pneumonia – caused by staphylococcal infection.

Current guidance advises that we treat as for other community-acquired pneumonia, but some authorities – for example, the BNF – recommend the addition of flucloxacillin to treat staphylococcal infection if the pneumonia follows influenza or measles, which is also associated with secondary bacterial infection.

6 What is the safest and most effective antibiotic to use for urinary tract infection (UTI) during the first three months of pregnancy?

If a UTI is suspected in pregnancy, send a urine sample for culture before starting antibiotic treatment. If asymptomatic bacteriuria has been detected, this should be confirmed by sending off a second sample before treating.

It is estimated that up to 10% of women with asymptomatic bacteriuria develop pyelonephritis later in pregnancy, and seven women would need treating to prevent one woman having this complication.[6]

In pregnancy it is safe to suggest paracetamol for symptomatic relief. But urine alkalinising agents or cranberry products have no clear evidence of benefit, so I wouldn't advise them as a remedy.

While awaiting urine microbiology in symptomatic women, prescribe an antibiotic empirically. If available, follow local guidelines based on local resistance patterns to guide this.

Both nitrofurantoin and cephalexin are considered to be relatively safe in pregnancy and are good choices for empirical use, and are given for seven days. Amoxicillin for seven days is only recommended if the organism is reported to be susceptible on the culture results and is the first-line drug if this is the case. Checking clearance of the infection by repeating urine culture and sensitivity is necessary. This should also be done at future antenatal visits.

Previously trimethoprim was not recommended in the first trimester of pregnancy, but recently there has been a shift of opinion and some authorities – but not the BNF – say that trimethoprim for seven days (off-label use) can be prescribed, particularly if there is resistance, intolerance or allergy to the other treatments.[7]

But there are some caveats to this – you should ensure that the woman is already taking a folic acid supplement if it is the first trimester and trimethoprim should not be prescribed if the woman is known to have folic acid deficiency, is taking a folate antagonist such as an antiepileptic, or has been treated with trimethoprim in the past year.

If you suspect a more severe UTI – for example, if the woman has fever or loin tenderness – consider seeking urgent specialist opinion or admitting the patient.

Dr Martin Duerden is a GP and deputy medical director for Betsi Cadwaladr Health Board in North Wales, an honorary senior lecturer at Bangor University and Cardiff University, and prescribing lead for the RCGP

Dr Pam Brown is a GP in Swansea

Further reading

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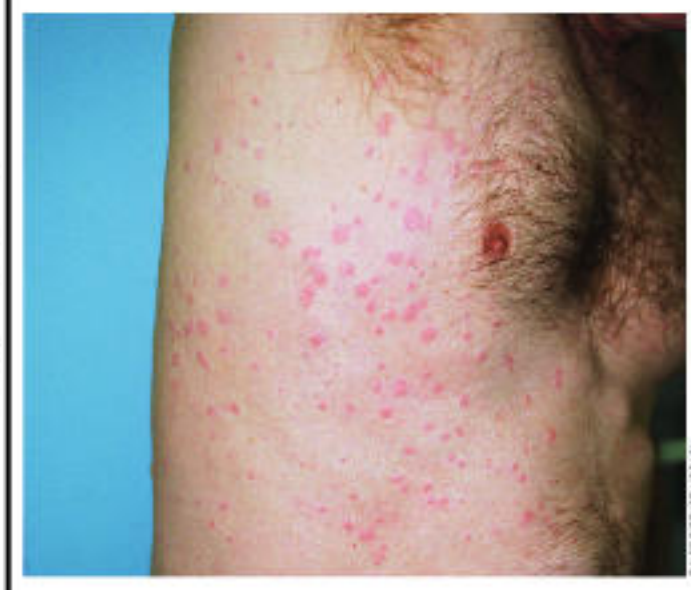
Go online to read an extended version of this article, with Dr Duerden answering questions on antibiotic use in quinsy and atypical pneumonia

SNAPSHOT DIAGNOSIS

Florid rash



Dr Keith Hopcroft explains how he reached the right diagnosis when this man presented to the emergency clinic with an extensive rash

The patient

This 30-year-old man turned up, somewhat apologetically, in the afternoon emergency clinic.

'I know it's not really urgent,' he said. 'I just want to make sure it's not catching.'

The rash had first appeared a couple of days previously and had rapidly developed into the florid lesions he showed me.

He had no relevant medical history and was on no regular medication – though he had taken some ibuprofen for what sounded like an upper respiratory tract infection a week or two previously.

The rash didn't itch, and he felt perfectly well in himself.

First instinct

Although the rash was quite impressive – with extensive, well-defined erythematous and slightly scaly lesions over his trunk – my reflex response was to label this as viral because I'd spent much of the afternoon seeing viral children, many of whom had non-specific rashes.

Perhaps it was linked to his recent URTI, or was the first sign of a new infection.

Because he'd only had the rash for a couple of days the possible differential was wide, though – as I explained to him – the viral hypothesis would be backed up if it resolved about as quickly as it had appeared.

Differential diagnosis

- Viral
- Drug reaction
- Guttate psoriasis
- Pityriasis rosea
- Lichen planus

I thought about the fact that he had taken ibuprofen. NSAIDs are a fairly common cause of skin reactions, though if this was the cause, it seemed unusually delayed.

Guttate psoriasis was certainly a possibility, given the appearance. He'd mentioned a preceding viral-type illness, but I hadn't thought to enquire further. It would have been interesting to know if he'd meant a severe sore throat, because a streptococcal infection can trigger this form of psoriasis.

Pityriasis rosea is something we see more commonly than guttate psoriasis, and the slight scale is characteristic. But these lesions looked more florid than those seen in most cases of pityriasis rosea, and he hadn't reported the typical 'herald patch'.

The only other differential, on the basis of the appearance, was lichen planus. This seemed unlikely, though, given the extensive distribution, the sudden onset and the lack of itch.

The hidden clue

The main giveaway was the fact that two weeks later he was back, with the rash as bad as ever.

