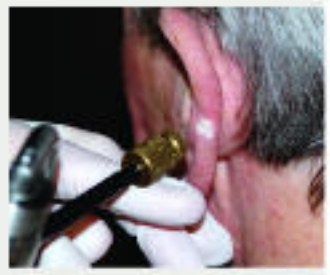

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BriefingMedia
At the heart of general practice since 1960

GPs lift lid on acute trust overcharging

LMC exposes 'institutional miscoding' of outpatient care as admissions

EXCLUSIVE
By Gareth Iacobucci

GPs have prompted an investigation into 'creative coding' by hospital managers after submitting a dossier of evidence detailing what they claim to be routine misuse of the payment by results system.

Hospital staff are accused of a raft of coding errors that have resulted in practices being overcharged by as much as £30,000 in some cases – with one patient reportedly admitted to hospital every day for three months.

GPs warned the alleged gaming – even where strictly within the rules – was a multimillion-pound drain on CCG finances. It also risks hitting GP pay directly through the quality premium, due to be tied to the ability of CCGs to stay within budget.

An Audit Commission report last month flagged coding within payment by results as a national problem, warning 'inconsistent treatment descriptions' were 'affecting patients, skewing management information and wasting NHS funding'.

A dossier of suspicious coding behaviour compiled by Avon LMC provides the most detailed evidence yet of how the problem is draining GP budgets. The LMC has formally complained to the Audit Commission and its PCT, which is investigating several cases with the hospitals concerned. Its motion to next week's LMC conference calls on ministers to ensure 'any creative coding or accounting by secondary care providers is exposed and dealt with as fraud'.

EDITORIAL ▶
Stop playing games with the NHS 13

Dr Simon Bradley: failure of PCT managers to recognise when hospitals are gaming is 'dereliction of responsibility'

Dr Simon Bradley, chair of Avon LMC, said there was 'institutional miscoding': 'We must not let this go unchallenged. The PCT's failure to address this has been a dereliction of responsibility, costing our health community millions of pounds.'

He said hospital managers had inappropriately coded episodes of care as admissions where patients had received oral iodine and even where paediatricians had been called to delivery suites to examine newborn babies.

He said women attending a maternity unit for cardiotocography monitoring were routinely charged as an admission rather than outpatient appointment: 'One patient will cost the NHS £30,000 or more because she's going up there for three months having one done every day, and each is being charged as an admission. The PCT said to me: "You have high admissions – you are a badly performing practice." And I told them outpatient procedures were being charged as admissions.'

Another example cited concerned patients attending A&E with chest pain who underwent troponin blood tests. Dr Bradley claimed patients who came back negative were placed in chairs in clinical decision units and charged as admissions, even when a further troponin test at 12 hours also came back negative.

NHS North Bristol Trust initially denied it had received any coding challenges, but later backtracked, and in a joint statement with NHS Bristol admitted it had received complaints. The statement confirmed coding of patients attending for cardiotocography had been questioned by the PCT: 'Controls have been put in the contract to limit the number of attendances paid for.'

It confirmed coding of patients attending A&E with chest pain had been raised: 'All patients in CDUs have a bed and a chair. All admissions from A&E to the CDU ward are unplanned and charged as emergencies. This is appropriate.'

Dr Chaand Nagpaul, GPC negotiator, said: 'These coding errors have a significant impact on commissioning budgets. This is a national problem. The system has built-in perverse incentives.'
@garethiacobucci

Creative coding or valid admission?

Woman admitted for a CTG scan daily for three months

Patients with negative troponin tests admitted as they had a bad beside their chair

Babies admitted as soon as they were born

Source: Avon LMC

The week in general practice

INSIDE

Dr Chris Salisbury

MORE ONLINE

▶ pulsetoday.co.uk/news

The MHRA 'must learn lessons' from its response to the PIP implants scare to provide stronger assurance for the public, concludes a DH report

▶ pulsetoday.co.uk/clinicalnews

Video of the week

Watch GPs give their reaction to BMA plans for industrial action in our videos from the pension roadshows

▶ pulsetoday.co.uk/videos

Download of the week

Read the BMA's briefing paper on changes to the NHS Pension Scheme and its plans for industrial action

▶ pulsetoday.co.uk/downloads

PULSENEWSEXTRA PENSION BALLOT

POLITICAL SUPPORT

Labour backs industrial action by GPs

Opposition provides political cover with support – but Patients Association is 'deeply concerned'

EXCLUSIVE

By Jaimie Kaffash

Say No to 30%

The Labour Party will support the proposed industrial action by GPs over pensions so long as measures are taken to prevent it damaging patient care, Pulse can reveal.

Shadow health minister Diane Abbott said she felt that there would be 'public support' for a day of action on pensions, and that Labour would have 'a lot of sympathy for the BMA'.

Her comments represent a significant move politically, with Labour normally extremely cautious about offering any support for industrial action for fear of being seen as too close to the unions. But in a sign of the fierce arguments to come, the Patients Association has taken the opposite view, warning of its 'deep concerns' over the proposed action.

GPs said Labour's support would be a major boost to the prospects of a vote for industrial action by providing

BMA answers GPs' roadshow questions

Why was this form of industrial action chosen?
It was designed to have an impact while assuring patient safety.

Why is there a question about strike action?
We have ruled out a full withdrawal of labour, but to maximise legal protection this question is on the ballot.

Why are other health unions not involved?
We would always look to take united action if we could, and we are in close contact with the other health unions.

How do you think the public will react?
We are providing additional briefings to the media. However, we do need to be realistic about the degree of public support we can expect.

What turnout is necessary?
No magic number. BMA Council will consider the ballot results before making a decision on the next steps.

Will there be any further industrial action?
We'll consider the impact before making a decision about any future action.

GPs chase missing

By Gareth Iacobucci

Hundreds of patients with suspected cancer urgently referred by GPs within the last year to the country's largest hospital trust may not have been seen within two weeks.

Imperial College Healthcare NHS Trust has written to GPs in London to ask for their help in tracking the patients, their carers or their representatives to 'ascertain whether the patient has received treatment or still requires treatment', after concerns up to 900 patient records were incomplete.

A spokesperson for Imperial College Healthcare said the problems arose from 'data collection' issues: 'Some records were opened and not closed, some records were duplicated.

'We are in the process of clinically validating all records that indicate that a patient may have been waiting longer than two weeks for a referral for suspected cancer.'

Patient choice 'significantly'

GP referral patterns have been 'significantly changed' by the introduction of patient choice, with four in 10 patients no longer opting to have an operation at their nearest hospital, an analysis by economists concludes.

Their study, published in this month's edition of *The Economic Journal*, looked at all the hip replacement referrals from 2006 to 2008 and found although 90% of patients had a hospital located within 20km of their home, around 40% preferred to travel further afield.

It also found distinct changes in GP referral patterns, with the proportion of GPs referring patients to no more than three hos-

Dr Andrew Dearden posting his ballot last week

BMA BALLOT

BMA turnout goal

EXCLUSIVE

By Jaimie Kaffash

BMA Council members will insist on a minimum turnout as well as a Yes vote before agreeing that the pensions ballot should trigger industrial action, Pulse can reveal.

The first ballot of doctors on industrial action for almost 40 years got underway this week and will last until 29 May, with the BMA hoping it will give it a mandate to stage industrial action short of a strike.

But the final decision on industrial action rests with BMA Council, which will hold a special meeting on 30 May to consider the ballot results. And BMA Council members told Pulse that even if most of those who vote in the ballot opt for action, they will insist on a respectable turnout before pressing ahead with a day of action.

Dr Chaand Nagpaul, BMA Council member and a GPC negotiator, said discussions had already been held about the dangers of a low turnout and urged all doctors to return their ballot papers.

'The interpretation of the ballot would have to take into consideration the turnout,' he said.

Dr Helena McKeown, another BMA Council member and a GP in Salisbury, said: 'I wouldn't be highly impressed with a 20% turnout. However, if 80% of a 20% turnout wanted to take action, we would have to take a look at that. It will be dependent on the two figures and maybe breaking it down to branch of practice.'

Dr Kailash Chand, who after his election last month will join BMA Council in June, said: 'I think we need a majority turnout.'

The Royal College of Nursing held a ballot in March asking members' views on the pension proposals, and held back from rejecting the deal – despite two-thirds of those who voted asking it to do so – because turnout was just 16%.

The BMA began its programme of roadshows last week, with fewer than 100 doctors attending the first event at BMA House. A BMA spokesperson declined to release figures for attendance at events around the country but insisted it had been 'healthy'.

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political cover.

Ms Abbott, Labour spokesperson for public health, said Labour could not support any action that would harm patients, but as long as that was not the case, would regard it as justified.

She said: 'So long as they are not compromising patient safety, clearly the BMA has a right to take industrial action and so long as it is a legal ballot, they have enough of a mandate.

'We have a lot of sympathy for the BMA because the Government has lost the confidence of professionals generally on its reforms, but also on the question of pensions. I think there will be public support. The public trust health professionals more than they trust ministers.'

But Katherine Murphy, chief executive of the Patients Association, said: 'We are deeply concerned how A&E departments will cope if people are denied consultations elsewhere.

'It also opens up patient safety issues. How does one identify when it's an emergency? It is a huge risk. It is a drastic action and its only impact would be on innocent patients.'

Dr Chaand Nagpaul, GPC negotiator, said Labour's support was 'encouraging': 'It is reassuring politicians can see this is not action against patients.'

Dr Andrew Dearden, member of the BMA pensions committee and a GP in Cardiff, said: 'It is good to have people agreeing with us.'

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'The public trust health professionals more than they trust ministers'
Diane Abbott

cancer patients

She added: 'The validation process involves contacting GP practices to review clinical records to ascertain whether the patient has received treatment or still requires treatment, their correct waiting time and to agree the most appropriate course of action. We are seeking to validate around 900 patient records of this type. To date, our investigations have found no suggestion that any delay in treatment has caused a patient to come to serious harm.'

Dr Michelle Drage, chief executive of Londonwide LMCs, told Pulse: 'It is of huge significance. We're still trying to unravel the implications. Our concern is clearly for patients.

'Until we have absolutely got our heads round it, we are recommending practices help identify those patients. However, a system should be in place for both the commissioners and the providers to have done that. Questions need to be asked.'

@garethiacobucci

changing GP referrals

pitals falling from 95% in 2003-6 to 75% in 2008/9.

The study will come as welcome news to the Government, after Pulse revealed in March that the Department of Health was investigating a sharp fall in Choose and Book use from 57% two years ago to around 50% in January 2012.

Dr Peter Bailey, a GP in Great Cambourne, Cambridgeshire, said: 'You can tell GP recommendation is really important to patients.

'They'll ask "What do you think doctor?" and the confidence with which the GP points to one hospital rather than another makes a big difference.'

How one practice cut direct back pain referrals to zero
▶ page 39

US trial stopped after finding threefold increase in mortality – raising questions over role of self-care in QIPP

SELF-CARE

Self-care linked to death spike

By Gareth Iacobucci

Moves to enshrine self-care as a central part of the NHS efficiency drive have suffered a serious blow after a US trial in COPD had to be halted early because of a spike in mortality in patients encouraged to manage their own condition.

Researchers found almost three times as many patients with COPD died in a group receiving an education programme and an action plan for identifying and treating exacerbations as among those receiving standard primary care.

Self-care has been identified by the Government's QIPP efficiency programme as one part of a three-step approach to driving down hospital admissions, which is being rolled out to CCGs covering 30 million patients.

But the authors of the new study, published online by respected US journal *Annals of Internal Medicine*, warned the results suggested self-care would not be suitable for all COPD patients. A leading GP commissioner who has led a programme of integrated care for COPD said it was key patients encouraged to self-care had a 'safety net'.

The study randomised 426 COPD patients to a 'comprehensive care programme' – including four individual educational sessions, one group session and an action plan for identification and treatment of exacerbations – or guideline-based primary care. Patients were over 40 years old and had been hospitalised for COPD during the previous 12 months, but had had no exacerbation in the previous four weeks.

Dr Joe McGilligan: patients need a safety net of professionals

There were 38 deaths from all causes in the self-care group, compared with 10 in controls. Ten deaths were ascribed to COPD, compared with three in controls – a 3.6-fold increase in risk. The self-care group was also 13% more likely to be hospitalised than controls.

Study leader Dr Vincent Fan, lecturer in critical care medicine at the University of Minnesota, said: 'Whatever the reasons for the high mortality, our findings suggest self-management may not be appropriate for all subsets of patients with COPD.'

Dr Joe McGilligan, a GP in Redhill, Surrey, and chair of ESyDoc CCG, was shortlisted for an NAPC Vision Award last year for a COPD integrated care programme.

He told *Pulse*: '[Schemes] need to be set up so patients have the safety net of professionals when they need it. It's about knowing who to call and when.'

Sir John Oldham, national clinical lead for QIPP at the Department of Health, said there was 'substantial' evidence that self-care done well was effective: 'Their intervention increased self-efficacy, but not knowledge. It was therefore bound to fail. You can't short-cut self-management, but done properly it works.'

@garethiacobucci

Increased risk

180%
Increase in deaths in intervention group (28) compared with usual care group (10)

13%
Increase in hospitalisation in intervention group

Source: *Ann Intern Med* 2012, online 15 May

PERFORMERS LISTS

Plan to scrap local lists

The NHS Commissioning Board is drawing up plans for a national performers list, in a move that could scupper 'local doctor only' policies developed by trusts to prevent a repeat of the Daniel Ubani case.

The Department of Health will consult on changes to the regulations around the performers lists in the summer, so doctors on one national list can work anywhere in the country from April next year.

A *Pulse* investigation last year found PCTs were bringing in new rules restricting out-of-hours work to GPs on local performers lists.

But a DH spokesperson said: 'The responsibility to maintain a national medical performers list, which ensures patients are protected from unsuitable or inefficient doctors, will sit with the NHS Commissioning Board from April 2013.'

Dr Stuart Gray, a GP in Kidderminster and son of the patient unlawfully killed by Dr Ubani, said: 'If they are going to scrap everything at a local level that would be a bad thing. Every locality is different, so you do need to be able to tweak it locally.'

But Dr Shane Gordon, a GP in Tiptree, Essex, and chief executive of North East Essex CCG, said a national performers list was a 'sensible' idea.

RISK REGISTER

Lansley stops publication

Health secretary Andrew Lansley has used his 'ministerial veto' to block the publication of the Department of Health risk register that outlines the possible threats from his controversial NHS reforms.

The move came after the Government earlier this year lost an appeal against the Information Commissioner's ruling that the register should be published.

Mr Lansley said he would use the ministerial veto rather than appeal the Commissioner's ruling as there was a 'fundamental disagreement' on where the public interest lay.

But the Government did publish a summary of how it has mitigated the risks in a draft of the risk register, leaked in March to health writer Roy Lilley.

Mr Lansley said: 'This is not a step I have taken lightly. I am a firm believer in greater transparency and this Government has done more than our predecessors in publishing information about the performance and results of our policies. But there needs to be a safe space where officials are able to give ministers full and frank advice in developing policies and programmes.'

Labour MP John Healey, who asked for release of the risk register when shadow health secretary in 2010, said the move was 'a desperate act', and 'there must be some very big risks for ministers to override the law.'

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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 localised infection involving the nasal mucosa. Patients who have experienced recent nasal surgery or trauma should not use a nasal corticosteroid until healing has occurred. **Precautions and Warnings:** Use with caution, if at all, in patients with active or quiescent tuberculous infections of the respiratory tract, or in untreated fungal, bacterial, systemic viral infections or ocular herpes simplex. There was no evidence of atrophy of the nasal mucosa following 12 months of treatment. Patients using Nasonex over several months or longer should be examined periodically for changes in the nasal mucosa. If localised fungal infection of the nose or pharynx develops, discontinuance of Nasonex therapy or appropriate treatment may be required. Persistence of nasopharyngeal irritation may be an indication for discontinuing Nasonex. The concomitant use of additional therapy may provide additional relief particularly of ocular symptoms. There is no evidence of HPA axis suppression following prolonged treatment with Nasonex. Patients who are transferred from long-term administration of systemically active corticosteroids to Nasonex require careful attention. The safety and efficacy of Nasonex has not been studied for use in the treatment of unilateral polyps, polyps associated with cystic fibrosis, or polyps that completely obstruct the nasal cavities. Unilateral polyps that are unusual or irregular in appearance, especially if ulcerating or bleeding, should be further evaluated. Patients who are potentially immunosuppressed should be warned of the risk of exposure to certain infections. Very rarely, nasal septum perforation or increased intraocular pressure have been reported following the use of intranasal corticosteroids. 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 loratadine. No interactions were observed. **Side Effects:** Adverse effects commonly reported in clinical trials in adult and adolescent patients include headache, epistaxis, pharyngitis, nasal burning, nasal irritation and nasal ulceration. Other less common and rarely reported side effects are listed in the SPC. **Package Quantities:** 18g per bottle, supplied with a metered-dose manual spray pump actuator which delivers 50 micrograms per actuation. **NHS Price:** £7.68 **Legal Category:** Prescription Only Medicine. **Marketing Authorisation Number:** PL 00025/0587 **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, HPA/BPR RDTA, November 2010 - October 2011

05-14 NSP-102782-0002

Date of preparation: February 2012

NICE guidance review to look at 'more accurate' eGFR calculation

CKD

Switching equation would cut CKD by 30%

By David Swan

A switch to a 'more accurate' equation to work out eGFR would reclassify the kidney function of a quarter of the general population, conclude researchers.