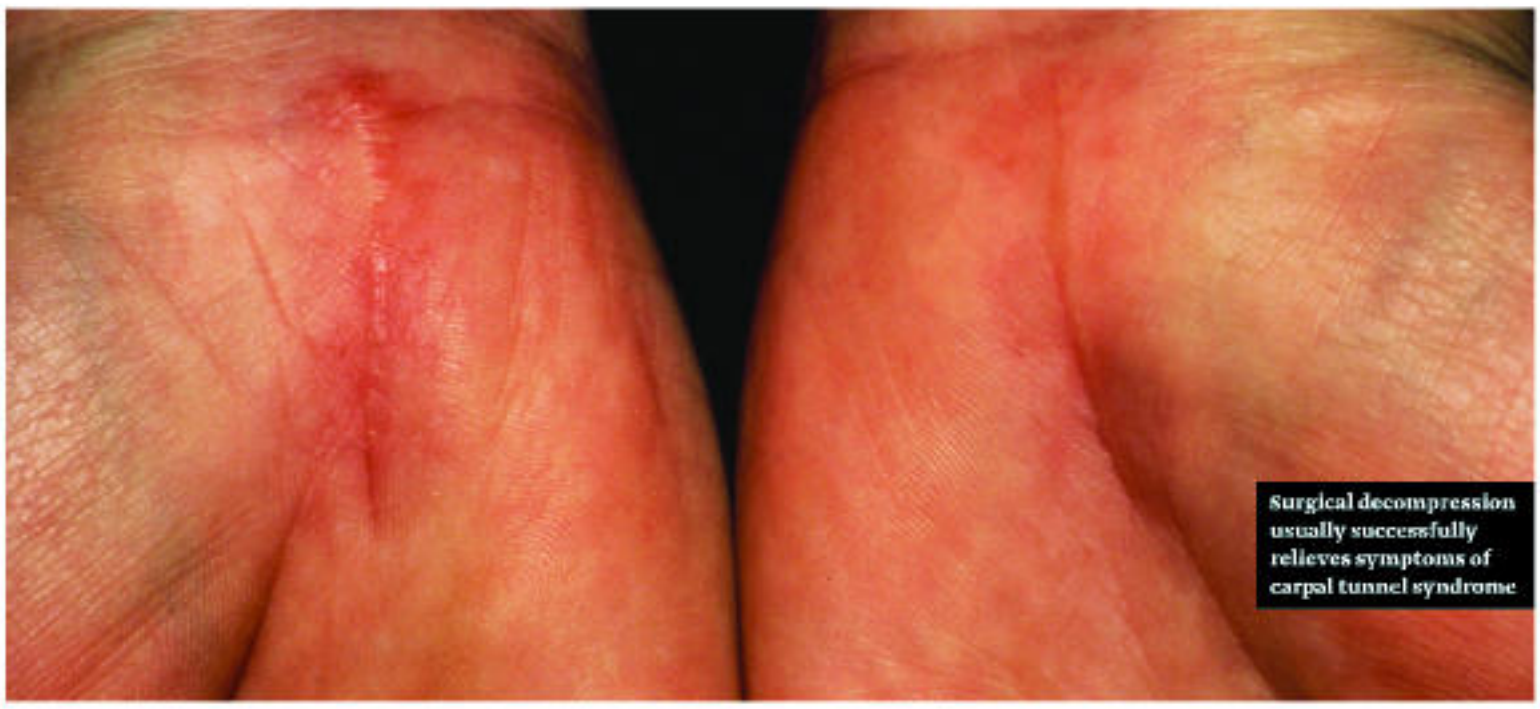
This effectively scrubbed a viral infection and a drug reaction off the list of possibilities – which meant that guttate psoriasis was now the prime suspect.

This was supported when I expanded the history to uncover the previously hidden clue that a couple of weeks previously his 'virus' had consisted of a really nasty sore throat, with a fever.

Getting on the right track

The icing on the cake was the fact that, although he had never suffered psoriasis himself, his father had. Other than reassurance, the only treatment required was some emollient – and within about six more weeks his guttate psoriasis had resolved.

Dr Keith Hopcroft is a GP in Laindon, Essex



Surgical decompression usually successfully relieves symptoms of carpal tunnel syndrome

OCCUPATIONAL MEDICINE

Work-related upper limb disorders

Dr Steven Ryder, consultant occupational physician, discusses these common complaints

The Health and Safety Executive estimates that work-related upper limb and neck complaints affect 186 per 1,000 adults per year, resulting in 4.7 million lost working days per year.

Recently, there has been some confusion and controversy surrounding these conditions. The term repetitive strain injury has justifiably fallen into misuse, as the term 'injury' is not always true and implies fault. Work-related upper limb disorder is an umbrella term for conditions thought to be caused by exposure in the workplace. These include well-defined syndromes such as tenosynovitis, carpal tunnel syndrome and epicondylitis, and the non-specific, less well-defined syndrome of non-specific diffuse forearm pain. These can also all have causes other than work.

Diagnosis

Diagnosis is usually made on history and examination. The diagnostic criteria for these are well recognised[1], and key tests include:

- **Finkelstein's test** Positive when ulnar deviation of the wrist with the fingers flexed over the thumb placed in the palm produces pain over the distal radius and radial side of the wrist. This suggests De Quervain's tenosynovitis.
- **Tinel's test** Positive when tapping over the carpal tunnel causes tingling in the thumb and radial two and a half fingers. Points to carpal tunnel syndrome
- **Phalen's test** Also for carpal tunnel syndrome, in Phalen's test both hands are held tightly and palmar-flexed opposite to a prayer position, creating at least a 90° angle between forearm and hand. It is positive if numbness and tingling are produced when the position is held for about 30 seconds.

Nerve conduction studies are useful for confirming carpal tunnel syndrome. Other conditions to consider include rheumatoid arthritis, diabetes and trauma.

Management and prognosis

Analgesics and NSAIDs are, of course, useful in managing all of these conditions.

Shoulder conditions
These usually respond to physiotherapy and steroids. Surgery may be useful if conservative measures don't help. Frozen shoulder can last 12 to 18 months.

Epicondylitis
This is treated with physiotherapy. Local steroid injection may be beneficial early on - but recurrence rates are high. Acupuncture, exercise therapy and ultrasound are also effective. Surgery can be successful in resistant cases. These conditions are self-limiting and some patients improve within one year - with or without treatment - but a majority still have symptoms after this. Recurrence is more common in manual workers.

Tenosynovitis
Patients with tenosynovitis should avoid aggravating movements. Topical anti-inflammatory agents can be useful, as can intra-synovial injection of steroids and local anaesthetics. Splinting is often recommended, but prolonged use can cause muscle wastage and local osteoporosis. Surgery may be required to relieve tethering.

Carpal tunnel syndrome
Patients should avoid possible work-related factors, such as:

- prolonged and extreme wrist flexion
- forceful and repetitive wrist movement
- direct pressure on the carpal tunnel
- the use of hand-held vibrating tools.

Steroid injections may relieve symptoms temporarily. There is little evidence that wrist splinting is beneficial. Where the diagnosis is confirmed, surgical decompression of the carpal tunnel usually relieves symptoms.

Non-specific diffuse forearm pain
This is a diagnosis of exclusion and needs to be distinguished from generalised pain syndromes such as fibromyalgia. Psychological factors are important and cognitive behavioural therapy may be helpful. Rehabilitation combining CBT with physiotherapy can be beneficial for workers who have been absent from work for over four weeks.

Upper limb disorders and work

These conditions are not exclusively related to occupation and causation by work should not be assumed until a workplace risk assessment has been carried out by an occupational health specialist. The known associations between mechanical factors and upper limb disorders are listed in a National Institute for Occupational Safety and Health critical review, which can be downloaded from pulsetoday.co.uk/tools-and-resources. Posture, degree of force, repetition and vibration are all important. Sports, hobbies and DIY can also be a cause, either exclusively or in combination with work.

Prevention

Prevention depends on the findings of the risk assessment. Consider:

- improved ergonomics of tool design, equipment and work layout to improve posture, reduce forces and repetition
- employee training
- job rotation to reduce time at a repetitive task
- an induction programme to enable a new employee to work at a slower rate initially
- rest breaks to allow recovery time
- rehabilitation of affected workers
- redeployment if the above measures aren't effective.

The role of the GP

It is important to identify the potential that the disorder may be associated with work - although you can't firmly establish causation until a workplace risk assessment has been carried out. Treatment alone without workplace modification is likely to be ineffective. I recommend the following approach:

- Establish the anatomical diagnosis.
- Consider work-related risk factors by asking the patient what they do at work in functional terms.
- Exclude recreational risk factors.
- A short break from work may be beneficial, although I wouldn't advise a long time off. Using the fit note (Med 3), suggest to the employer that work may be a factor and recommend a workplace risk assessment. Many employers have access to occupational health specialists. If not, you can contact the local Health and Safety Executive officer.

Patients may be keen for you to write 'RSI' on the sick note - but I would avoid doing this, saying something like: 'We tend not to use this term any more.'

If you think that the disorder may be caused by factors at work, it is more useful to call it work-related upper limb disorder rather than something vague such as 'forearm pain' - but prompt the employer to investigate. A recent literature review highlighted that:[2]

- Early return to work is important, though some work may be difficult to perform for a while. Work should be comfortable and accommodating.
- Upper limb disorders can be triggered by everyday activities and over-attribution to work can be detrimental to recovery.
- Many cases settle with self-management and this should be encouraged, though some need treatment. Intervention should take a stepped approach.

The Health and Safety Executive[3] provides useful resources, including a risk assessment worksheet, guidance for using display screens and a booklet for employers who run small businesses - download these from pulsetoday.co.uk/tools-and-resources.

Dr Steven Ryder is a consultant occupational physician and director of occupational health services for NHS Highland

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3 The Health and Safety Executive. hse.gov.uk (accessed 16 April 2012)

Further reading

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- Healthy Working UK. healthyworkinguk.co.uk (accessed 16 April 2012)

The Faculty of Occupational Medicine sets standards for specialists and also seeks to support GPs who are working part-time in occupational medicine or have an interest in work and health as it affects their patients. The diploma in occupational medicine, taken by many GPs, covers the effects of work on health, assessment of fitness for work, health surveillance, rehabilitation, workplace visits, ethics and the law. For further details on the diploma, other training and careers, and for more information on occupational medicine for GPs visit fom.ac.uk/education/education-for-GPs.

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

Date of preparation: March 2012 IND12 C052

Prescribing information can be found overleaf

NOVARTIS

ENT CLINIC

Ramsay Hunt syndrome

ENT GPSI Dr Raj Singh continues our series with a disease that is often misdiagnosed

Case

A 51-year-old woman presented to her GP with a three-day history of gradually increasing left-sided head pain.

She was being treated for hypertension and also used a triptan to control her migraine. But she insisted this head pain was different, especially in the way it radiated out to her ear.

Examination revealed a reddened, swollen right external auditory canal with a normal tympanic membrane. She was diagnosed as having simple otitis externa and prescribed ciprofloxacin drops.

Two days later she presented to A&E with dramatically worsened head pain, left-sided pulsatile tinnitus, vertigo and left-sided facial weakness. The swelling and redness in her left ear had worsened and there were now four small vesicles on the concha. She was seen by an ENT consultant and – after she confirmed she had had varicella infection as a child – diagnosed with Ramsay Hunt syndrome. She was given a dose of intravenous acyclovir and steroids, then discharged with a two-week course of oral acyclovir and steroids. At three weeks' follow-up the symptoms had all resolved.

The problem

- Ramsay Hunt syndrome is a varicella zoster virus infection of the head and neck involving the facial nerve, usually the seventh cranial nerve.
- It accounts for 18% of facial palsies in adults and 16% of all causes of unilateral facial palsies in children.[1]
- It is thought to be the cause of as many as 20% of clinically diagnosed cases of Bell's palsy.[2]
- There is some confusion over nomenclature – there are three syndromes that use the same name: the one described here, also called herpes zoster oticus; Ramsay Hunt cerebellar syndrome, a rare condition involving seizures and cognitive impairment; and Ramsay Hunt syndrome III, a neuropathy of the ulnar nerve.