The study found the Chronic Kidney Disease Epidemiology Collaboration (CKD-EPI) equation reduced the prevalence of CKD stages 3-5 from 8.7% to 6.3%, 28% lower than the current guideline-recommended equation.

NICE guidance recommends the Modification of Diet in Renal Disease Study (MDRD) equation for estimating glomerular filtration rate (GFR), but the new study found the CKD-EPI calculation was more accurate at predicting the risk of death or end-stage renal disease. The Department of Health's kidney tsar said the debate over formula was in the scope of NICE's ongoing update of CKD guidelines, although he warned the study did not include an assessment of adding in proteinuria on patient outcomes.

A new eGFR calculation could reduce the number with CKD

Percentage of patients reclassified using the CKD-EPI equation

	Lower stage (%)	Higher stage (%)
General population	24.4	0.6
High-risk patients	15.4	1.2
CKD patients	6.6	3.2

Source: JAMA 2012;307:1941-51

US researchers conducted a meta-analysis of 1.1 million patients from 45 study cohorts, and calculated the risk of all-cause mortality, cardiovascular mortality and end-stage renal disease for different levels of eGFR.

In the general population, the CKD-EPI equation reclassified 24.4% of participants to a lower CKD stage and 0.6% to a higher stage, compared with calculations with the MDRD equation. Most reclassifications occurred in patients with CKD stages 1-3, but among patients at high risk of CKD or cardiovascular disease, 15.4% were reclassified to a lower CKD stage and 1.2% were reclassified to a higher CKD stage.

When just individuals diagnosed with CKD were looked at, 300 reclassification rates were lower, with 6.6% moved to a lower stage and 3.2% moved to a higher stage of disease with the CKD-EPI equation. The reclassification by the CKD-EPI equation significantly improved the prediction of patients' outcomes.

Study leader Dr Josef Coresh, professor of epidemiology at the

COMMON COLD

Zinc shortens cold symptoms in adults

Zinc supplements shorten the duration of cold symptoms in adults but not children, according to a meta-analysis of current evidence.

Researchers in Canada analysed 17 randomised trials involving 2,121 patients and comparing oral zinc treatment with placebo or no intervention.

They found in all age groups zinc significantly reduced the duration of cold symptoms by 1.65 days, compared with placebo or no intervention, and that the evidence was of 'moderate quality'.

In adults, zinc reduced cold symptoms by an average of 2.63 days compared with placebo or no intervention, but in children the average was only 0.26 days – a non-significant difference.

Study leader Dr Michelle Science, lecturer in infectious diseases at McMaster University, Canada, said: 'We found moderate quality of evidence to suggest orally administered zinc reduces the duration of symptoms.'

***CMAJ* 2012, online 7 May**

CONTRACEPTION

IUDs 'highly effective' emergency birth control

Intrauterine devices are a 'highly effective' method of emergency contraception, concludes an analysis of recent evidence by a group of international researchers.

They looked at 42 studies involving 7,034 women that analysed the effectiveness of IUDs provided as emergency contraception in preventing pregnancies. They found the pregnancy rate – excluding one outlier study – was 0.09% with IUDs fitted within two to 10 or more days. The majority of insertions (74% of studies) occurred within five days of intercourse. After post-coital IUD insertion there were 10 pregnancies, resulting in an overall failure rate of 0.14%.

Study leader Professor James Trussell, professor of economics and public affairs at Princeton University and visiting professor at the Hull York Medical School, said: 'IUDs are a highly effective method of contraception after unprotected intercourse.'

***Hum Reprod* 2012, online 8 May**

BREASTFEEDING

Weight gain higher with expressed than breast

Breast-fed babies gain less weight than those fed by bottle with either formula or expressed milk, conclude US researchers.

Their study investigated 1,900 infants born after 35 weeks' gestation with a birth weight of at least 2.25kg. Mothers reported their feeding patterns and infants' weight gain at three, five, seven and 12 months.

Babies fed mostly by bottle gained 71g and 89g per month more with human and non-human milk, respectively, compared with those fed by breast.

Study leader Dr RuoWei Li, medical epidemiologist at the Centers for Disease Control and Prevention in Atlanta, said breast milk should be first choice to prevent future obesity in children, adding: 'Regardless of milk type, bottle feeding might be distinct from breastfeeding in its effect on infant weight gain. Breast needs to be first choice.'

***Arch Pediatr Adolesc Med* 2012; 166:431-6**

CPD TIP OF THE WEEK

Use baseline T-score to decide osteoporosis testing frequency

The baseline T-score is the most important determinant of the frequency with which you test bone mineral density (BMD) in patients at risk of fractures, according to a case-based learning module. Researchers looked at 5,000 women aged 65 or over with no history of fracture or osteoporosis. All participants underwent BMD testing and were then grouped according to T-score. Less than 1% of women with normal BMD and 5% with mild osteopaenia went on to develop osteoporosis. The authors recommend GPs should scan women with normal baseline BMD every 15 years, and those with moderate osteopaenia every five years.

CASE-BASED LEARNING
See the Hot topics in osteoporosis module at pulse-learning.co.uk

Welch Centre in Maryland, said: 'Given more accurate GFR estimation, lower CKD prevalence estimates and better risk categorisation by the CKD-EPI equation without additional laboratory costs, its implementation could contribute to more efficient prevention and management.'

Dr Donal O'Donoghue, clinical director of renal medicine at Hope Hospital in Salford and national clinical director for kidney care at the DH, said: 'I'm pleased that NICE has it within the scope of its review for the CKD guideline. What's perhaps not apparent in the paper is the important role of proteinuria in both helping to confirm CKD when the eGFR is close to 60 and its role as an independent and amenable risk factor for CVD and progressive CKD.'

Professor Mike Kirby, professor of health and human sciences at the University of Hertfordshire and a GP in Letchworth, said: "This looks like good data from a large cohort and I think it will change practice. To continue to use the MDRD equation would be inappropriate.'

JAMA 2012;307:1941-51

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GPs told to look for COPD in over-35s

By Nigel Praities

GPs will be tasked with going through their records to find anyone aged over 35 who may have COPD, under Government guidance issued to CCG leaders.

The guidance is designed to identify two million patients who remain undiagnosed with COPD, and urges GPs to go through their records to find anyone who has presented with symptoms such as exertional breathlessness or chronic cough.

It also reveals the Department of Health is trialling the use of 'microspirometry' and peak flow testing in GP practices to see if they should be rolled out to better identify patients with the disease, although GPs have warned spirometry would still be needed to confirm diagnosis.

The document is designed to support CCG targets under last year's *Outcomes Strategy for COPD and Asthma*, which the DH claimed would help save 7,800 lives a year.

Several other DH documents have recommended COPD case finding in primary care, but this is the first initiative to be rolled out to CCGs, and COPD targets are likely to be backed with financial incentives once details have been agreed of the planned quality premium.

The list of targets for CCGs includes reducing premature mortality and improving quality of life for COPD patients through a 'proactive approach' to early identification of disease.

The guidance said: 'NICE recommends COPD should be considered in people over 35 who have a risk factor (generally smoking) and present with exertional breathlessness, chronic cough, regular sputum production, frequent winter "bronchitis" or wheeze.

'Targeted case finding can be done through auditing GP registers to identify people whose treatment history and symptoms suggest COPD may have been missed or that COPD has been incorrectly diagnosed.'

The guidance said any initiative to address COPD under-diagnosis should not increase COPD misdiagnoses, and that the DH is trialling case-finding tools in practices in York and Hull, with a view to a wider rollout.

Health minister Simon Burns said: 'We're encouraging GPs to look for patients who are at risk and make sure they're properly tested and diagnosed.'

Dr Kevin Gruffydd-Jones, a GP in Box, Wiltshire, and member of the education committee of the Primary Care Respiratory Society, said it was 'refreshing' the Government was testing new techniques before rolling them out.

He added: 'There is good evidence that hand-held spirometers are a useful initial screening tool, but they are no substitute for quality-assured diagnostic spirometry to make the actual diagnosis.'

@nigelpraities

There are up to two million patients with undiagnosed COPD

ANTIBIOTICS

Probiotics 'prevent diarrhoea'

Probiotics are an effective therapy for treating and preventing antibiotic-associated diarrhoea, says a new meta-analysis.

The US study included 63 trials that compared probiotic use as adjunct to antibiotic treatment with a control group receiving no treatment, placebo or a different probiotic or probiotic dose. Patients taking probiotics were 42% less likely to develop diarrhoea than patients not taking probiotics.

When restricting the analysis to trials explicitly aimed at preventing or treating antibiotic-associated diarrhoea, patients taking probiotics were again 42% less likely to develop it than those not taking the probiotics.

Trials that reported incidence of antibiotic-associated diarrhoea after stopping antibiotics found the probiotic groups were 56% less likely to experience diarrhoea after treatment than controls.

Study leader Dr Susanne Hempel, a researcher at RAND Health in California, said: 'Our review found sufficient evidence to conclude that adjunct probiotic administration is associated with a reduced risk of antibiotic-associated diarrhoea.'

JAMA 2012;307:1959-69

Patients get GPES opt-out

Patients will be given the right to stop identifiable data being extracted from GP records under proposed changes to a Government scheme to create a central NHS patient data service.

Under the proposal, patients will be able to refuse having certain types of identifiable data uploaded using the GP Extraction Service, even if practices give their consent to do so.

GPES will replace the current reporting system for QOF from April 2013, with data also planned to be used for secondary purposes, such as research.

An NHS Information Governance Board paper, seen by Pulse, admits large-scale opt-outs could 'damage' the scheme, but promises to reinforce patient trust if this happens.

The document says: 'This is to articulate the intentions to enable patients to opt out of certain types of disclosures of patient-identifiable data from their general practice records.'

Dr Neil Bhatia, a GP in Yateley, Hampshire, who obtained the paper under a Freedom of Information Act request, said the Government should launch an information campaign to prevent 'degradation in confidence' between GPs and patients: 'It will be down to GP practices to make it clear their information is going to be used in more ways than just to look after their care.'

Bid to slash drugs threshold to £13,000

The NICE threshold above which drugs are considered too expensive for the NHS could be lowered to £13,000 for some diseases, academics have suggested.

Researchers at the University of York are looking into whether the threshold of around £30,000 per quality-adjusted life year (QALY) should be revised for certain diseases.

Preliminary results presented to ministers last year found the cost per QALY for cancer, circulation, respiratory and gastrointestinal problems was £12,824, suggesting drugs costing more should be rejected.

Cost per QALY for seven other diseases including neurological problems and infectious diseases was around £23,924 per QALY.

The move would have meant that drugs such as dabigatran and insulin glargine would never have been approved for NHS use.

Study leader Professor Karl Claxton, professor of economics at the University of York, told the *Financial Times*: 'Manufacturers with a patented drug have an incentive to price right up to whatever threshold is in place.'

Stephen Whitehead, chief executive of the ABPI, said: 'The current threshold should be increased, not slashed, so that the UK can improve levels of medicines uptake.'

Key questions: peripheral arterial disease
▶ page 20

CQC 'will require patient groups'

GPC's wide-ranging guidance on CQC regulations warns practices will need a patient participation group

By Gareth Iacobucci

All GP practices will be required to have a patient participation group in order to comply with CQC registration standards, the GPC has warned.

The CQC requirement raises the possibility that ministers could withdraw payment for the patient participation DES, which Pulse reported last year had left some practices 'confused and overburdened'.

New GPC guidance on how GPs should gear up for CQC registration next April lists a 'patient participation scheme' as one of several requirements to ensure that a practice is 'likely to be compliant'.

The guidance, *CQC registration – what you need to know*, advises practices on how to prepare for the 16 essential standards practices will need to comply with.

It warns practices must offer newly registered patients a health check with a healthcare assistant, practice nurse or a GP 'within six months of registration', and provide a consultation on request for 'any registered patients aged 16 to 75 who have not attended a consultation in three years'.

The guidance also advises GP principals to put themselves forward as the 'registered managers' legally responsible for their practice's CQC compliance, saying they should not leave the role to practice managers or administrators because of the scale of the responsibility involved.

On premises standards, an area where the GPC has warned many surgeries may not be compliant, practices are advised to carry out a health and safety risk assessment of their buildings, and ensure premises meet contractual requirements and are 'reasonably accessible to all patients' under the terms of the Equality Act 2010.

Dr Laurence Buckman, GPC chair, said: 'We've produced this guidance to help GPs and practice managers through the process, trying to make it as straightforward as possible.

'However, we believe all practices should already be able to fulfil and demonstrate the essential standards through the work they currently do.'

Dr Laurence Buckman: practices should already be demonstrating these standards

One GP in Hereford, who asked not to be named, said: 'I didn't know about the patient participation groups.

'As if I don't have better things to do than write 250 new policies to be compliant with the CQC and pay them for the privilege.'

Dr Paul Spencer, a GP in Telford, Shropshire, said his practice's patient participation group was 'surprisingly working quite well', but he had 'no confidence in the CQC'.

He added: 'We will continue to jump through hoops as and when they present.'

@garethiacobucci

What practices must do

- Have a patient participation scheme
- Offer new patients a health check within six months of registration and provide a consultation for any registered patient aged 16 to 75 who has not attended in three years
- Provide lifestyle information to patients when appropriate
- Discuss referral options with patients
- Have a repeat prescribing policy and medication reviews
- Conduct a health and safety risk assessment of premises
- Ensure premises meet contractual requirements
- Ensure premises are reasonably accessible to all patients and where practicable meet the requirements of the Equality Act 2010
- Appraise all staff on a yearly basis

Source: CQC Registration – what you need to know, GPC

PCTs fail to set up boundary LESs

Managers across the country have yet to finalise agreements to support home visits for commuters registering with practices near their place of work in the Government's boundary removal pilots.

A snapshot survey carried out by Pulse of 20 PCTs in non-pilot areas reveals that none have yet agreed a LES with their LMC to support home visits to commuters in pilot areas. The agreements were supposed to be signed last month to ensure commuters registered in urban areas still had access to urgent care in hours and could have visits from GP practices close to home.

The delay comes after Pulse revealed last week that not one practice had signed up to the scheme in the six pilot sites, although 11 practices have now signed up in Westminster.

Dr Paul Roblin, secretary of Berkshire, Buckinghamshire and Oxfordshire LMCs, said he was close to agreeing a LES that would pay GPs £60 for a home visit and £20 for a consultation.

But he said: 'At the moment, it looks like a big failure because not enough practices are signed up in the pilots.

'We're virtually there. We've agreed a pricing structure, a form, a means of communicating the fact that a consultation has occurred. But we don't know if it has been a lot of work for a tiny number of patients.'

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Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard Adverse events should also be reported to Astellas Pharma Ltd. Tel: 0800 783 5018.

Date of preparation: April 2012
VES12142UKb

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Contra-indications Respiratory depression, head injury, paralytic ileus, acute abdomen, delayed gastric emptying, chronic obstructive airways disease, cor pulmonale, severe bronchial asthma, hypercarbia, known sensitivity to oxycodone or any of the constituents, moderate to severe hepatic impairment, severe renal impairment, chronic constipation, concurrent administration of monoamine oxidase inhibitors or within two weeks of discontinuation of their use, galactose intolerance, lactase deficiency, glucose–galactose malabsorption, any situation where opioids are contraindicated, pre–operative use or use during the first 24 hours post operatively, pregnancy.