Features

- Patients usually present with paroxysmal pain deep within the ear – often radiating out into the pinna – but may have a more constant, diffuse background pain.
- Up to 80% of cases also have a vesicular rash of the ear or mouth – soft palate and anterior two-thirds of the tongue – usually developing hours or even days after the onset of pain.
- Lower motor neuron facial paresis or palsy can develop after the rash and pain and usually reaches maximum severity by a week after onset of symptoms.
- Other features can include vertigo, hearing loss, tinnitus, headaches, dysarthria, gait ataxia and fever.

Diagnosis

- The diagnosis is clinical and straightforward when classic features are present: peripheral facial nerve paresis with associated rash or herpetic blisters in ear or mouth.
- The unilateral facial weakness is very similar to Bell's palsy, but the rash is the key differentiator.
- Take a careful history – ask about childhood varicella infection – and perform a focused but thorough physical examination.
- Initiation of treatment within 72 hours of symptom onset improves outcomes, so urgent referral is warranted.[3]

Management

- Ramsay Hunt syndrome is a self-limiting disease, not usually associated with mortality.
- Complete recovery rate is around 50% – 75% if treatment is started within 72 hours – and the primary morbidity is from facial weakness.
- Poor prognostic factors include age older than 50 years and complete facial paralysis.
- Oral steroids and acyclovir – oral or IV followed by oral – is the usual treatment.

Dr Raj Singh is an ENT GPSI in Manchester

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2 Gilchrist J. Seventh cranial neuropathy. *Seminars in Neurology* 2009;29:5-13
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GP and clinical assistant in rheumatology Dr David Richardson outlines five key recent developments

1 The risks and benefits of calcium supplementation

Calcium supplementation in the treatment of osteoporosis has been the subject of considerable debate over the past year – focusing on both safety and efficacy.

First a reanalysis of Women's Health Initiative data published in the *BMJ* in April 2011 suggested calcium supplements, taken with or without vitamin D, were associated with a slightly increased risk of an MI – a borderline significant hazard ratio of 1.22. That data was then included in a reworking of an earlier meta-analysis, with researchers then finding an even lower – but still borderline significant – hazard ratio of 1.16 for both MI and stroke.[1] The results are interesting, but as the MHRA pointed out later in 2011, no reason not to offer calcium and vitamin D to any woman being treated for osteoporosis unless they are receiving an adequate dietary daily intake of both.

Second, a large prospective study from Sweden published in the *BMJ* last year suggests more is not better for calcium intake. More than 61,000 women were followed for an average of 19 years, during which there were almost 18,000 fractures and more than 3,800 hip fractures. Only the women who had an intake of calcium under about 750mg a day had an increased risk of fracture. There was also a suggestion of an increased risk of hip fracture in women with an intake above 1,100mg a day. The study concluded that moderate levels of calcium intake are best for bone health. And we shouldn't be advising more than the UK recommended intake of 1,300mg a day.

It's a reasonable assumption that many women will get about 700mg a day from diet alone, so may need no more than an additional 500-600mg a day from calcium supplements. Women taking a very high dose of calcium, often 1,200-1,500mg a day, should be advised to cut down.

1 Bolland M, Grey A, Avenel A et al. Calcium supplements with or without vitamin D and risk of cardiovascular events: reanalysis of the Women's Health Initiative limited access dataset and meta-analysis. *BMJ* 2011;342:d2040
2 Warensjo E, Byberg L, Melhus H et al. Dietary calcium intake and risk of fracture and osteoporosis: prospective longitudinal cohort study. *BMJ* 2011;342:d1473

2 Bisphosphonates after joint replacement surgery

The number of people needing a hip or knee replacement has increased dramatically – and is set to increase further with the UK's ageing and increasingly heavy population. But too many patients need revision arthroplasty after the primary surgery – 2.9% for hip and 3.6% for knees – which is more costly and has a poorer clinical outcome. So anything that pushes that rate down would be welcome.

In December 2011, a group of UK researchers published a paper with the latest

WHAT'S NEW IN...

Musculoskeletal medicine

- and probably the most convincing - data suggesting use of bisphosphonates could nearly double replacement implant survival time. They identified almost 42,000 patients who underwent hip or knee replacement surgery for osteoarthritis from 1986 to 2006, including 1,912 bisphosphonate users.

After 15 years follow-up, they found 0.93% of those taking a bisphosphonate had revision surgery compared with 1.96% of those who did not. Bisphosphonate use was linked to a near doubling in implant survival time, and the researchers estimated that the number needed to treat to avoid one revision was 107 for oral bisphosphonates.

The most common cause of replacement joint failure is loosening, which accounts for about half of arthroplasty revisions done in the UK. This is thought to occur through a chronic inflammatory reaction causing bone loss, which may be prevented by bisphosphonate treatment - although this is, of course, not an indication included in the license.

1 Prieto-Alhambra D, Javaid M, Judge A et al. Association between bisphosphonate use and implant survival after primary total arthroplasty of the knee or hip: population-based retrospective cohort study. *BMJ* 2011;343:d7222

3 The latest on glucosamine

Glucosamine has become hugely popular as a nutritional supplement, particularly for osteoarthritis, but the evidence to back its use has never been particularly striking.

A few years ago GPs were in arguably a more comfortable position with regards glucosamine - there was no prescribable formulation. We could then advise our patients that the evidence was not great, but if they wanted to buy it for themselves we could recommend they try it for three months and see if it had any effect.

A Cochrane review in 2005, updated in 2007, made one positive finding - that 1,500mg of glucosamine sulphate a day, compared with placebo, was associated with a 60% reduction in pain and a 33% increase in function in patients with knee osteoarthritis. Other analyses looking at glucosamine hydrochloride or hip osteoarthritis found evidence of efficacy. Our position was made less clear when Alateris - a prescribed formulation of glucosamine - became available in 2008. But as that was the hydrochloride we could still reasonably refuse to prescribe it. In the last year or so two glucosamine sulphate formulations have appeared in the BNF - Dolenio and Glusartel - so we have to tackle the issue of whether to prescribe it. Anyone not keen to prescribe could always simply stick to the NICE guidance, which says it should not be prescribed on the NHS. But as this advice is from 2008, I'm not sure it's a tenable position.