Precautions and warnings Hypothyroidism, opioid dependent patients, raised intracranial pressure, hypotension, hypovolaemia, toxic psychosis, diseases of the biliary tract, pancreatitis, inflammatory bowel disorders, prostatic hypertrophy, adrenocortical insufficiency, alcoholism, delirium tremens, chronic renal and hepatic disease, severe pulmonary disease, debilitated patients, elderly and infirm patients, history of alcohol and/or drug abuse. Do not use where there is a possibility of paralytic ileus occurring and if this is suspected or occurs during use discontinue immediately. Patients about to undergo additional pain relieving procedures (e.g. surgery, plexus blockade) should not receive ***OxyContin*** tablets for 12 hours prior to the intervention. ***OxyContin*** 60 mg, 80 mg and 120 mg tablets should not be used in opioid naïve patients. ***OxyContin*** tablets should be used with caution following abdominal surgery, and not used until normal bowel function returns. ***OxyContin*** tablets have a similar abuse profile to other strong opioids. ***OxyContin*** tablets must be swallowed whole and not broken, chewed or crushed which leads to a rapid release and absorption of a potentially fatal dose of oxycodone. Concomitant use of alcohol and ***OxyContin*** tablets may increase the undesirable effects of ***OxyContin*** tablets; concomitant use should be avoided.

Interactions ***OxyContin*** tablets, like other opioids, potentiate the effects of transquilisers, anaesthetics, hypnotics, antidepressants, sedatives, phenothiazines, neuroleptic drugs, other opioids, muscle relaxants and antihypertensives. Monoamine oxidase inhibitors are known to interact with narcotic analgesics, producing CNS excitation or depression with hypertensive or hypotensive crisis. Inhibitors of CYP3A4 or CYP2D6 may inhibit the metabolism of oxycodone. Alcohol may enhance the pharmacodynamic effects of ***OxyContin*** tablets; concomitant use should be avoided.

Pregnancy and lactation Not recommended.

Side effects Common (≥ 1%): constipation, nausea, vomiting, dry mouth, anorexia, dyspepsia, abdominal pain, diarrhoea, headache, confusional state, asthenic conditions, dizziness, sedation, anxiety, abnormal dreams, nervousness, insomnia, thinking abnormal, somnolence, bronchospasm, dyspnoea, cough decreased, rash, pruritus, hyperhidrosis, chills.
Uncommon (≤ 1%): but potentially serious: anaphylactic reaction, anaphylactoid reaction, hypersensitivity, biliary colic, cholestasis, ileus, gastritis, dysphagia, dental caries, hallucinations, depression, dysphoria, affect lability, mood altered, restlessness, agitation, euphoria, disorientation, amnesia, vision abnormal, vertigo, drug tolerance, drug dependence, drug withdrawal syndrome, paraesthesia, speech disorder, convulsions, urinary retention, ureteral spasm, libido decreased, supraventricular tachycardia, hypotension, orthostatic hypotension, respiratory depression, syncope, oedema, oedema peripheral, increased hepatic enzymes, exfoliative dermatitis, urticaria, amenorrhoea, erectile dysfunction. Overdose may produce respiratory depression, pin–point pupils, hypotension and hallucinations. Circulatory failure and somnolence progressing to stupor or deepening coma, skeletal muscle flaccidity, bradycardia and death may occur in more severe cases. The effects of overdosage will be potentiated by the simultaneous ingestion of alcohol or other psychotropic drugs. Please refer to the SmPC for a full list of side effects. Tolerance and dependence may occur. It may be advisable to taper the dose when stopping treatment to prevent withdrawal symptoms.

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Marketing Authorisation number
PL 16950/0097–0100, 0123, 0139–0141, 0150

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Tel: 01223 424444.
Member of the Napp Pharmaceutical Group. For medical information enquiries, please contact medicalinformationuk@napp.co.uk

Date effective January 2012 (UK/OXYC-11026).

Adverse events should be reported. Reporting forms and information can be found at use www.mhra.gov.uk/yellowcard. Adverse events should also be reported to Napp Pharmaceuticals Limited on 01223 424444.

1. Department of Health. Building a safer NHS for patients: Improving medication safety. 2004.
2. Dickman A. Branded prescribing of strong opioids should be adopted as good practice. The Pharmaceutical Journal 2005; 275: 546.
3. Davies ED et al. A prevalence study of errors in opioid prescribing in a large teaching hospital. International Journal of Clinical Practice 2011; 65(9): 923–929.

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Code: UK/OXYC-12001e. Date of preparation: April 2012.

Poorer practices 'need small lists'

Study finds practices in deprived areas are coping with up to twice rate of comorbidity of more affluent

By Nigel Praities

GPs working in deprived areas need smaller caseloads to compensate for their far higher numbers of patients with multiple health problems, primary care experts have said after the publication of a major new study.

UK researchers found people in deprived areas had the same rates of multi-morbidity as more affluent people who were 10 to 15 years older.

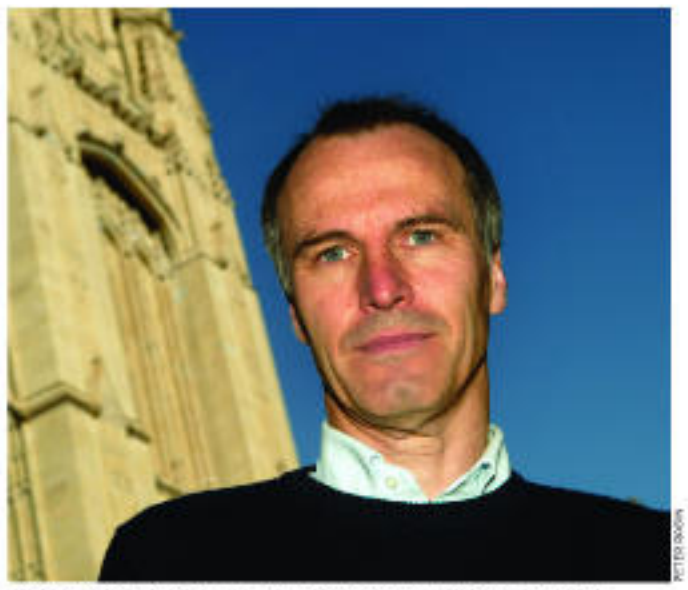
Among patients aged 45 to 55, the rate of comorbidity was twice as high among the most deprived patients as the least deprived, while a quarter of patients across the board had multiple health conditions.

The study, published by *The Lancet* last week, analysed data from 314 GP practices covering 1.7 million registered patients in Scotland – about a third of the country's population.

Half the overall population had at least one illness by the age of 50, and in the 50-54 age group 37% of the most deprived patients had multiple morbidities, compared with 18% of the least deprived. Coronary heart disease, diabetes, COPD and cancer were all more common in deprived areas than more affluent ones, although there was a 'small reverse gradient' for dementia and atrial fibrillation.

Study leader Professor Bruce Guthrie, professor of primary care medicine at the University of Dundee and a GP in the city, said: 'Approaches focusing on patients with only one disease dominate most medical education, clinical research and hospital care, but increasingly need to be complemented by support for generalists, providing continuity and co-ordination for people with multi-morbidity.

'This approach is most needed in socioeconomically deprived areas, where multimorbidity happens earlier, is more common and more frequently includes physical-mental health comorbidity.'



Dr Chris Salisbury: a redesign of general practice is needed

Professor Chris Salisbury, professor of primary healthcare at the University of Bristol and a GP in the city, wrote in an accompanying commentary that a redesign of general practice was needed: 'Doctors working in deprived areas need smaller caseloads because of the increased complexity of patients' needs. Instead of attending several disease-specific clinics, patients should have all of their chronic diseases reviewed in one visit by a clinician with responsibility for co-ordinating their care.'

Scottish health secretary Nicola Sturgeon said the study underlined that effective systems were needed in primary care to tackle health inequalities: 'I look forward to further results coming from the research team, which is assessing a primary care-led approach as a mechanism for improving the quality of life of people with multi-morbidity.'

@nigelpraities

Patients with multi-morbidity

Age group	Least deprived 10th (%)	Most deprived 10th (%)
45-49	13.4	26.8
50-54	18.3	36.8
55-59	26.8	45.4
60-64	34.8	54.2
65-69	46.5	64.1
70-74	58.3	70.6

Source: *Lancet* 2012, online 10 May

Create QOF for alcohol, MPs told

GPs should be incentivised through the QOF to ask all patients about their alcohol intake and have a 'stepped programme' of interventions for problem drinkers, MPs have been told.

The Alcohol Health Alliance – a coalition of 31 medical associations including the RCGP and the BMA – said the Government could save £1.7bn if it invested in better alcohol services and included payment for interventions in the QOF.

The call came after the Government released its alcohol strategy, which proposed a minimum price of 40p per unit of alcohol.

But the alliance said this did not go far enough to tackle alcohol-related health problems, and proposed more money to tackle problem drinking in primary care.

It said: 'NICE states that primary prevention of alcohol-related harm at the primary care level is both effective and cost-effective.

'This should be incentivised through including a measure in the QOF for GPs to record the alcohol intake of their patients and to give brief advice where indicated.'

Its proposal was made last month in a written submission to MPs on the Commons health committee, which is holding an inquiry into the Government's alcohol strategy.

Dr Simon Tickle, a GP in Leeds, said that the recording requirements were 'reasonable', but 'probably don't go far enough'.

IN BRIEF

Don't say 'obesity'

NICE guidelines have advised that GPs should avoid the 'derogatory' term 'obesity' when communicating with the public.

Full story ▶ pulsetoday.co.uk/clinicalnews

Alcohol price set

The Scottish Government has announced a 50p-per-unit minimum price for alcohol, in a bid to curb binge drinking.

Full story ▶ pulsetoday.co.uk/politicalnews

Hospital deaths drop

The number of people dying in hospital has dropped from 58% to 53% in five years, an NHS report reveals.

Full story ▶ pulsetoday.co.uk/clinicalnews

Avoid coding pitfalls in the new QOF
▶ page 35

Dr Kamal Sidhu: hopes quality accounts will be scrapped

GP practice quality accounts shelved

Practices spared costs and workload of accounts for foreseeable future

By Gareth Iacobucci

GPs will not have to publish practice quality accounts for the foreseeable future, after the Government decided to kick the policy into the long grass to prevent a clash with CQC registration.

The Government had planned to require all practices to submit annual reports to be published on NHS Choices, to allow the public to assess the quality of their services.

A Department of Health estimate in 2010 suggested producing the accounts could be extremely costly, with the annual cost to providers for collating patient safety, experience and outcomes data put at between £14,000 and £22,000.

But ministers have now decided to delay the rollout in primary care and make the process voluntary for GPs until further notice, because of the administrative workload already facing practices preparing for CQC registration next April.

This is the second time in as many years that the rollout has been postponed. Quality accounts were originally scheduled to begin in April 2011, but were delayed after a pilot study found wide variation in the quality and format of accounts, and that many GP practices struggled to produce them.

The policy is already a requirement for acute, mental health and ambulance trusts, and learning disability NHS services.

A DH spokesperson said: 'Quality accounts are essential to the improvement of services and modernisation of the NHS, and provide the public with information about the quality of services they should expect to receive.

'We are continuing to evaluate the potential for extending quality accounts to primary care. At the moment we encourage GPs to produce them voluntarily.

What are quality accounts?

- Annual reports on quality of NHS services, published by providers and available to the public
- Proposed in 2008 Darzi review and backed by the coalition
- Intended to encourage providers to assess quality 'with an eye to continuous improvement'
- Cover all providers of acute, mental health, ambulance and learning disability NHS services

Source: Department of Health

'We plan to extend quality account requirements to GPs. But in light of wider changes affecting primary care, such as CQC registration, the timing is under review. CQC registration will provide a foundation for quality improvement that quality accounts can build on.'

Dr Kamal Sidhu, a GP in Peterlee, County Durham, welcomed the announcement: 'I hope the Government will go a step further to scrap this unnecessary idea that only adds another layer of bureaucracy.

'General practice is already burdened with enough paperwork and tick-boxes.'

But Dr Steve Kell, a GP in Worksop, Nottinghamshire, whose practice has been voluntarily piloting quality accounts, said the scheme had benefits.

'We have found it useful in terms of monitoring,' he said.

@garethiacobucci

Stop playing games with the NHS

Richard Hoey
Editor

The Department of Health, under both the current and previous government, has had an Orwellian tendency to dream up names for its policies that bear little relation to their true purpose.

The planned quality premium, for instance, will tie GP pay primarily not to quality but to budgetary control – and is hardly much of a premium, given it is to be funded from the existing primary care budget.

Then there's QIPP, which again adopts the 'quality' tag, throws in innovation and prevention, and leaves only the word 'productivity' to hint at its main purpose of again driving down costs.

But of all the dodgy names for dodgy policies, none is as much of a misnomer as 'payment by results' – the system for determining how much money PCTs, and now CCGs, should pay to hospitals.

Payment by results does not, in fact, pay hospitals by results at all, but by the volume of activity they generate. Attaching cash to each episode of care was supposed to make hospitals compete for the right to treat patients – but instead it has driven them into battle with primary care, and seen them suck activity into the costly acute sector.

Attaching cash to care has driven hospitals into battle with GPs

Payment by results would be a failed policy even if every claim hospitals put in was justified, given it has worked directly against the Government's planned shift of care into the community.

But on top of that, there is now increasing evidence the policy has spawned a cottage industry in gaming of admission codes, to artificially boost hospital payments. The Audit Commission last month warned 'inconsistent treatment descriptions' were 'skewing management decisions and wasting NHS funding'.

It didn't spell out exactly how those inconsistencies were arising, but this week we reveal a group of GPs in Bristol has done just that, with a detailed dossier of dubious hospital claims.

It doesn't make pretty reading – with one patient admitted every day for three months, as part of a systematic classification of outpatient appointments as full admissions.

For GP commissioners, alleged gaming by hospital trusts is a huge issue.

It allows hospital managers to claim thousands of pounds of extra payment per patient, and threatens to leave multimillion-pound black holes in CCG budgets.

And under the quality premium, it will soon be GP practices that ultimately pay the price for those missing millions, because part of their payment is set to be tied to the ability of CCGs to stay within their commissioning budgets.

The Audit Commission released guidance clarifying the codes it said were being misused, and differentiating between day cases, outpatient attendances and full-on admissions.

It's essential the Government polices hospitals against that guidance, and stamps down hard on the kind of practices exposed in Bristol should they be found to be in breach. But this is a problem that goes beyond a few ambiguous codes and the odd over-enthusiastic accountant. Successive governments have sought to turn the NHS from a collaborative public service into a competitive market.

When human beings are asked to compete, they bend or break the rules. It's in the nature of games.

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

An historic opportunity to vote on action

GPs face a once-in-a-generation choice over whether to support industrial action on pensions. BMA chair Dr Hamish Meldrum urges all to have their say

As a profession we must consider whether we take a step we haven't taken since 1975. Most GPs who are BMA members will be receiving their ballot papers in the post this week. It's decision time.

We've arrived here reluctantly, and we would have far preferred to get to a fairer solution through negotiation. But the Government's refusal to consider any rethink of its unfair and unnecessary changes to the NHS Pension Scheme has left us with no alternative. If you have an NHS pension, you have already started paying significantly more than you were up until April, and a lot more than you would if you were a senior civil servant on the same income. If you are under 45, you are probably facing working to at least 68 to get anything like the current deal on retirement.

There are some doctors who believe what the Government is doing is fair, but I believe they are in the minority. The question now is not whether the changes to our pensions are justified, but whether we take industrial action to fight them. We all put our patients before anything else, and clearly this is a very difficult decision for many. However, the model of action we are asking GPs to take has been very carefully thought through to have an impact, while still assuring patient safety. There are three key principles: that doctors attend their workplaces as usual; that all urgent and emergency care continues to be provided, but with non-urgent work postponed; and that we engage in advance planning for this action.