I can only offer what I think is a reasonable approach to its use. A trial of glucosamine sulphate 1,500mg once daily is a reasonable option in patients with osteoarthritis of the knee, after trying - or in combination with - paracetamol. I would recommend Glusartel, as it is the same product used in trials showing improvement in symptoms. Prescribe for three months and then review before adding to the repeat system. If patients request glucosamine for joints other than the knee, I would suggest advising them to buy it over the counter as evidence is lacking.

Finally, some evidence is emerging that suggests glucosamine could well be an effective and safe anti-inflammatory, but a low bioavailability and variability in the formulations used in trials could explain the lack of evidence.[1,2] But until new formulations arrive with improved bioavailability, or large trials with high doses are published, it makes sense to stick with the dose, the formulation and the indication where there is at least some evidence.

1 Block J, Oegema T, Sandy J et al. The effects of oral glucosamine on joint health: is a change in research approach needed? *Osteoarthritis Cartilage* 2010;18:5-11
2 Miller K and Clegg D. Glucosamine and chondroitin sulfate. *Rheum Dis Clin North Am* 2011;37:103-18

4 Effective rheumatoid arthritis treatment and cardiovascular risk

It's now very clear that patients with rheumatoid arthritis are at increased risk of cardiovascular morbidity and mortality, and that this increase is detectable early in the course of the disease. It's also clear that earlier use of DMARDs and new biological therapies have had a dramatic impact on disease activity in rheumatoid arthritis.

But what has only become recently clear is the link between these two - that effective RA therapy reduces the cardiovascular risk in patients with RA. In 2011, two studies were published that suggest this is the case.

The first study tracked the progress of 442 patients newly diagnosed with RA both in terms of their disease activity and their cardiovascular health. In that time - although smoking rates and average weight went down - there was a significant increase in the proportion of patients being treated for hypertension, from 24.5% to 37.4%, and the proportion diagnosed with type 2 diabetes, from 7.1% to 9.5%.[1]

After five years of follow-up, 97% of the patients had been treated with a DMARD - with 82% being given methotrexate and 14% biological agents. Some 48 patients had suffered a cardiovascular event, of which 12 were fatal.

But a DMARD given within three months of diagnosis reduced the risk of a cardiovascular event by 60%, compared with that individual's risk at the time of diagnosis. Any DMARD treatment decreased cardiovascular risk by 12% per month. There was no protective effect seen in patients treated with NSAIDs or steroids.

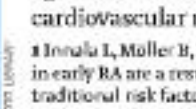
The second study compared the rate of cardiovascular events in three groups of patients with RA: those on biological therapy, those taking methotrexate and those on non-DMARD therapy, mainly NSAIDs and steroids.

There was a 61% reduction in cardiovascular risk with biological therapy but a non-significant 6% reduction with methotrexate, both compared with the non-DMARD group.

The results from this study are somewhat different from the first study - and from other published data on the subject - in that the impact of biological therapies on cardiovascular events is much greater and the impact of methotrexate much smaller.

But both studies emphasise that diagnosing inflammatory arthritis early and treating it effectively can not only reduce disease activity dramatically, but also reduce the risk of a cardiovascular event. We should also make sure RA is included when we're calculating cardiovascular risk and intervene against the usual suspects in terms of cardiovascular risk factors.

1 Innala L, Möller B, Ljung L et al. Cardiovascular events in early RA are a result of inflammatory burden and traditional risk factors: a five year prospective study. *Arthritis Res Ther* 2011;13:R131
2 Greenberg J, Kremer J, Curtis J et al. Tumour necrosis factor antagonist use and associated risk reduction of cardiovascular events among patients with rheumatoid arthritis. *Ann Rheum Dis* 2011;70:576-82



5 DXA scan frequency in postmenopausal women

When a postmenopausal woman should have another DXA scan after having had a 'normal' one is one of the thorniest questions in the management of osteoporosis, and the guidelines don't really have an answer.

We know women start losing bone quickly after the menopause and a rule of thumb used by many is that it may well be worth doing a repeat scan in five years - especially if the woman has other risk factors.

Now a group of US researchers has looked at whether it's possible to develop recommendations for bone mineral density testing intervals based on baseline T scores, and their results suggest the intervals could be a lot longer than you might think.

They analysed data from 4,957 women aged 67 years or older who did not have osteoporosis at baseline from a previous prospective analysis, the Study of Osteoporotic Fractures. Women were placed into four groups according to T score range (all at femoral neck or total hip):

- normal BMD - a T score of -1.00 or higher
- mild osteopenia - a T score of -1.01 to -1.49
- moderate osteopenia - a T score of -1.50 to -1.99
- advanced osteopenia - a T score of -2.00 to -2.49.

They found that women at baseline with a normal BMD took 16.8 years to develop osteoporosis, those with mild osteopenia took 17.3 years, those with moderate osteopenia took 4.7 years and those with advanced osteopenia took 1.1 years.

They then calculated appropriate testing intervals - defined as the time it would take 10% of women to develop osteoporosis. Those intervals were 15 years for women with normal BMD or mild osteopenia, five years for women with moderate osteopenia, and one year for women with advanced osteopenia.

The authors recommended that this could form the basis for a more formalised recommendation on screening intervals - but should include other variables such as age, weight loss and decreased mobility.

1 Margaret L, Gourlay M, Fine J et al. Bone-density testing interval and transition to osteoporosis in older women. *N Engl J Med* 2012;366:225-33

Dr David Richardson is a GP in Glasgow and clinical assistant in rheumatology

Competing interests None declared

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Dissecting the practice boundary pilots

GPs at the centre of the negotiations for the scheme discuss the implications for practices within and outside the pilot areas

Dr Richard Vautrey

Dr Stewart Bingham

Dr Paul Roblin

The patient choice pilot is focusing on six pilot sites in three cities – NHS Westminster, NHS Tower Hamlets and City & Hackney Teaching PCT in London; Manchester Teaching PCT and NHS Salford in Greater Manchester; and NHS Nottingham City. But it also has implications for every practice in the country, because their patients may be commuting to the pilot areas and might want to register there.

The scheme will run from 30 April for a year, during which time any patient living outside a pilot area can register with a participating practice to receive primary medical services from them. While the Department of Health has published guidance to help both pilot practices and neighbours, the outlook is far from clear for the next 12 months.[1]

What should GPs know about the pilots?

Dr Richard Vautrey is deputy chair of the GPC and part of the team that negotiated pilot terms

The pilot generally applies to patients who are working in the pilot areas – so, for instance, a Leeds patient could register in one of the pilot sites in Manchester, Nottingham or London if they worked there. However, the patients eligible for the pilot scheme differ from the usual category of temporary residents in that they can be people who are away from home for less than 24 hours, such as commuters. The pilot scheme does not affect existing arrangements for temporary residents or emergency treatment.

Practices should familiarise themselves with the advice available on the pilot so they know how to verify that the patient works in a pilot area and that it's appropriate for the patient to be treated by the new practice.

The DH guidance advises that if the patient needs a package of home- or community-based support, then it wouldn't be practical for a remote practice to be asked to co-ordinate treatment. The likelihood is that they will be on the whole fit and healthy, without complex health needs. When the patient wants to register, they're offered two choices – they can either become day patients or they join the pilot practice list as a temporary resident.

Patients in the pilots are likely to be healthy and without complex needs

Practices should treat patients in the same way whether they are day cases or temporary patients – basing decisions on medical examinations and the patient's history. Therefore it's imperative that both the new and the old practice have a fast, reliable flow of information so day patients receive as good a service as if their records had moved with them. The record should be kept fully up to date by both practices so that one can warn the other if there are potential concerns, such as a patient who requests controlled drugs.

If the patient is accepted onto a practice list under the pilot scheme, the new practice receives funding. For day case patients, the practice is funded £12.93 per consultation for each of the first five consultations, with no funding after that. Fully registered patients bring the relevant global sum allocation.

The financial risk for the pilot PCTs is that new patients, whether day case or fully registered, will not bring extra funding for referrals or secondary care during the pilot – something the GPC highlighted some time ago. So one scenario that might take place if the pilot is rolled out nationally is patients who 'play the system', by switching from one CCG to another to pursue

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a treatment or drug which has been rationed at their home practice.

Financially, it's unlikely to make a great difference to practices this year, especially as I expect patients will prefer to register as day cases because of the difficulty of providing home visits to a patient who commutes miles to your practice area. I think the Government wants people to use the pilot practices in the same way as a Darzi centre, and I don't see why patients wouldn't do that.

If the scheme rolls out nationally, a sudden shift in registration could leave practices in commuter towns in financial difficulty, left with responsibility for the young and old. Being a GP works because you're not seeing all your patients all the time – it's based on balance. While I don't think anyone will make money out of the pilots this year, there are still major financial implications at a national level.

What are the potential benefits and risks for practices in the pilot areas?

Dr Stewart Bingham is a GP in Canary Wharf and co-deputy chair of Tower Hamlets CCG

The day registration fee is, in my opinion, not worth bothering with – looking after day patients is fraught with potential problems when providing out-of-hours care, home visits and moving patient information between the home and pilot practices.

The main potential benefit to Tower Hamlets, where I work, is that if we develop a more fit and healthy patient population by registering local commuters, those people will use less of their health budgets than, say, a patient with a long-term condition.

The main drawback is the delay in funding when a patient registers

There's not a great benefit to practices who hope to develop their own finances through, for instance, providing extra services such as travel clinics. We provide musculoskeletal and psychological services, sexual health screening and smoking cessation, which commuters already tap into successfully.

Of course, there could be a benefit to those practices looking to expand their practice list, but the practice where I work has been growing by around 2,500 new patients a year for four or five years now – so for us, there's no direct benefit.

The main drawback is the delay in funding when a patient registers with a pilot practice, as it could take up to 18 months to come through. If the cost per patient is, for instance, £2,000, and 10,000 new patients register within the borough, then Tower Hamlets is immediately owed £20m. Our borough is already overstretched in terms of health needs. Another drawback if the scheme was rolled out nationally might be that the commuter patients on our list lead to our deprivation payments being reduced.

The GPC has agreed to the idea of patient choice in principle, and it's true that there is a small population in the UK who can't access GP services because they work outside our opening hours. However, there still remains a lot to be resolved as the pilot goes live, given the lack of clear guidelines about receiving funding.

What are the main implications for practices outside the pilots?

Dr Paul Roblin is chief executive of Buckinghamshire, Berkshire and Oxfordshire LMCs and has led the development of one of the country's first LESs for practices outside the pilot areas

Areas like mine have large commuter populations, but you only need one patient who wants to register elsewhere for you to have an obligation to set up a system for home visits. There's not a PCT in the country left unaffected. The DH guidance for the pilot includes a template for a LES. However, while the template defines the activity that PCTs will want to purchase from GPs, the LMC must negotiate on cost.

When the pilot was announced I emailed all the PCTs I've worked with before to get an idea of suggested costs for patient attendance at the surgery they've de-registered from, and also for home visits. The offer on visits from my PCT, at £50 plus mileage, was acceptable, but the £12.93 figure for surgery attendance was not.

Given that a walk-in centre would receive £25-27 per attendance, and perhaps more for a Darzi centre (there aren't any publicly available figures for it as it's 'commercially sensitive') we felt that PCTs needed to do more to incentivise doctors to do what will essentially be a voluntary task. GP practices are small businesses and where there's no case to take up a LES, other NHS services will pick up the slack.