So if action were to go ahead:

- practices would remain open, for the same number of hours they would be usually
- patients considering themselves in need of urgent attention would get it that day
- you would continue to undertake urgent work such as reviewing test results and

Laxido Orange, powder for oral solution: Please refer to the Summary of Product Characteristics (SPC) before prescribing Laxido Orange. **Abbreviated Prescribing Information. Presentation:** Single-dose sachet, each containing a white powder composed of: Macrogol 3350 13.125g, sodium chloride 350.7mg, sodium hydrogen carbonate 178.5mg, and potassium chloride 46.6mg. **Indications:** Treatment of chronic constipation and faecal impaction. **Dosage: Chronic constipation:** A course of treatment for chronic constipation with Laxido Orange does not normally exceed 2 weeks, although this can be repeated if required. Extended use may be necessary in the case of patients with severe chronic or resistant constipation, secondary to multiple sclerosis or Parkinson's Disease, or induced by regular constipating medication in particular opioids and anticholinergics. **Adults, adolescents and the elderly:** 1-3 sachets daily in divided doses, according to individual response. For extended use, the dose can be adjusted down to 1 or 2 sachets daily. **Children below 12 years old:** Not recommended. **Faecal impaction:** A course of treatment for faecal impaction with Laxido Orange does not normally exceed 3 days. **Adults, adolescents and the elderly:** 8 sachets daily, all of which should be consumed within a 6 hour period. **Children below 12 years old:** Not recommended. **Patients with impaired cardiovascular function:** For the treatment of faecal impaction the dose should be divided so that not more than 2 sachets are taken in any one hour. **Administration:** Each sachet should be dissolved in 125 ml water. For use in faecal impaction, 8 sachets may be dissolved in 1 litre of water. The reconstituted solution should be stored covered in a refrigerator (2°C to 8°C), for up to six hours. **Contraindications:** Intestinal obstruction or perforation caused by functional or structural disorder of the gut wall, ileus and in patients with severe inflammatory conditions of the intestinal tract (e.g. ulcerative colitis, Crohn's disease and toxic megacolon). Hypersensitivity to the active substances or any of the excipients. **Warnings and Precautions:** The faecal impaction diagnosis should be confirmed by appropriate physical or radiological examination of the rectum and abdomen. If patients develop any symptoms indicating shifts of fluids/electrolytes, Laxido Orange should be stopped immediately. **Interactions:** There are no known interactions of Laxido Orange with other medicinal products. Alterations to the absorption of certain drugs administered concurrently cannot be excluded. Therefore, other medicines should not be taken orally for one hour before and for one hour after taking Laxido Orange. **Pregnancy and lactation:** There is no experience with the use of Laxido Orange during pregnancy and lactation and so it should not be used unless clearly necessary. **Effects on ability to drive and use machines:** Laxido Orange has no influence on the ability to drive and use machines. **Undesirable effects:** Allergic reactions are possible. Potential gastro-intestinal effects include abdominal distension and pain, borborygmi and nausea. Mild diarrhoea may also occur, but normally resolves after dose reduction. **Overdose:** Refer to SPC. **Legal Category:** P. **Pack Size:** Cartons of 20 or 30 sachets. **NHS Price:** 20 sachets: £3.56; 30 sachets: £5.34. **MA Number:** PL 21500/0067. **MA Holder:** Galen Limited, Seagoe Industrial Estate, Craigavon, BT63 5UA, UK. **Full prescribing information available from:** Galen Limited, Seagoe Industrial Estate, Craigavon, BT63 5UA, United Kingdom. **Date of Preparation:** April 2010.

Fixtrex 20mg tablets Prescribing Information Please refer to the Summary of Product Characteristics (SPC) before prescribing Fixtrex 20mg tablets. **Presentation:** Round, white, film-coated tablets each containing 20mg trospium chloride. **Indications:** Symptomatic treatment of urge incontinence and/or increased urinary frequency and urgency as may occur in patients with overactive bladder (e.g. idiopathic or neurologic detrusor overactivity). **Dosage: Adults:** 20mg twice daily, except in patients with severe renal impairment where 20mg once daily or every second day is recommended. Tablets should be swallowed whole with a glass of water before meals on an empty stomach. Review treatment at intervals of 3-6 months. **Children under 12 years:** Not recommended. **Contra-indications:** Urinary retention, severe gastro-intestinal conditions including toxic megacolon, myasthenia gravis, narrow-angle glaucoma, tachyarrhythmia and hypersensitivity to trospium chloride or any of the excipients. **Warnings and Precautions:** Gastro-intestinal obstructive conditions, urinary flow obstruction with risk of urinary retention, autonomic neuropathy, hiatus hernia, reflux oesophagitis, those in whom fast heart rates are undesirable (e.g. in hyperthyroidism, coronary artery disease, and congestive heart failure), renal impairment. Caution should also be exercised in patients with mild to moderate hepatic impairment. Use of Fixtrex 20mg tablets in cases of severe hepatic impairment is not recommended. Organic causes of frequency, urgency and urge incontinence should be considered before beginning treatment. Fixtrex 20mg tablets contain lactose; patients with rare hereditary problems of galactose intolerance, Lapp lactase deficiency or glucose-galactose malabsorption should not take this product. **Interactions:** Potentiation of the therapeutic effect of other drugs that possess anticholinergic properties; enhancement of the tachycardic action of S-sympathomimetics; decrease in the efficacy of pro-kinetic agents. Alterations to the absorption of drugs administered concurrently cannot be excluded. Medications containing guar, colestyramine and colestipol may inhibit the absorption of Fixtrex 20mg tablets, so simultaneous administration is not recommended. Metabolic drug interactions are not expected with Fixtrex 20mg tablets. **Pregnancy and lactation:** Caution should be exercised with the use of Fixtrex 20mg tablets during pregnancy and lactation. **Effects on ability to drive and use machines:** Ability to operate a motor vehicle or machinery may be impaired by disturbance of visual accommodation. **Side effects: Very common (> 10%):** dry mouth; **common (> 1%):** dyspepsia, constipation, abdominal pain, nausea; **uncommon (< 1%):** flatulence, diarrhoea; **rare (< 0.1%):** micturition disorders, urinary retention, tachycardia, disorders of accommodation, dyspnoea, rash, asthenia, chest pain; **very rare (< 0.01%):** tachyarrhythmia, myalgia, arthralgia, angioedema, mild to moderate increase in serum transaminase levels, anaphylaxis, headache, dizziness. **Overdose:** Please refer to SPC. **Basic NHS cost:** £18.20. **Legal classification:** POM. **Marketing Authorisation Holder:** Galen Limited, Seagoe Industrial Estate, Craigavon, Northern Ireland, BT63 5UA. **Marketing Authorisation Number:** PL 27827/0025. **Full prescribing information available from:** Galen Limited, Seagoe Industrial Estate, Craigavon, Northern Ireland, BT63 5UA. **Date of Preparation:** August 2009.

Calceos® Chewable Tablets Prescribing Information Please refer to the summary of Product Characteristics (SPC) before prescribing Calceos®. **Presentation:** Chewable tablets containing calcium carbonate 1250mg (i.e. 500mg of elemental calcium) and colecalciferol 10 micrograms (corresponding to 400 IU of vitamin D_3) for oral use. **Indications:** Correction of vitamin D and calcium deficiency in the elderly. Vitamin and calcium supplement as an adjunct to specific therapy for osteoporosis. **Dosage:** *Adults:* One tablet to be chewed and taken with a glass of water, twice per day. *Children:* Not recommended. **Contra-indications:** Calceos® is contra-indicated in patients with hypercalcaemia, hypercalciuria, calcium lithiasis, tissue calcification, vitamin D overdose, myeloma and bone metastases, renal insufficiency and hypersensitivity to any of the ingredients. This product contains partially hydrogenated soybean oil. Patients should not take this medicinal product if they are allergic to peanut or soya. **Warnings and Precautions:** Care should be taken with use of other medication containing vitamin D. Renal function, plasma calcium and urinary calcium levels should be monitored, especially in the elderly, in patients with renal failure or in cases of long-term treatment. This product contains sorbitol (E420) and sucrose. Patients with rare hereditary problems of fructose intolerance, glucose-galactose malabsorption or sucrase-isomaltase insufficiency should not take this medicine. The sucrose in this product may be harmful to teeth if taken chronically e.g. for two weeks or more. **Interactions:** Caution should be exercised when combining Calceos® with digitalis glycosides and thiazide diuretics. Calcium may impair the absorption of tetracyclines, etidronate, fluoride and iron and therefore allow at least 3 hours between Calceos® and these agents. Possible interaction with some foods, refer to SPC for more details. **Pregnancy and lactation:** Calceos® may be prescribed during pregnancy and in nursing mothers but should be given at least 3 hours before or after any iron supplementation. Calcium is excreted in breast milk but not sufficiently to produce an adverse effect in the infant. **Effects on ability to drive and use machines:** None known. **Side effects:** Nausea, hypercalciuria, hyperphosphataemia, hypercalcaemia and mild gastro-intestinal disturbances such as constipation. **Overdose:** Please refer to SPC. **Basic NHS cost:** Packs containing 4 tubes of 15 tablets £3.08. **Legal classification:** P. **Marketing Authorisation Holder:** Laboratoire Innotech International, 22 avenue Aristide Briand, 94110 Arcueil, France. **Marketing Authorisation Number:** PL 10152/0001. **Full prescribing information available from:** Galen Limited, Seagoe Industrial Estate, Craigavon, Northern Ireland, BT63 5UA. **Date of Preparation:** December 2011.

Reference: 1. Data on file, Galen Limited.

PWR-MAR-2012-0181
Date of preparation: March 2012

This advertisement is intended for healthcare professionals only

GALEN

Adverse events should be reported. Reporting forms and information can be found at www.yellowcard.gov.uk. Adverse events should also be reported to Galen Limited on 028 3833 4974 and select the customer services option, or email info@galen.co.uk. Medical information enquiries should also be directed to Galen Limited.

acting on abnormal results, and dealing with urgent prescription requests.

However:

- you would not handle routine appointments
- pre-booked appointments would be cancelled in advance
- you would not undertake non-urgent routine work.

The BMA will provide advice and support, but there would necessarily be some local flexibility. Each practice would need to decide how it would operate, discuss its plans with its primary care organisation, and ensure that the arrangements were well publicised to patients. GP partners would need to act reasonably in terms of what they ask staff to do on the day of action, but steps such as asking reception staff to operate a different system for booking appointments would not be unreasonable. Regardless of the practice's stance, we would urge all GPs to support colleagues who choose to participate.

Clearly, the action we are proposing does not constitute a full withdrawal of labour, and it's not strike action as the term would normally be understood. But the ballot paper contains two questions – one asking if you are prepared to take part in industrial action short of a strike, and one asking if you are prepared to participate in a strike. You should vote Yes to both questions if you want to give us a mandate to go ahead with the action.

Completed ballot papers must be received by post by the Independent Scrutineer, Electoral Reform Services Ltd, by 5pm on Tuesday 29 May. We need as high a turnout as possible, and I can't emphasise enough how important it is that you vote, and help us get the vote out by talking to colleagues. This is a critical moment for our profession – it's too important for you not to have your say.

Dr Hamish Meldrum is chair of BMA Council

SUPPORT OUR PENSION CAMPAIGN

Say No to 30%

For the next stage in Pulse's campaign against the Government's pension changes we've adopted a slogan coined by GPs on our website – *Say No to 30%* – to highlight the astonishing proportion of pay some GPs will lose in employee and employer contributions.

Many GPs feel the plans will hit young GPs disproportionately, perhaps even putting future medics off choosing the profession. Others worry about the clinical risks of working until 68. What are your concerns about the Government's plans to hike GP pension contributions? You can add your name to the campaign by emailing editor@pulsetoday.co.uk or visiting pulsetoday.co.uk/saynoto30.

Dr Alison Vickers This increase in contributions makes me so angry. I resent that I can't wait to retire from a job I always loved.

Dr Stephen Harris With added years to be able to retire at 60 it's 37.5%, not 30%, so I support this protest completely.

Dr Colin Durnin The pension changes are a sop that the Government is throwing to the credit agencies.

Join our campaign

For more information and to sign up, go to pulsetoday.co.uk/saynoto30

Whiplash: a shameful fiction

Most whiplash claims are a fabrication to keep solicitors – and compliant GPs – in business, **Phil** fumes

Despite the fact that I have never crashed a car or made an insurance claim in 30 years of driving, I am informed that my premium is going up again this year, by a further 20%.

From an initial annual premium of £80 or so – mind you, £80 *was* £80 in those days – they now want £400-odd, and I realise I am getting the better end of the deal here. Should my son ever get off his pampered arse and apply for a licence, it would cost him (or rather me) upwards of £3,000 for the privilege of having him drive my car around Sunderland with his mates mooning out of the windows. I think I'll just keep paying for his taxis.

The roads have never been safer. It's probably all those bloody speed bumps. In only the last five years, road traffic accidents have decreased by 23%. But for some reason insurance claims have increased by 70% in the same period. We know what that reason is, and it goes by the weasel name of 'whiplash'.

Never since the days of Sigmund Freud has so much utter rubbish been draped in the cloak of medical respectability. Let's get this out of the way right now; whiplash injuries are almost all shameful fiction, and our profession is complicit in perpetrating a load of expensive, fraudulent toss.

My own practice was once approached by a firm of solicitors to assess road traffic accident claims privately. They offered £200 per report, a tidy sum. We needed the money, so we said okay, and they sent three 'victims'.

I did the reports myself. We had two-hour slots and I took their history and made a more than usually careful examination. All three patients had something in common: there wasn't much wrong with them at all. I said as much in my reports. The solicitors then decided not to put any more business our way.

My conclusion from this is logically inescapable. Doctors who do whiplash reports regularly are all bent. This needs saying.

The last time my wife crashed our car (an intermittent hobby of hers, bless her, but not on this occasion her fault) we were each sent unsolicited cheques for £300 by the insurance company, on the condition that we wouldn't pursue whiplash claims. We hadn't even suggested we might. Such is the insurance companies' fear of the whiplash monster.

Doctors who do whiplash reports regularly are bent

Currently, to all accounts, organised gangs are packing buses with stooges and ramming them with stolen cars, instantly producing dozens of whiplash victims, whose terrible suffering is being compensated by you and me via our insurance premiums. I'm frankly not happy about this at all.

There is a book called *Whiplash and Other Useful Illnesses* by Andrew Malleson. It documents the insane alliance between the personal injury compensation industry and those of us in the medical profession with a financial interest in perpetuating fictional maladies. It should be required reading for both doctors and our transport secretary Justine Greening, whose Whitehall summit is charged with putting some sort of limit on this shite.

In Australia, after a tsunami of claims for so-called repetitive strain injury, the government put a limit of $150 on any compensation deal. Oddly enough, the malady disappeared overnight. A similar approach here to whiplash injuries would result in about £90 off your car insurance premium, and maybe a slight increase in paracetamol consumption. Personally, I'll chip in for the paracetamol. But not for anything else.

Dr Phil Peverley is a GP in Sunderland

MargaretMcCartney

Shining a light on self-test kits

A big, pink 'Breastlight' is one of a number of private tests being marketed to an unsuspecting public, **Margaret** warns

A couple of years ago, I was in Boots the chemist – the high-street store that also offers NHS stop-smoking and sexual health services. It had a prominent advert on the pharmacy counter. It was big and pink, and it was for 'Breastlight' – effectively, a red torch that women were being encouraged to shine into their breasts. To use their own description, it's 'a new health and wellbeing product for women that helps women notice any changes in their breasts over time,' via use of a 'harmless red light' which will apparently mean you can 'get to know what's normal for you, spot any changes and hopefully feel more confident that you're looking after your body the way you'd like to'.

And I was thoroughly annoyed, what with it costing almost £90, and the company's website claiming that its device could 'help detect cancer early'.

This was and is incorrect. There have been several trials done of the Breastlight device, none of which examined the accuracy of it in asymptomatic women. Its website says that it has been 'tested on over 1,200 women'. It has indeed been trialled, in women who have breast lumps and other symptoms. In one trial it showed a shadow in 12 out of 18 cancers proven by biopsy, meaning a third were missed. Just after I complained to the Advertising Standards Authority about them, the company that marketed Breastlight – PWB Health – went into liquidation. But Breastlight is now back on high-street shelves under new owners. The phrase 'helps detect cancer early' does not appear on the new company's website, but it persists in saying 'for earlier detection'. Of what? Why?

Breastlight says that women with larger breasts 'reported that Breastlight gave them more confidence' – but what's the point of more confidence if it's misplaced? The Breastlight website says that the light used in the torch is 'harmless', but this rather misses the point. What about false positives and false negatives? What about the further harms of, for example, a young woman who finds what seem to be changes or abnormalities in her breasts – what then?

Fears are played upon – and we already know women overestimate their risks of getting breast cancer and underestimate their chances of being successfully treated for it. The NHS is left to sort out the guddle, and so is the taxpayer – the original company got £1.1m from the Scottish Enterprise Co-Investment Fund in 2007, which I understand was lost in the subsequent liquidation. How can it have been right to invest money in a product that had no proven benefit in the population it was being marketed at?

But the real issue is about how we can protect people against potentially harmful and unhelpful health products, and the lack of effective regulation surrounding devices like Breastlight. The ASA acts in these circumstances in retrospect, and can take weeks or months to make a decision. Trading Standards usually passes medical devices to the MHRA, which tells me it is still investigating. And women are offered the idea that technology might offer better odds than what we know can modify risks for breast cancer – attention to weight and alcohol, probably exercise, and breastfeeding. We need better ways to get better healthcare information about evidence to the public.