The listserver, an email forum for LMCs, has been a useful resource for the process of establishing the required funding.[2] But if my PCT refuses to offer extra funding I feel that others will take this as a precedent. Quite why the DH didn't create a national DES I'm not sure, as hundreds of people will need to negotiate arrangements on the same issue. It's hard to know how the loss of our patients to city practices will affect the global sum, but presuming they're young, healthy patients it could be £50-60 a year per patient. We're not sure yet what the take-up will be like. Technically, the remaining patients will be better off for funding for prescribing and referrals.

References

1 Department of Health. *Choice of GP practice: the patient choice scheme*. 2012. tinyurl.com/8cowm8y

2 The listserver is a private email resource run by the BMA for LMCs. Email info.gpc@bma.org.uk for access

Dr Penny Newman and **Dr Ed Garratt** explain how GP commissioners can ease the load on partners – by involving salaried GPs and locums

Six ways to get sessional GPs involved in commissioning

While the number of salaried GPs and locums in the UK has boomed in the last decade, research shows that many still feel isolated. Sessional GPs face a lack of information about systems and support, missed opportunities for peer interaction and professional difficulties through lack of feedback and unintended ignorance of protocols – all of which keep them at arm's length from commissioning.

Salaried GPs and locums are poorly represented on the new boards of CCGs – because of a lack of engagement between the boards and the sessional sector – but GP commissioners must review this if they are truly going to represent all the GPs at their member practices and get the best out of them. All GPs will need to modify their referral and prescribing decisions in line with new pathways, and to keep within budget, so inclusion of sessional GPs is critical. If sessional GPs refused to comply with certain commissioning decisions, for instance, the effect would be disastrous.

The CCG governing body also needs to reflect the workforce demographics. The evidence is that by sharing leadership and distributing responsibility, better decisions are made and those with the best skills or knowledge for the job are utilised. Given current trends and the large numbers of partners planning to retire in the next five years, sessional GPs are likely to remain central to the model of primary care.

Here are six ways GP commissioners can engage better with salaried GPs and locums.

1 Take advantage of spare capacity in the sessional sector

Many factors contribute to the increased workload GPs are experiencing in their surgeries. GPs in the UK face 300 million consultations every year[1] and consultations are longer and more complex than ever, as the prevalence of long-term conditions rises. Every GP experiences pressure, but it disproportionately falls on GP partners, given their responsibility to run a practice and engage with commissioning.

However, the sessional sector has a huge capacity for backfill – in a recent BMA survey, three-quarters of salaried GPs reported they were only working part-time, and locum GPs' work is flexible by nature.[2]

Some salaried GPs or locums may be motivated by project work or a leadership role as part of their career development and could provide input in their own time, without any impact on the practice and its appointments. In some cases it is more cost-effective for a partner to employ a sessional doctor for commissioning work than to take time out of their practice themselves.

2 Enable sessional GPs to vote on commissioning decisions

The GPC states: 'All GPs – partner and sessional – should be eligible to stand and vote in CCG elections. The constitution of the CCG should explicitly state this and outline electoral processes inclusive of all GPs in the CCG area. In particular, all GPs regardless of contractual status should have the opportunity to stand for all elected positions – at board level or below – and vote in elections.'[3]

Excluding salaried GPs and locums from voting for members of the CCG governing body may disengage as many as half of GPs locally.

Sessional GPs may be less well known locally than partners, and therefore less likely to have peer support and success in elections, so some CCGs have therefore co-opted them onto the governing body to represent their colleagues.

3 Use small tasks to identify talent

Giving sessional GPs a small piece of project work will test their skills and commitment and allow them to develop the same sort of skills as partners. Work could include helping on a project such as tackling obesity, redesigning a clinical pathway such as COPD or an audit on prescribing.

Most large companies have a formal process for talent management in a deliberate attempt to attract, develop and retain people who can meet current and future organisational needs.

Sessional GPs with enthusiasm and talent for commissioning can be spotted at practice level and encouraged to contribute in similar ways to partners. There are plenty of tools available to measure performance and potential.

There is a self-assessment tool available as part of the Leadership Framework, made available by the NHS Leadership Academy, which sessional GPs could undertake by themselves to find out whether they're ready for a leadership position.

Commissioners might want to set the questionnaire for sessional GPs who identify themselves for leadership roles, and use the personal development plan templates in the *Leadership Framework* to set them up for senior roles.[4]

However, it's important to remember that sessional doesn't mean inexperienced or lacking in expertise. Many GPs have left or avoided partnerships to pursue their own careers, meaning that some may already have the expertise and leadership experience you're looking for.

Identifying talent in these GPs should be as simple as reading through their CVs and seeking references. The NHS Leadership Academy is developing a process of talent management through an online leadership needs assessment available this summer.

4 Invite salaried GPs to practice meetings

The demands on general practice are unprecedented, with increases in consultation rates and length, and more case management for long-term conditions. This means managing a large team well is vitally important to make use of everyone's talent and potential.

Inviting salaried GPs to practice business meetings will help them develop the skills to become leaders in primary care and commissioning in future, and they may offer new and useful insights.

CCGs should use technology to enable participation where part-time sessional GPs struggle to attend meetings – for example, by setting up a conference call to get a sessional GP's view. Practices could use video conferencing through WebEx or Skype (the latter is free), or a conference calling system such as Spiderphone.

On a very basic level, it also helps to take notes at every meeting and make them available by email or by posting them online, perhaps by using Google Documents.

5 Work with locum chambers on commissioning cover and project work

A GP chambers is a group of GP locums working together to provide medical services to GP practices and CCGs. In return for a membership fee, the chambers manages all non-clinical aspects of being a locum GP – such as all aspects of booking work – as well as providing professional development and educational support, the latter also open to salaried GPs.

Locum chambers offer quality of service, know the local practices well, are able to share good practice and are more cost-effective than locum agencies.

In some areas, locum GP chambers also contribute members to their local CCG governing body and help undertake project work. Locum GPs from chambers are being used effectively by CCGs on their emerging governing bodies, as they often know a variety of local surgeries well and can share good practice.