Dr Margaret McCartney is a GP in Glasgow

Breastlight's reply

PWB Health UK, the new company which markets Breastlight, released the following statement to Pulse: 'The Breastlight is sold as an aid to breast awareness/self-examination. Women are encouraged to use the Breastlight as an additional part of their regular breast awareness routine where women should regularly look for changes in the appearance and texture of their breasts. If they see or feel any changes, women are encouraged to report the changes to their GP.'

ILLUSTRATIONS: DAN YULL

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JANUVIA can be used as monotherapy in patients contra-indicated to or intolerant of metformin when diet and exercise does not provide adequate glycaemic control; or added on to metformin, a glitazone, a sulphonylurea, a stable dose of insulin (with or without metformin), metformin + a sulphonylurea, or metformin + a glitazone, when the current regimen plus diet and exercise does not provide adequate glycaemic control.

Once-daily Januvia® (sitagliptin)

MSD

Prescribing Information can be found overleaf

It is consultants, not GPs, who overuse lab tests

From Dr Tom Craig
Co. Tyrone

I had been expecting to read this story, about the Government's plans to cut the cost of pathology services, for some time ('GPs to be ranked on lab test use', pulsetoday.co.uk/news).

Is high lab testing due to an over-investigating GP and low activity to the conscientious one, or vice versa? This should be easy for trusts to monitor.

To avoid extra lab work, why can't the hospital send GPs the results of tests that are done by them?

It has been my experience that it is hospital doctors, rather than GPs, who tend to over-request lab tests.

LETTER OF THE WEEK

Is monitoring lab testing too difficult to put into practice?

● **From Dr Stuart Berry**
Pendle, Lancashire
via pulsetoday.co.uk

Monitoring and reducing lab testing is difficult to put into practice. It looks like an easy target for an organisation to set, but will probably be meaningless in the short term. Has anyone got examples of GPs consistently over-requesting blood tests - surely that is more often seen in hospital medicine than primary care?

● **From Dr James Bissett**
Comber, Belfast
via pulsetoday.co.uk

This is a great idea - how about a referral management system linked to it too?

Then we don't need to worry because a specialised, highly trained individual can scrutinise all our test requests and decide which to allow and which to reject.

And when the patient sues we can sleep easy in our beds because it was nothing to do with us anyway.

We must fund consultations, not cut them

From Dr Louise Irvine
Amersham Vale, south London
BMA Council member
via pulsetoday.co.uk

There is no evidence that the traditional GP model has stopped working ('Face-to-face consultations by GPs "no longer sustainable"', pulsetoday.co.uk/news).

In fact, given the proven cost-effectiveness of that model of caring for people with complex and long-term illness in the community, general practice should be built on and developed, and there should be a recruitment drive to attract more young doctors to the specialty. As many have said already, a key objective should be to move to average 15-minute consultations.

In practice, a 15-minute consultation increases usable time by more than 50% from a 10-minute consultation. In 15 minutes GPs can deal more effectively both with the patient's presenting problem and chronic disease management, as well as having more time for listening, explaining and incorporating psychosocial aspects.

In my experience, longer consultations are associated with lower stress and error levels and higher clinical effectiveness, patient satisfaction and GP job satisfaction. If 15 minutes became standard we would need more GPs so we would need to invest in this, but it should make the job more attractive to young doctors.

High-quality healthcare in the community cannot be done on the cheap, by machines. It needs caring, well-trained, dedicated people, with the time to do their job properly - and I'm afraid that costs money.

But the costs of not investing in this care will be far greater.

● **From Dr David Bush**
Wolverhampton
via pulsetoday.co.uk

If reform is required, the target has to be to facilitate the traditional consultation, not to eradicate it. Perhaps we should start to question the relative costs and benefits of health surveillance and preventive medicine, and try to restore a balance so that it is possible to provide treatment and advice to the sick when they want it.

● **From Dr Jonathan Tomlinson**
Hackney, east London
via pulsetoday.co.uk

Competition for places on our local vocational training scheme has never been higher and the quality of candidates is better than ever. While Hackney is an island of idealism, the increasing professionalism of general practice makes it more attractive for doctors not wanting to be seen as taking a soft option wherever they choose to work.

But the denigration of the therapeutic relationship is part of a wider shift away from meaningful or difficult personal relationships towards virtual communities, increasingly impersonal relationships and higher rates of divorce.

This social atomisation needs careful analysis and thoughtful criticism rather than passive acceptance or active encouragement by management consultants who, unlike patients, are well equipped to take care of themselves.

We happily quit extended hours

From Dr Hasmukh Shah
Luton, Bedfordshire
via pulsetoday.co.uk

We quit extended hours after a trial six months ('GPs face pay cut as patients shun extended hours', pulsetoday.co.uk/news). While it was popular with certain working patients, it was mainly used by people (a lot of them retired) who could come at any time and it started affecting the overall provision of a regular service.

We have prided ourselves on excellent access for our patients and the ditching of the extended hours was a financial penalty we were prepared to pay to maintain the standard of core services.

● **From Dr Abbas Virji**
Denmark Hill, south London

Poorly attended extended-hours surgeries are just one example of the way primary care has ended up as a political football. The resigned look on the faces of impotent GPs reminds me of the way the wildebeest look in the Serengeti just before they end up as dinner for the crocodiles.

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.

Day of action will only create work

From Dr Malcolm Foulds
Sydenham, south London

I can't help thinking that a day of providing only urgent care will not make any difference at all.

All that will happen is for us to be busier than usual afterwards.

Instead, why don't we stop being gatekeepers for a day? We could, for instance:

- refer everyone to secondary care rather than sorting problems out ourselves
- prescribe what we feel patients need clinically, rather than worrying about the cost
- prescribe branded rather than generic drugs
- stop using Choose and Book and refer to named consultants
- investigate everything, and not worry about how much the tests cost.

These are a few examples of things that would remind the Department of Health that we save the NHS a huge amount of money every day.

Patients will still receive the care they need, whether urgent or routine, and will not suffer at all.

They may even be grateful that we are asking for a specialist opinion more often and prescribing expensive drugs.

If it costs more, it's bound to be more effective, right?

I am nearing the end of my career and have enjoyed it immensely, despite endless political interference.

I feel that we owe it to our younger colleagues to make a stand, otherwise primary care as we have known it will no longer exist.

Sticking with simvastatin

From Dr Pete Budden
Manchester
via pulsetoday.co.uk

I for one will not be planning to switch a single patient from simvastatin to atorvastatin simply because the latter is now cheap, and neither will anyone else who applies common sense and an understanding of the literature ('Price of atorvastatin plummets 93% as patent ends', pulsetoday.co.uk/news).

I've spent the last few years as a prescribing adviser.

My approach has been that if your patient can lose 30% of initial cholesterol, achieve a total cholesterol:HDL ratio of four or less and can tolerate simvastatin, then use it; if not use atorvastatin. In my experience that meant about 60% of patients could be managed on 40-80mg simvastatin.

Despite what the QOF and British Hypertension Society spout, all the major statin trials – even the high-dose atorvastatin trials – reported outcomes based on those sort of reductions, not on any pre-determined cholesterol targets.

I will be a lot happier that the 12 months of high-dose mega statin after MI will now cost buttons, and I will use atorvastatin 10mg as my initial statin now to avoid the need for a brand switch if the required reduction is not met.

For the record

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

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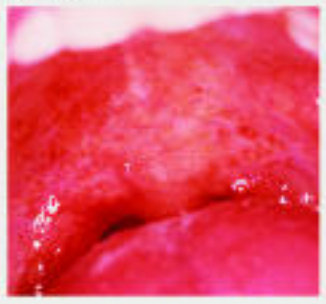

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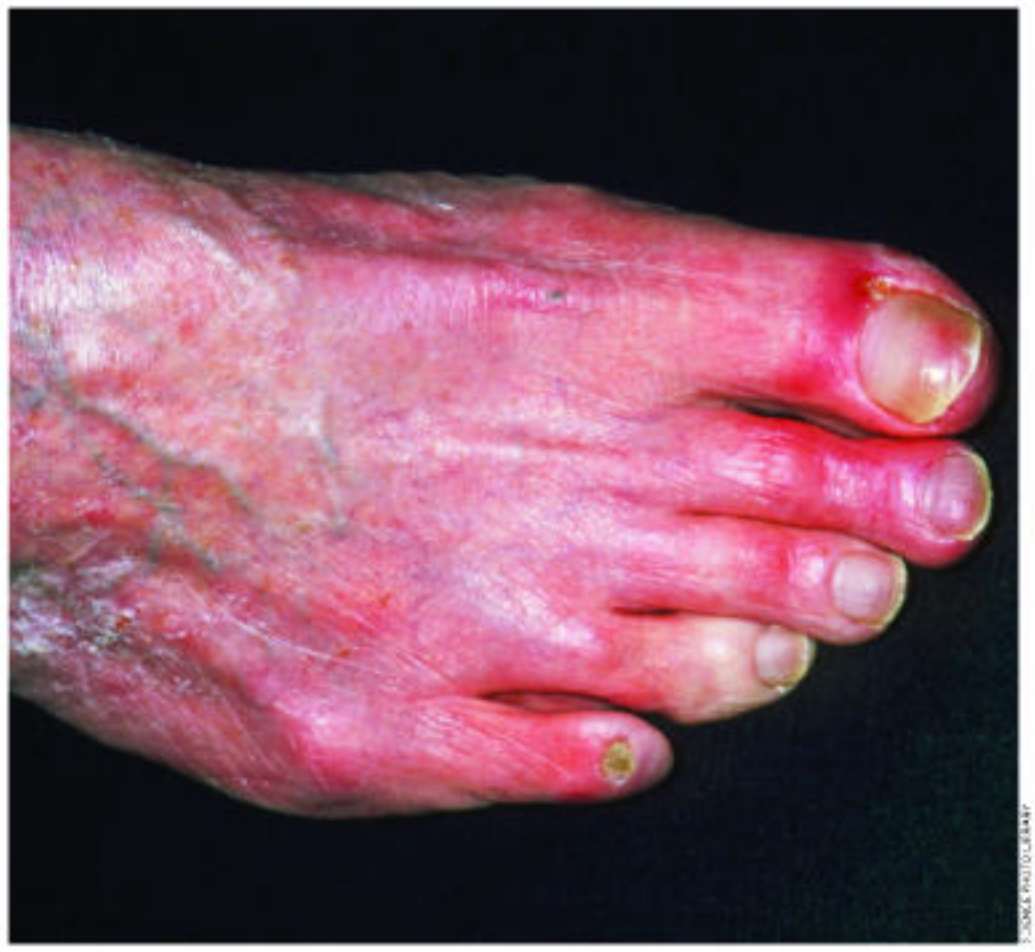
Resource of the week A checklist to determine Fraser competence in patients under the age of 16

KEY QUESTIONS

Peripheral arterial disease

Professor Gerard Stansby, professor of vascular surgery, and Dr Adriano Sala Tenna, specialty trainee, answer questions from GP Dr Julian Spinks on diagnosing and managing PAD



1 Thigh and calf pain are common presentations in primary care. What features in a patient's history would lead you to suspect peripheral arterial disease?

Patients with PAD usually describe pain that is absent at rest and develops progressively in the calves, thighs or buttocks on walking. It is cramping in nature and forces the patient to stop. The pain typically eases on standing still for a few minutes and then reappears after walking again, and is worse on exertion and up hills. Differential diagnoses include osteoarthritis, spinal stenosis, nerve root irritation and venous problems.

Patients tend to have consistent risk factors in their histories and the incidence is slightly higher in men than women. There is an increase with age – PAD occurs in 14% of men over 65 years and 21% of men over 85 years. Smoking is a major risk factor – heavy smokers have a fourfold increased risk of PAD, and smokers with PAD are more likely to progress to critical ischaemia than non-smokers.

After smoking, diabetes is the single most important risk factor. Every 1% increase in HbA_1c is associated with a 28% increased risk of PAD. Hypertension is also associated with PAD, although it is less of a risk factor than diabetes or smoking. Hypercholesterolaemia increases risk (a fasting cholesterol greater than 7mmol/l doubles the risk), as does hypertriglyceridaemia. Low HDL cholesterol or an increased LDL:HDL ratio are also independent risk factors.

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2 Some guidelines recommend carrying out a measurement of the ankle brachial pressure index (ABPI). How useful is this test and how do you interpret the results?

ABPI measurements are a standard part of the initial routine assessment of patients with PAD. A normal systolic pressure at the ankle is usually slightly higher than brachial pressure, giving a normal ABPI of 1.0-1.2. A reduced ABPI in symptomatic patients confirms occlusive disease – the lower the ABPI, the more severe the disease. An ABPI of less than 0.9 is sensitive and specific for PAD, and an ABPI of less than 0.5 is associated with critical ischaemia.

Patients with a normal ABPI in the presence of exercise-related leg pain can safely have PAD excluded. A falsely elevated ABPI is usually due to calcification of the calf or ankle vessels. Patients with diabetes or renal dysfunction can have non-compressible ankle pulses or pressures in excess of 300mmHg. The waveform of the pulses should then be assessed. Monophasic foot pulses and elevated ABPI suggests calcification. Biphasic or triphasic signals with a normal ABPI can exclude PAD in patients with leg pains that do not seem to be vascular.

A reduced ABPI is also a useful predictor of the risk of future adverse cardiac events – the lower the ABPI, the higher the risk. An ABPI of less than 0.9 is associated with a three- to sixfold increased risk of cardiovascular mortality.

3 What lifestyle and exercise recommendations would you give a patient with PAD?

The main cause of death in patients with PAD is myocardial infarction, so risk reduction strategies should be the same as for patients with established coronary artery disease.

Smoking is the most important modifiable risk factor and the cornerstone of PAD management. A cessation programme coupled with GP assistance and nicotine replacement therapy gives a 22% cessation rate at five years, compared with only 5% with advice alone, conferring a significant survival advantage.[1] Smoking cessation can also improve walking distance, and so reduce risk of cardiac events and progression of PAD. Smoking increases the failure rate of any vascular intervention.

Dietary control is important as claudication distance decreases and glucose intolerance increases with increased weight. Reduced salt intake lowers blood pressure,

and aggressive cholesterol lowering increases survival.[4]

Exercise programmes are beneficial for patients with PAD, and evidence has shown that exercise therapy is the best initial treatment of intermittent claudication. Supervised programmes of 30 minutes exercise three times a week for six months are the most beneficial in improving walking distance and confer a significant reduction in cardiovascular risk – with a five-year cardiovascular event-free survival rate of up to 80.5% – compared with patients with a sedentary lifestyle. There is a direct correlation between activity levels and ABPI, suggesting that an active lifestyle can reduce PAD.

4 What is the role of specific anti-claudication drugs such as naftidrofuryl and cilostazol in the management of PAD?

Cilostazol has been licensed for use in the treatment of intermittent claudication in patients who do not have rest pain or tissue loss. Evidence has shown up to a 51% increase in walking distance in 24 weeks for patients taking cilostazol 100mg twice daily.[3] But cilostazol has moderate side-effects, and although there are improvements in quality-of-life scores, this treatment has questionable cost-effectiveness.[4] NICE does not recommend cilostazol, pentoxifylline or inositol nicotinate in the management of PAD,[5] but patients who are already taking them should have the option to continue.

Naftidrofuryl is used in patients with PAD where vasodilator therapy is appropriate. It can improve pain-free walking distance in moderate disease, but trial results have been inconsistent. One large meta-analysis showed a 26% improvement in pain-free walking distance compared with placebo, although others have shown benefits from 15% to 100%, but with no significant effect on maximal walking distance.[6] Patients taking naftidrofuryl should be assessed for improvements after three to six months.

5 Are antiplatelet treatments or anticoagulants useful in PAD? If so, which should we use?

An antiplatelet agent should be used in patients with PAD in preference to anticoagulation.

In PAD, the focus of treatment should be on reducing cardiovascular risk. The benefit of treatment with antiplatelet agents in reduction of cardiovascular events and mortality (they don't improve walking performance) must be balanced against the risk of bleeding. A recent meta-analysis has shown a significant 24% reduction in risk of all-cause mortality – and 46% reduction in risk of cardiovascular mortality with antiplatelets in patients with symptomatic PAD.[7] Compared with aspirin, clopidogrel appears to confer a significant benefit in reduction of cardiovascular events, and it is recommended by NICE as first line for PAD risk factor modification.