6 Encourage sessional GPs to set up a self-directed learning group

CCGs might want to consider setting up a self-directed learning group for salaried GPs and locums, to ensure they are kept up to date with best practice and the latest evidence. Sessional GPs in some areas meet regularly to address their professional development needs, including the skills they need for commissioning.

These groups can help generate evidence of continuous professional development for members' appraisals and revalidation, but also provide a local knowledge base, networking opportunities and flexible learning opportunities.

Groups make the workforce better skilled and more adaptable to the needs of the local CCG, so it is in sessional GPs' and commissioners' mutual interests to set them up and maintain them. Commissioners might want to consider liaising with group leaders to provide training sessions or mentoring partnerships.

Dr Penny Newman is a salaried GP in Ipswich, and a member of the NHS Midlands and East commissioning development team

Dr Ed Garratt is chief operating officer of West Suffolk CCG

The authors would like to thank Dr Richard Fieldhouse, chief executive of the National Association of Sessional GPs and a GP in Chichester, for his help with this article.

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If you wish to join our enthusiastic team please apply with CV and covering letter by email or to:
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Tel 01270 610686.

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If you would like further information or to arrange an informal visit to the practice, please email us as below or telephone Sarah or Cheryl on 0114 2505467.

To apply for the post please complete the application form on the practice website and email it to either sarah.wylie@nhs.net or cheryl.fielder@nhs.net

Closing date: 31st May, 2012

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for 8 sessions by a 3 partner PMS practice,
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Excellent salary plus equal share of private income.
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Jane Banks (Practice Manager)
Unsworth Group Practice, Peter House,
Captain Lees Road, Westhoughton,
Nr Bolton. BL5 3UB
Tel : 01942 812525
Or e-mail jane.banks@nhs.net

Closing Date for applications : Friday 18th May 2012 (5pm)
Interviews to be held : Wednesday 13th June 2012

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Experience of EMIS Web is preferred.

Input into practice development, working alongside the consortium is a necessary requirement as is practical experience diabetes.

The start date is preferably mid July, however we are prepared to wait for the right candidate.

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Carol McRae
Practice Business Manager,
Western Avenue Medical Centre,
Blacon, Chester CH1 5PA

Informal visits are encouraged, enquiries to Carol McRae at above address or by phone on: 01244 390 735

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www.prospect-house.co.uk

Please send full CV with covering letter and names of two referees (one from current place of work). Please include details of sickness absence in last two years and statement of health.

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For further information or an informal chat contact: Dr John McManus on 01536 513494. Previous applicants need not apply.

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Closing date: *Wednesday 9th May 2012*
Interviews: *Saturday 19th May 2012*

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Dr D Durica or Practice Manager - Patsy Campbell.
Patsy.campbell@nhs.net
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Fax 0208 451 7268
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Dr S Ramdahen & Partners, The Medical Centre,
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EDITOR'S CHOICE

Five tips to survive the First5

Dr Jaspreet Kaur Grewal shares the five top tips she's learned in her first five months as a fully qualified GP – lessons only experience can teach

It's been five months since I qualified as a GP, so I thought I would summarise five things I've found useful.

1 Ensure you have your paperwork sorted This includes your CCT certificate, proof you are on the performers list as a GP in the area where you intend to do most of your work and organising medical indemnity, which will depend on the number of sessions you are planning to do.

2 Get work If you're planning on working as a locum you need to ensure you have registered as self-employed - you can do this yourself on the HMRC website. Helpful websites for finding locum and partnership positions include GPNetworks and the *BMJ* careers website. If you're taking up a salaried position, check the conditions against the BMA model contract.

3 Money matters It is important to get organised - ensure you have records

Dr Jaspreet Kaur Grewal

of locum work for invoices, remember to put aside money owed for tax and national insurance, keep records of expenses and so on. Some people find the software Penny/Perfect and Locum Organiser helpful. Ensure you get your pension form 'A' completed by your practice manager each month. Transfer the information to pension form 'B' and post along with a cheque to your PCT.

4 Get involved with the RCGP and your local faculty There are an abundance of opportunities to get involved and have your say. Each RCGP faculty has a First5 lead and you can find yours on the RCGP website.

5 Keep up to date Make sure you stay up to date with CPD and arrange appraisals. It is a good idea to keep a list of all your learning and CPD points. It is also essential to have Resus training annually.

Dr Jaspreet Kaur Grewal is a newly qualified GP and RCGP First5 and communication lead for Southwest Thames Faculty

MORE ONLINE
Read the full blog, including links to helpful resources, at pulsetoday.co.uk/careers

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WHAT YOU'VE BEEN SAYING

▶ pulsetoday.co.uk/forum

"I have a patient who has repeatedly and aggressively demanded free food"
... on patients adding to their own medical records

"I think Australia is calling me!"
... on approval of the RCGP's four-year training plan

"I predict it will all end in tears"
... on strike action by BMA staff threatening the GP pensions ballot

"This is exactly the kind of situation we were warned about"
... on DH tenders for long-term care

OFF DUTY

Up for an Aussie adventure?

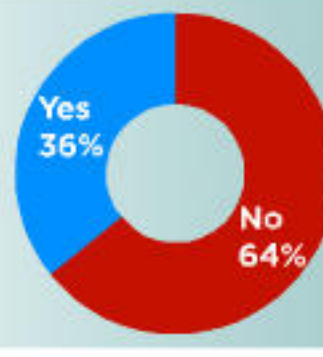
Recently there has been a renewed interest among UK GPs in work opportunities abroad. There is a healthcare workforce shortage in Australia, especially with GPs, and the government there is encouraging recruitment and retention of doctors, especially for rural and remote areas. After I emigrated to Australia I witnessed a flurry of GP interest for this so I wanted to provide a guideline for doctors planning to emigrate...

OFF DUTY
More from Dr Amal Paul in Australia
pulsetoday.co.uk/off-duty

THIS WEEK'S POLL

Should CCGs have a role in performance-managing practices?
Vote at ▶ pulsetoday.co.uk/polls

Last week's poll
Does off-label prescribing endanger patient safety?



Turn inside for this week's Phil Peverley and Margaret McCartney columns
▶ pages 14-15