It can be used in patients with symptomatic PAD, with or without evidence of other cardiovascular disease.

Dual antiplatelet therapy of aspirin and clopidogrel in patients with stable PAD does not show any benefit over monotherapy, but combined therapy is superior in patients with unstable coronary symptoms. The combination of antiplatelet and warfarin is no more effective than antiplatelet alone in preventing cardiovascular events in patients with PAD, unless the patient has atrial fibrillation.

6 The association between PAD and other cardiovascular disease is well known – what should I tell a patient about their prognosis?

Patients with asymptomatic PAD are just as likely to progress to critical ischaemia as those with intermittent claudication – symptoms depend on levels of activity. Around 75% of patients' symptoms will actually remain stable or get better with risk-factor modification and only 25% will deteriorate. Patients can be reassured that only 1-3.3% will ever progress to needing major amputation over a five-year period, which is what patients are usually most worried about. Patients with diabetes and those who continue to smoke have the worst outcomes.

Predicting which patients will deteriorate is problematic, but a rapidly decreasing ABPI is likely to be the best indicator of which patients will go on to need intervention. An ABPI of less than 0.5 and two risk factors are significant. In these patients you should stress the increased risk of cardiovascular events more than the risk of limb loss – they are much more likely to have a stroke or non-fatal MI than to need an amputation. Make these patients aware of the 2–4% risk of having a non-fatal cardiac event within the first year after diagnosis, and a 1-3% risk yearly thereafter. There is a total risk of more than 30% over 10 years.

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Competing interests None declared

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Go online to read an extended version of this article, with the authors answering questions about examination, supplements in PAD, surgical interventions and the benefits of targeted screening programmes

TEN TOP TIPS

Vitamin D deficiency

Endocrinologists Professor Pierre-Marc Bouloux and Dr Aikaterini Theodoraki offer their tips on vitamin D deficiency

1 A healthy diet is usually not enough to achieve vitamin D sufficiency.

A recent survey found that 47% of the UK adult population have low vitamin D (less than 40nmol/l).[1]

From October to April, 90% of the UK lies above the latitude that permits adequate exposure to sunlight necessary for vitamin D synthesis.

And a healthy diet is usually not enough to achieve vitamin D sufficiency, as few foods contain substantial amounts of vitamin D – the most significant dietary sources are oily fish and cod liver oil.

2 Be aware of which patients are at high risk of vitamin D deficiency.[2]

People with pigmented skin are at high risk, as are the elderly, who spend more time indoors, and obese patients, who metabolise vitamin D differently. Other at-risk groups include patients with fat malabsorption syndromes and nephrotic syndrome, patients who have had bariatric surgery, and patients taking anticonvulsants and antiretrovirals.

3 Look for the typical signs of vitamin D deficiency.

Children with profound vitamin D deficiency present with the classical skeletal deformities of rickets. Osteomalacia in adults usually presents with pain in the ribs, hips, pelvis, thighs and feet. Severe muscle weakness and hypotonia may be a prominent feature.

These patients have a definite indication for treatment. In the absence of bone disease, low vitamin D levels have been associated with non-musculoskeletal conditions such as cardiovascular disease, diabetes, cancer and multiple sclerosis.[3] But a causal relationship hasn't been established and it is not known if vitamin D treatment alters the prognosis of these conditions.

4 To assess vitamin D status, measure 25hydroxyvitamin D levels.

Vitamin D status is most reliably determined by assay of serum 25(OH)D. Parathyroid hormone is only raised in a proportion of patients with vitamin D deficiency and cannot be used as a surrogate for 25(OH)D. Vitamin D deficiency is defined as a 25(OH)D below 50nmol/L.[4] Patients with symptomatic osteomalacia or rickets usually have a 25(OH)D less than 25nmol/l.

5 Treat with a loading dose followed by a maintenance regimen.

Vitamin D deficiency is treated with oral calciferol in the bioequivalent forms of either ergocalciferol (vitamin D2, from yeast) or cholecalciferol (vitamin D3, from fish or lanolin).

Loading therapy replenishes vitamin D stores – then patients are continued on a lower maintenance dose.

Adults can be treated with 20,000-50,000IU of vitamin D2 or vitamin D3 once a week for eight weeks, or its equivalent of 2,000-6,000IU of vitamin D2 or vitamin D3 daily, followed by maintenance therapy of 1,000-2,000IU daily.

6 In children with rickets, consider treating the rest of the family, too.

It is likely that other family members of a child with rickets will also be vitamin D deficient, and a maintenance dose of calciferol is recommended for them, too.[5]

7 Resolution of biochemical and skeletal abnormalities may take a long time.

A relatively rapid biochemical response to supplementation is seen in children, with normalisation of alkaline phosphatase levels within three months. But skeletal lesions take longer to heal.

It may take a year for alkaline phosphatase and parathyroid hormone levels to fall into the reference range in adults.[3]

8 Adult patients will need to take supplements for the rest of their lives.

Given that few adults have reversible risk factors for vitamin D deficiency, assume that vitamin D supplements should be given lifelong, or at least lifelong during winter months.

9 Avoid calcium and vitamin D combinations.

Avoid giving combined calcium and vitamin D preparations long term because the calcium component is not usually necessary and reduces compliance. But in children, calcium supplementation (50mg per kg a day) is advised during the first weeks of therapy.[3]

10 Parenteral doses of vitamin D can be given in adults with severe malabsorption.

An intramuscular dose of 300,000IU calciferol monthly for three months followed by the same dose once or twice a year is an alternative to oral supplements in adults with severe malabsorption.

But recently, intermittent treatment with a high calciferol dose was shown to be associated with falls and fractures among elderly patients.[5] So it is wise to reserve parenteral or oral high intermittent calciferol doses for patients who do not tolerate the oral, continuous low-dose supplements.

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GUIDELINE UPDATE

NICE epilepsy guidance

GP and epilepsy associate specialist Dr Jane Williamson distils the 2012 guideline

The guideline

The epilepsies: the diagnosis and management of the epilepsies in adults and children in primary and secondary care (update). NICE 2012;CG137

The key changes at a glance

- **Carbamazepine should be prescribed as a controlled-release formulation.**
- **A first anti-epilepsy drug (AED) should be chosen on a diagnosis of seizure syndrome when possible, but seizure type if not.**
- **Lamotrigine and carbamazepine are first-line options for newly diagnosed focal seizures.**
- **Valproate is now the preferred first-line option for newly diagnosed generalised tonic-clonic seizures – lamotrigine if valproate is unsuitable.**
- **All AEDs appear to be associated with a small increased risk of suicidal thoughts and behaviour – possibly within a week of starting treatment.**
- **Children who have not responded to AEDs should be referred for a ketogenic diet.**
- **The risks of AEDs to the unborn child should be discussed with women and young girls – doses of valproate higher than 800mg a day and multi-drug combinations, especially if they contain valproate, are of particular concern.**

Epilepsy is the most common serious neurological condition seen in primary care. It has been estimated that around 70% of those with active epilepsy could be seizure free with effective management. But it is widely recognised that the level of care is far from ideal and specific problems identified include misdiagnosis, suboptimal treatment, sudden unexpected death that might have been prevented and the management of epilepsy during pregnancy.

NICE updated its 2004 epilepsy guidance in January this year, primarily to review the role of anti-epileptic drugs (AEDs) in the light of new data.[1]

This article will outline the main changes in the 2012 guidance, focusing on the treatment of focal seizures and generalised tonic-clonic seizures, the management of epilepsy in women of childbearing age and on the role of a ketogenic diet. It will omit new recommendations on the management of patients who have been admitted to hospital with a seizure and those who are likely to be managed totally in a secondary or tertiary setting with GPs having little role in their ongoing care – such as with infantile spasms or Dravet syndrome.

More pragmatic approach to drug therapy

The 2004 guideline recommended that AED therapy should only be started once the diagnosis of epilepsy is confirmed, except in 'exceptional circumstances' – but the update is more pragmatic. It states that – if possible – the AED should be chosen on the basis of the epilepsy syndrome, for example idiopathic generalised epilepsy. But if this is not clear at presentation the decision should be made on the seizure type – for example, generalised tonic-clonic.

Another new recommendation concerns the prescribing of carbamazepine. Controlled-release formulations have been available for a long time but the evidence about their benefit was conflicting. As recently as 2011, a Cochrane review said there was some evidence to suggest fewer adverse events in newly diagnosed patients prescribed the controlled-release form but no evidence it had any impact on seizure rates.[2]

However, the NICE guideline development group, based on their clinical experience and opinion, have recommended controlled-release formulations be prescribed to avoid peak concentrations of the drug.

New first-time role for lamotrigine in focal seizures

The new advice on focal seizures is arguably the most important of the changes to recommended treatments and is based largely on the conclusions of the influential Standard and New Anti-epileptic Drugs (SANAD) trial.

In 2004, the place of the newer AEDs like lamotrigine and topiramate was still very uncertain. SANAD – published in the *Lancet* in 2007 – was an NHS-funded, pragmatic, randomised, unblinded trial comparing new AEDs with what was considered standard therapy at that time: carbamazepine for focal seizures (arm A) and sodium valproate for generalised seizures (arm B).

The results from arm A suggested that lamotrigine is both a clinically and cost-effective alternative to carbamazepine as a first-line treatment[3] and this is reflected in the new guidance.

If the first-line treatment is not effective, patients should be offered one of the following as adjunctive treatment: carbamazepine, clobazam, gabapentin, lamotrigine, levetiracetam, oxcarbazepine, valproate or topiramate.

Patients whose seizures are still not adequately controlled should then be seen in tertiary care for consideration of other AEDs. One of these is vigabatrin, which used to be a recommended adjunctive treatment, but concern over a risk of irreversible visual field damage has led to a more cautious approach.

Valproate first choice for generalised tonic-clonic seizures

The 2004 guidance recommended four AEDs as options for patients newly diagnosed with generalised tonic-clonic seizures, but

the new guidance cites valproate first line. This is partly based on SANAD data again – in arm B it was seen to be better tolerated than topiramate and more efficacious than lamotrigine.[4]

But there is also evidence that the other options may exacerbate seizure rates in some patients. So lamotrigine is now recommended as a first-line treatment if valproate is unsuitable, but it may exacerbate seizures in patients with myoclonic seizures and those with juvenile myoclonic epilepsy. Similarly, carbamazepine and oxcarbazepine may exacerbate myoclonic seizures.

Recommended adjunctive treatments are now clobazam, lamotrigine, levetiracetam, valproate or topiramate.

Warning over suicide risk

In 2008, the MHRA told AED manufacturers to reword their labels after a European review of data on anti-epileptic treatments found that approximately two in every 1,000 patients experienced suicidal thoughts or behaviour. These findings were then confirmed in a similar US study.[5]

So the new NICE guideline recommends prescribers maintain a high level of vigilance for the emergence of neuropsychiatric problems and that the small risk of suicidal thoughts and behaviour applies to all AEDs and may occur as early as a week after starting treatment.

Wider role for ketogenic diet

A ketogenic diet is a diet high in fat and low in carbohydrate and protein, designed to mimic the biochemical response of the body to starvation when ketone bodies become the main fuel for the brain's energy demands.

Although the diet has been recommended for the treatment of epilepsy in children for almost a century, the guideline development group now recommends it for children and young people whose seizures have not responded to AEDs.

In fact, it states a successful and sustained response to the ketogenic diet can allow for the successful withdrawal of some or all AEDs in some patients. However, there is no data on the use of the diet in adults.

New data on women and epilepsy

Data from the UK Epilepsy and Pregnancy Register and similar registers across the world mean that a lot more is known about the risks of AEDs during pregnancy than was the case in 2004. So the new recommendation is much more detailed than the one included previously, citing specific concerns over the use of valproate in pregnancy – although we still know less about the newer drugs.

The 2012 recommendation states that the risk of AEDs causing malformations and possible neurodevelopmental impairments in an unborn child should be discussed with women of childbearing age. But it also stresses those discussions need to take place with young girls who will probably need to take AEDs into their childbearing years, and their parents if appropriate.

The continued use of valproate is of particular concern, especially with higher doses – over 800mg a day – which are associated with greater risk. Multi-drug combinations are also of concern – especially if they include valproate.

There is also a new recommendation about the interaction between lamotrigine and oestrogen-based contraceptives, which can result in a significant reduction in lamotrigine levels.

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

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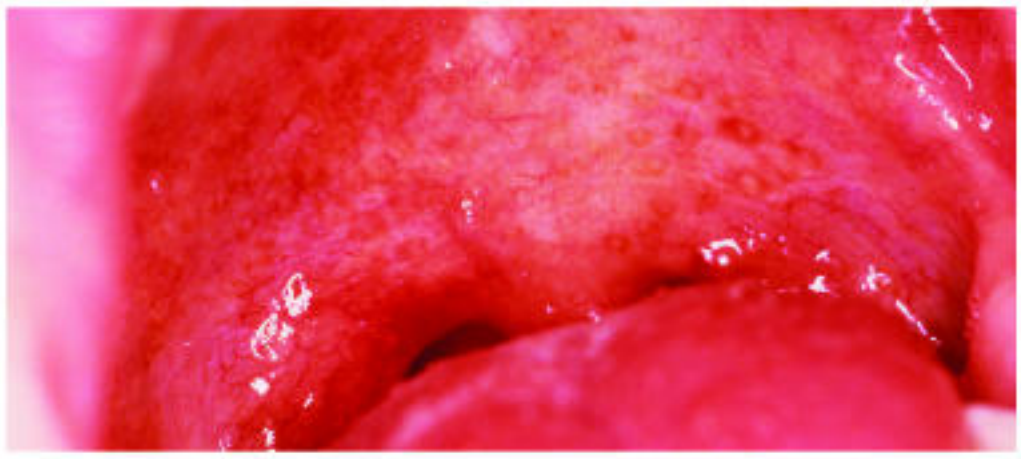
SNAPSHOT DIAGNOSIS

Spots in the mouth

GP Dr Keith Hopcroft explains what made him realise his initial diagnosis was wrong in this unwell child with small spots in his mouth



THE PATIENT

This 10-year-old boy was just one of a procession of children brought to my emergency surgery. The story was familiar – a mild fever, catarrh, sore throat and a cough. It looked like he was probably developing some conjunctivitis, too. Otherwise he seemed reasonably well, had no significant past medical history and was on no medication. The parents' main concern was some 'spots' they had noticed in his mouth, which they thought might have been causing his sore throat.

First instinct

Examination showed clusters of small, white lesions on his soft palate and buccal mucosa. He had a few mildly enlarged cervical nodes too, and was obviously febrile. There were no similar lesions elsewhere, he had no rash and there was no history of contact with any particular infectious disease. My gut reaction was that this was just a non-specific viral illness – it's not unusual for these to produce oral lesions.

Differential diagnosis

- Herpangina
- Hand, foot and mouth disease
- Herpetic stomatitis
- Other viral illness
- Aphthous ulcers.

Off the top of my head, I could think of three well-defined viral illnesses that could present in this way. Primary herpetic stomatitis is one we see fairly often – although usually in younger children, with more extensive oral lesions and ulceration, and markedly enlarged lymph nodes.

Hand, foot and mouth disease is common and can affect this age group – but there were no signs of any lesions on the hands or feet. So this left herpangina, which is caused by a Coxsackie virus. The lesions and the distribution – towards the back of the oropharynx – were certainly typical, although it's not a diagnosis we make in general practice very often.

The only other thought that crossed my mind was aphthous ulceration. But the lesions were not typical, they were unusually numerous and he had no history of previous problems – besides, the fever and coryza pointed very strongly towards a viral aetiology.

So I favoured the 'non-specific viral illness' diagnosis – though, if I was pushed to give a label, herpangina seemed to be the most likely.

The hidden clue

I gave the usual advice and was surprised to see that the child was slotted in as an 'urgent' at the end of my surgery a couple of days later. By now, the oral lesions were less of a concern – the parents were much more worried about the florid and extensive erythematous blanching rash that had developed the day after I'd seen him. He was clearly more unwell, though not ill enough to need admission. I'd never encountered a real case of measles before, but this certainly resembled pictures I'd seen of the exanthem.

This led me to check his immunisation status – and there was the clue, in his notes: 'No previous MMR vaccination.'

Getting on the right track

In retrospect, the oral lesions must have been Koplik's spots – part of the measles prodrome. Given that measles is a notifiable disease, laboratory confirmation of the diagnosis was required, so saliva samples were sent.

The patient made an uncomplicated recovery over the next week or so, and, subsequently, the lab results confirmed that he had suffered measles.

Dr Keith Hopcroft is a GP in Laindon, Essex

OCCUPATIONAL MEDICINE

Low back pain

Dr Steven Ryder, consultant occupational physician, advises on the features and investigation of low back pain

Low back pain is the most frequent musculoskeletal complaint in working people and the most common cause of absence from work, with 4.9 million days per year lost because of it. It is the most common cause of work-related ill health, with 468,000 people affected. Low back pain is an extremely common episodic symptom, often short-lived but sometimes becoming persistent. See the key points box (far right).

Occupational factors

Whether an individual attributes their lower back symptoms to work or whether they report the symptoms as 'injuries' and seek healthcare or time off depends on complex individual psychosocial and work organisational factors.

Low back pain is often blamed on various work activities – but the reality is complex. The following points are worth considering:

- Lifting may be the cause, or may simply be the trigger, of symptoms. Back symptoms are more commonly reported in those undertaking heavy lifting, lifting bulky objects away from the body, lifting from ground level or repetitive lifting. But it is unclear whether these activities are causal, or if low back pain just has a greater impact on people undertaking these duties. It is often assumed that reducing manual handling activity will reduce the prevalence of low back pain and reduce incapacity, but the evidence doesn't support this.
- Twisting has no correlation with simple back pain.
- Sitting at work is not significantly associated with low back pain.
- Driving for long periods is associated with increased rates of low back pain, but the strength of the association is unclear.
- There is little evidence for association of repetitive actions with low back pain. Most employees who appear to develop low back pain because of repetitive actions have usually already undertaken similar duties for many years.

Types of back pain

Most back pain is 'simple' – meaning a pathological cause cannot be identified. Less than 5% of the lifetime prevalence of low back pain is due to nerve root pain, and less than 1% is due to serious spinal pathology.

The traditional medical approach is to look for a pathological cause to explain the physical symptoms. But this does not work at all well for low back pain, since clinical findings can be as common in people who do not have back pain as they are in people who do. So effective clinical management of low back pain requires a triage approach where cases are managed according to the nature of the presentation. There are three triage groups.

Simple back pain

Other terms used to describe this are 'non-specific low back pain' and 'mechanical back pain'. Factors and symptoms suggesting simple back pain include:

- pain limited to the lumbosacral region, buttocks and thighs, though it can extend below the knee
- pain is 'mechanical' – it varies with physical activity and over time
- the patient is systemically well.

Patients with simple back pain can be reassured that there is no nerve damage or any serious spinal pathology.

Nerve root pain

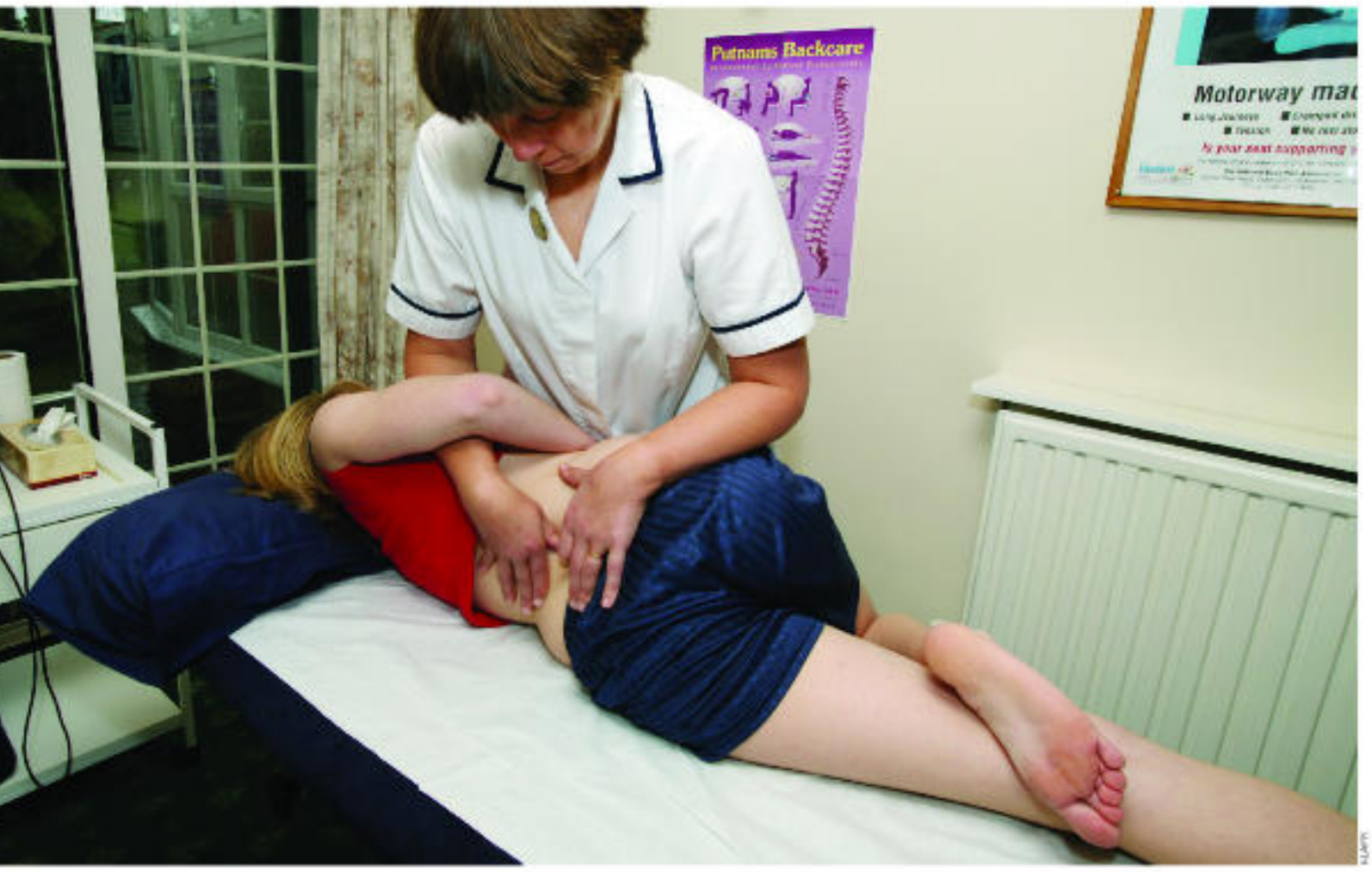
This term is preferable to 'sciatica', since it recognises that different roots may be affected and there are different causes for the pain. These include disc prolapse, spinal stenosis and surgical scarring. Symptoms suggestive of nerve root pain include:

- unilateral, linear leg pain that is worse than the back pain
- pain generally radiates to the foot or toes
- numbness and paraesthesia in the same distribution
- signs of nerve irritation – straight leg raise is reduced and replicates the pain
- sometimes motor, sensory or reflex changes, limited to one nerve root.

Serious spinal pathology

Causes include infection, inflammation – such as ankylosing spondylitis – trauma and spinal tumours. Features suggestive of this are red flags, and include:

- age younger than 20 or older than 50 – back pain is common across all ages in primary care, but in secondary care it is those younger than 20 or older than 50 who are disproportionately like to have serious causes
- violent trauma such as a fall from height or a road traffic accident
- constant, progressive, non-mechanical pain
- a past history of cancer, HIV or systemic steroids
- the patient is systemically unwell – for example, with unexplained weight loss
- widespread neurological abnormality
- structural deformity.



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Key points

- Some 60-80% of people will get notable low back pain at some point in their lives.
- Most episodes settle rapidly, but residual symptoms and recurrences are common.
- Some 35-40% of people report low back pain lasting over 24 hours each month, and 15-30% of people report symptoms every day.
- The best predictor for future low back pain is a past history.
- A small proportion of people develop persistent pain and disability.

Cauda equina syndrome, where there is compression of the nerve roots in the lower spinal canal, is a surgical emergency. Patients with the following features should be referred to a spinal surgeon as an emergency:

- problems with micturition or loss of anal sphincter tone
- saddle anaesthesia around the anus, perineum and genitals
- widespread or progressive motor weakness.

Clinical features and investigations

Pain radiating to the thigh is common, and is reported in approximately 40% of cases presenting with low back pain. In most cases, pathology is not defined (non-specific or mechanical low back pain). But a small minority – fewer than 10% of cases – have identifiable pathology, such as nerve root compression.

Disc degeneration has also been suggested as a structural cause for low back pain, but there is no causal association between degenerative changes and symptoms.

Investigations aim to distinguish cases of serious spinal pathology. This is done mainly on the basis of clinical markers. X-rays and MRI are not useful in most cases of mechanical back pain because changes seen on these scans are often incidental, and are seen as commonly in individuals without low back pain.

Management

Biopsychosocial factors

It is clear that biopsychosocial factors are involved in the causation of back pain – and research has suggested that beliefs are key determinants of disability (reduced daily activity) and incapacity (not being able to work).

A flag system has been developed to identify and categorise these biopsychosocial factors, and assist with a stepped approach to managing low back pain (see table below).

It is a tool for identifying and tackling the obstacles to recovery – covering features of the individual and their workplace. Considering the different flags in your clinical assessment can facilitate the rehabilitation process.

There are two types of flags: clinical flags and psychosocial flags. Clinical flags such as red flags for musculoskeletal disorders indicate possible serious pathology – if suspected, these require urgent further investigation and often surgical referral.

Psychosocial flags reflect the different factors that can affect recovery. Important ones include yellow, blue and black flags.

Yellow flags refer to the person and how they manage their situation with regard to their thoughts, feelings and behaviours.

Blue flags are about the workplace and the employee's perceptions of health and work.

Black flags are about the context and environment in which that person functions, including other people, systems and policies.

To help rehabilitation of patients with low back pain, GPs should:

- encourage activity – early physiotherapy, analgesia and reassurance
- advise early return to work – job adjustments and redesign can be considered, and this can reduce employment costs and litigation
- only recommend restriction from work or redeployment rarely, in recurrent or persistent cases.

Workplace adjustments

Workplace adjustments can include:

- eliminating the need for manual handling by redesigning the task
- undertaking a suitable and sufficient assessment for those manual handling operations that cannot be avoided
- providing mechanical assistance as much as possible.

GPs can use the 'fit note' to recommend that a workplace risk assessment be conducted.

You can also suggest the patient uses their employers' own specialist occupational health services, physiotherapy and counselling services if available. You can suggest adjustments to work routine, as discussed above, and restriction from certain duties if necessary.

Prognosis

- Most episodes of mechanical low back pain are self-limiting.
- Over 50% of episodes resolve completely within four weeks, but up to 20% have some symptoms for a year.
- There is a marked tendency to recurrence – 70% of those with low back pain go on to experience three or more attacks.
- Some 20% of patients with low back pain develop chronic symptoms.
- Individual beliefs, pending compensation and attribution to work are strong predictors of outcome. Clinical examination and investigations are poor predictors.
- Probability of return to work reduces with increased duration of sickness absence.

Go online to see a table of common patient myths about low back pain and to download an NHS Plus document on its management from pulsetoday.co.uk/tools-and-resources.

Clinical and psychosocial factors in low back pain

Red flags
(Serious spinal pathology)
- Sphincter disturbance
- Gait disturbance
- Saddle anaesthesia
- Age <20 or >50
- Non-mechanical pain
- Thoracic pain
- Past history of cancer, steroids or HIV
- Unwell, weight loss
- Widespread neurological abnormality
- Structural deformity.

Yellow flags
(Person)

Thoughts:
- Catastrophising – focusing on the worst possible outcome
- Inaccurate beliefs about the condition, pain and harm
- Negative expectations about the future.

Feelings:
- Worry, distress or low mood
- Fear of movement
- Uncertainty about the future.

Behaviour:
- Extreme symptom reporting
- Passive coping strategies
- Repeated ineffective therapy.

Blue flags
(Workplace)
- Fear of re-injury
- High physical demand job
- Low expectation of return to work
- Low job satisfaction
- Low support
- Lack of adjustments
- Poor communication.

Black flags
(Context)
- Misunderstanding between key players – patient, employer and doctor
- Financial or compensation problems
- Process delays – such as waiting lists
- Sensationalist media reporting
- Spouse or family beliefs
- Social isolation
- Unhelpful company policies.

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

Further reading

- Smedley J, Dick F and Sadhra S. *Oxford handbook of occupational health*. Oxford University Press, 2007
- Waddell G, McIntosh A, Hutchinson A et al. *Low back pain evidence review*. RCGP, 1999
- RCGP and the NHS Executive. *The back book: the best Way to deal with back pain – get back active*. Stationery Office Books, 2002

The faculty of occupational medicine sets standards for specialists and supports 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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OCCUPATIONAL MEDICINE

Careers in occupational health

Dr Michael Lambert – a GP who has trained in occupational medicine – advises on why it is worth considering as a career

Occupational medicine is a fascinating, multidisciplinary, wide-ranging speciality covering health and safety and employment law, public health, disability and work-related disease – making it an ideal choice for GPs looking for a new skill set and an additional income stream. It also lends itself particularly well to sessional work.

Training

The increasing complexity of occupational medicine – especially the legislative aspects – means additional training is a must. The RCGP's faculty of occupational medicine provides high standards of training and also publishes guidance, for example, on ethics and confidentiality. Its website provides information on training and academic qualifications and is a good first source of information for GPs interested in opportunities within occupational medicine.[1]

For most GPs, the diploma exam (DOccMed) would be sufficient. For entrance to the exam you need proof of satisfactory completion of a recognised course. There are three courses geared towards GPs looking to do sessional work in occupational medicine, all priced at around £2,000:

- The Royal Society for Public Health in London offers a concentrated, two-week course.[2]
- The University of Birmingham offers a course divided into two one-week modules.[3]
- The Centre of Occupational and Environmental Health at Manchester University offers a six-month distance learning course.[4]

The advanced diploma course covers the subject in more detail and is ideal for GPs keen on further training. Beyond this, there is the opportunity of doing a two-year MSc followed by becoming a member of the Faculty of Occupational Medicine, which is normally achieved by entering approved specialty training.

Opportunities and benefits

There is little doubt that the opportunities for GPs in occupational medicine will increase as the needs of organisations change. Though the heavy manufacturing base of the UK has diminished, there has been a steady growth in small and medium-sized businesses that need advice on occupational health, including sickness absence, rehabilitation to work, workplace adaptations and disability, which is now covered by the Equality Act.

Training in occupational medicine can also benefit our daily practice – particularly in musculoskeletal problems and stress-related disorders – by helping our patients return to work earlier.

Many practices have developed sophisticated occupational medicine services, set up limited companies employed trained nurses, and now have a strong business model to add to the practice portfolio. In our practice we are looking to expand our services to our local university. Another benefit of occupational medicine training has been the improvement in our own health and safety procedures, which now feel more robust.

Occupational medicine could be a fascinating adjunct to a GP's or practice's portfolio, and I would encourage anyone to look seriously at this as a career opportunity.

Dr Michael Lambert is a GP trained in occupational medicine in Winchester

References

1 The Faculty of Occupational Medicine. facoccmed.ac.uk (accessed 20 April 2012)
2 Royal Society for Public Health. rsph.org.uk (accessed 20 April 2012)
3 University of Birmingham. Occupational and Environmental Medicine. birmingham.ac.uk/schools/haps/departments/ioem (accessed 20 April 2012)
4 The University of Manchester. Centre for Occupational and Environmental Health. medicine.manchester.ac.uk/eeh (accessed 20 April 2012)

Further reading

The Society of Occupational Medicine. som.org.uk (accessed 20 April 2012)

Personal experience

I did the six-month distance learning course at the Centre of Occupational and Environmental Health at the University of Manchester. It was very well organised, with course material sent through the post and supported by online tutorials.

The diploma exam requires you to produce a portfolio, including a workplace assessment and a clinical case. This was challenging as my previous postgraduate study was 16 years earlier, for the MRCGP, but the benefit of the eTutor groups and the online tutor was excellent.

Tackling any academic course is a challenge, but doing this on top of your normal job is even more difficult.

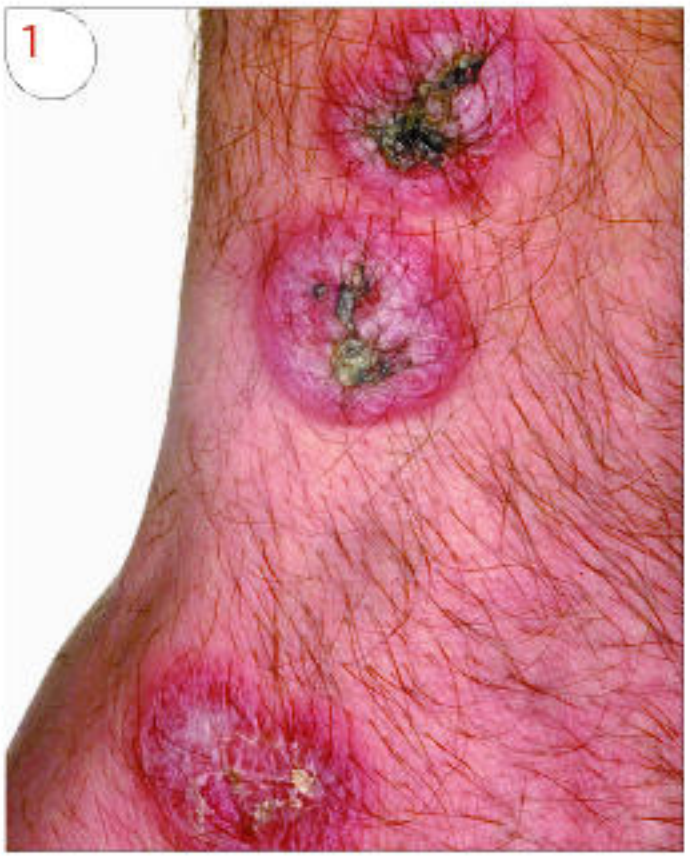
I negotiated with my partners a session per week of protected study through the six-month course, which really eased the pressure – although, of course, there was still significant home study required.

I also accrued some annual leave to give myself a week of study leave prior to the exam.

PICTURE QUIZ

Bacterial skin infections

These five patients presented with lesions on their skin. Can you work out the diagnosis in each case? Answers are at the bottom of the page



This man had noticed a scabby lesion appear on his wrist a few weeks previously. He'd been absent-mindedly picking at it intermittently since, but became alarmed when further lesions appeared on his forearm. He was otherwise well.

ANSWERS

1 Impetigo

Impetigo is a superficial cutaneous infection caused by *Staphylococcus aureus* or rarely by group A streptococci. It is common in the young, and especially where people live in close proximity with one another. Typically the initial lesion is a superficial blister that ruptures to leave an eroded area, which may be sore or itchy. The erosion becomes covered by honey-coloured crust, indicative of *S. aureus* infection. New lesions may arise close to the original crusted area. Initially, you should remove the crusts with warm saline or a dilute solution of potassium permanganate. Topical antibiotic ointment can be used – for example, fusidic acid or mupirocin – applied to the affected area three times per day for seven days.

2 Erysipelas

Erysipelas is an acute infection of the dermis caused by group A or other staphylococci. In erysipelas, there is infection of the dermis and superficial subcutaneous tissues. Erysipelas and cellulitis both present acutely with a hot, painful, red, oedematous area of skin. Erysipelas most commonly occurs on the face and is usually unilateral. Since the infection is superficial in erysipelas, the margins are more clearly demarcated than in cellulitis. The diagnosis is usually made clinically. Oral fluclоxacillin 500mg four times per day is the treatment of choice – or erythromycin if the patient is allergic to penicillin.

3 Folliculitis

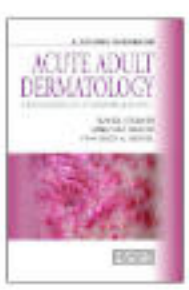
Folliculitis is a pustular inflammation of hair follicles. *S. aureus* is the most common infecting organism. In folliculitis, red papules or pustules centred on hair follicles develop within hair-bearing skin. Individual lesions may be painful. The limbs, especially legs, are commonly affected in staphylococcal folliculitis. The torso is typically involved in Gram-negative folliculitis. This is a case of Gram-negative folliculitis, with multiple lesions occurring after bathing in water colonised by *Pseudomonas aeruginosa*. Topical mupirocin, fusidic acid ointment or clindamycin gel can be applied to the affected areas twice per day for seven days.

4 Hidradenitis suppurativa

Hidradenitis suppurativa is a dermatosis in which inflammation of the apocrine sweat glands produces nodules, abscesses, discharging sinuses and scarring. It occurs slightly more commonly in women, who often report premenstrual and menstrual flares. Despite the involvement of suppurative inflammation, the role of bacteria in the aetiology of hidradenitis suppurativa is unknown. Hidradenitis suppurativa generally runs a chronic course – however, acute exacerbations often cause the patient to seek an urgent opinion. Surgical incision and drainage of a tender abscess is sometimes necessary. Recommend potassium permanganate soaks to cleanse debriding areas. Careful hygiene to affected areas is important as is loss of weight in the obese. Topical antibiotics, such as clindamycin, may be helpful in controlling exacerbations.

5 Cellulitis

Erysipelas and cellulitis are acute infections of the dermis and subcutis, caused by group A or other streptococci. In cellulitis, the infection extends into the subcutis. Cellulitis is a common complication of lymphoedema. Erysipelas and cellulitis are serious infections accompanied by a severe, systemic illness and significant morbidity. Cellulitis typically occurs as an ascending inflammation of the leg or can complicate a wound or ulcer. In cellulitis, blisters and ulceration may develop within the area affected by erysipelas. Cellulitis is an acute bacterial infection of the dermis and subcutaneous tissues. Erysipelas and cellulitis both present acutely with a hot, painful, red, oedematous area of skin. Erysipelas most commonly occurs on the face and is usually unilateral. Since the infection is superficial in erysipelas, the margins are more clearly demarcated than in cellulitis. The diagnosis is usually made clinically. Oral fluclоxacillin 500mg four times per day is the treatment of choice – or erythromycin if the patient is allergic to penicillin.



These cases are taken from *Acute adult dermatology – a colour handbook* by Daniel Creamer, Jonathan Barker and Francisca A Kendel. ISBN 9781840761023 (Manson Publishing); available from mansonpublishing.com/colour_handbooks and all good booksellers priced £29.95

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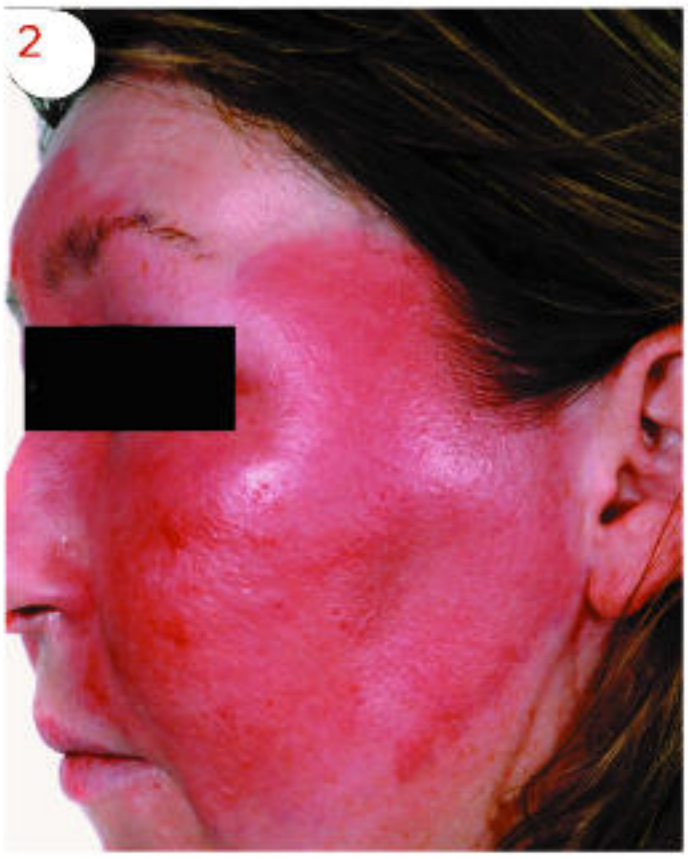
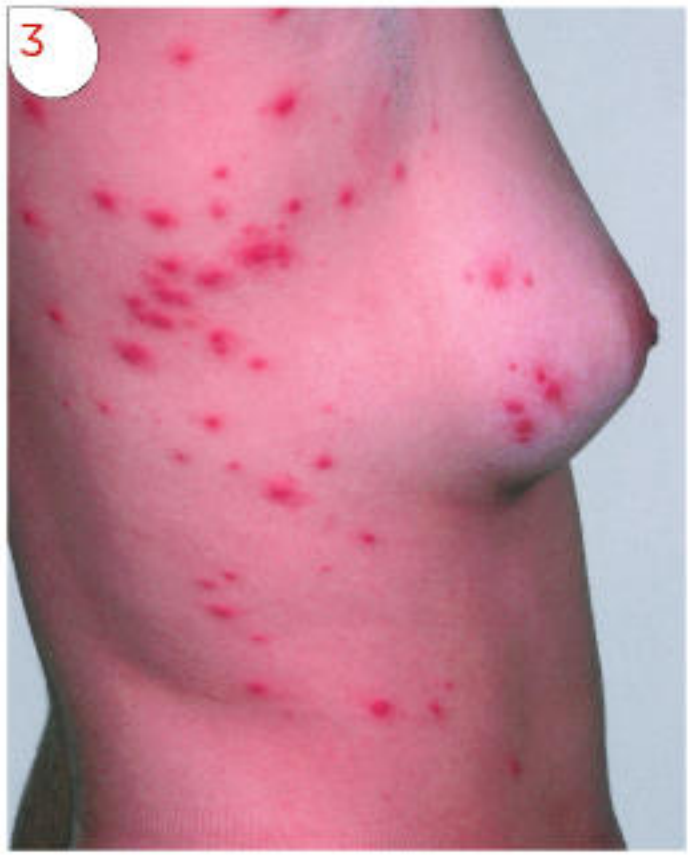


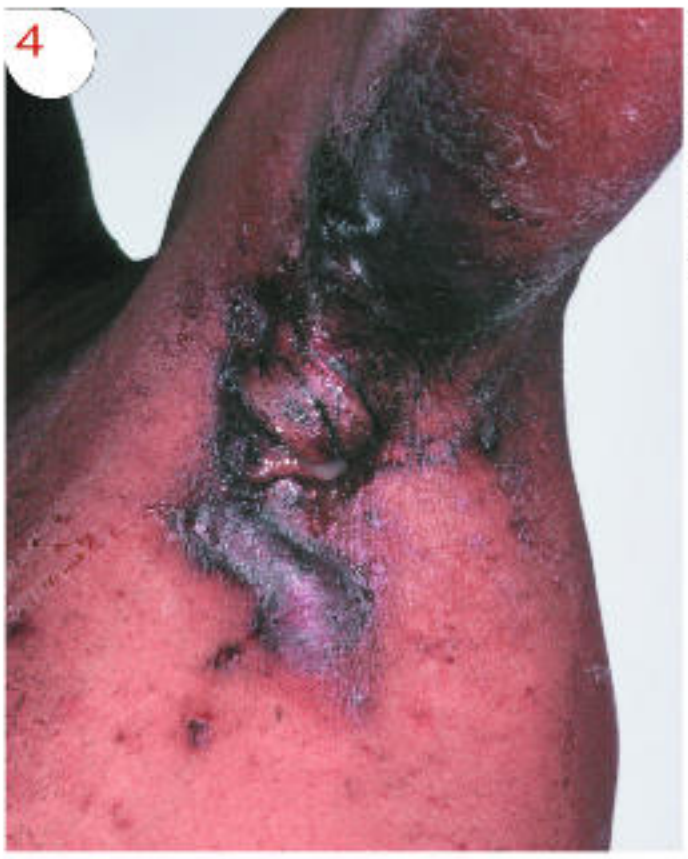
This lady developed an erythematous rash on one side of her face over a couple of days. She felt shivery and vaguely unwell and, on examination, was found to have a fever and mild tachycardia.

3



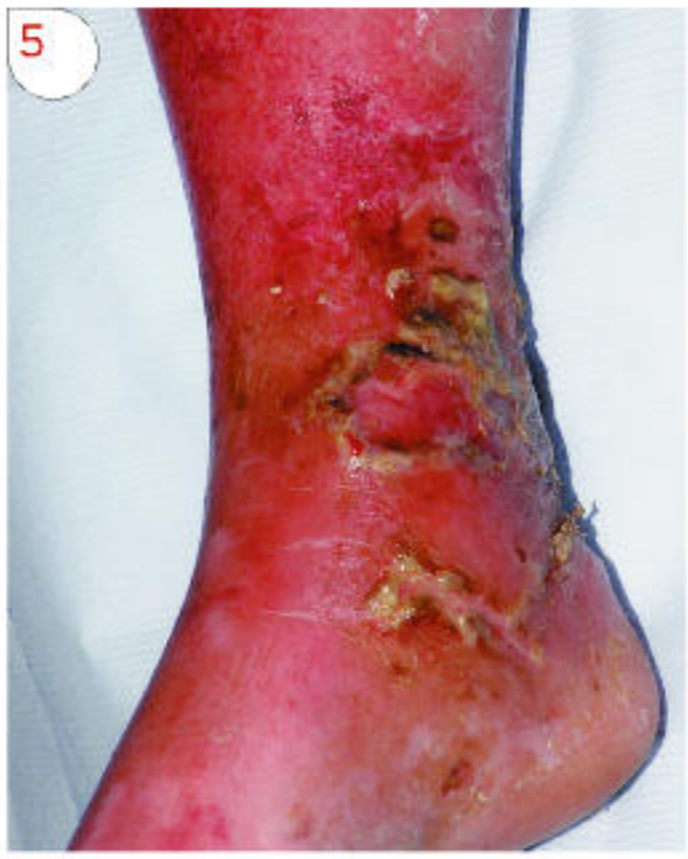
A few days after soaking in a Jacuzzi, this young woman developed this widespread, mildly irritating rash. She was on no medication and felt perfectly well in herself.

4



The presentation in this case was: 'Yet another boil, doctor.' The patient had been suffering repeated problems for a year or more. At his previous consultation, he'd had a blood screen that revealed a normal FBC and glucose level.

5



This lady had been suffering from a varicose leg ulcer for a few weeks. It had been healing, but over the past week her leg had become much more painful and she felt as though she was developing a flu-type illness.

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Avoiding the pitfalls in the new 2012/13 QOF

Dr Simon Clay guides GPs through the coding minefield of the new QOF rules

The newest iteration of the QOF rules from April 2012 introduces wide and complex changes – more so than in recent years – plus two whole new disease areas. In this article, I have highlighted some of the main revisions and also signposted resources where all the changes are covered in detail.

Many of the revised or new targets will be hard to achieve – which makes it imperative that practices cascade the knowledge of the new requirements rapidly to their key clinical and administrative staff.

No fewer than 56 separate indicators have had their lower thresholds increased, and 13 have had their upper thresholds increased. This will have a major impact on those practices that struggle to score full points across the QOF and could lead to significant losses if the practice does not improve its coverage across these indicators.

Atrial fibrillation

Indicator AF4 is retired, so you no longer need to document by Read code that atrial fibrillation has been confirmed by ECG or referral. A number of new AF indicators have been introduced:

AF5 (10 QOF points, 40-90% threshold)
Patients with AF now need an annual CHADS2 score, within 12 to 15 months of the referral date, except for those whose score was coded as 2 or more previously (at any time, for instance in a previous QOF year).

The only valid Read code is 38DE.

The CHADS2 score helps clinicians decide on which anticoagulant is advisable.

Valid antiplatelets for the QOF are aspirin, dipyridamole and clopidogrel; valid anticoagulants are warfarin, phenindione, dabigatran or rivaroxaban.

Patients scoring 0 or 1 should be offered aspirin, dipyridamole, clopidogrel or warfarin. Patients scoring 2 or more should be offered an oral anticoagulant.

AF6 (six points, 50-90%)
This looks at all patients with a CHADS2 score of exactly 1 in the previous 15 months and at what proportion are on an antiplatelet drug.

AF7 (six points, 40-70%)
This indicator looks at all patients whose latest CHADS2 (at any time previously) was 2 or more. Then it assesses the percentage of those patients who have had an anticoagulant prescribed in the six to 12 months before the reference date.

Exception coding

- AF6: an expiring or persisting exception code is required to all four of aspirin, dipyridamole, clopidogrel and warfarin.
- AF7: a patient needs only to have any valid expiring or persisting exception code to warfarin or the anticoagulants.

One notable change in the AF domain is that now the few patients who score 0 in CHADS2 do not penalise the practice, even if on no medication, despite the probable clinical benefit of aspirin.

Osteoporosis

Osteoporosis is one of two new disease areas added to the QOF for 2012.

OST1 (three points)
This indicator collates a combined register of two separate groups of patients:

- Patients aged 75+ who have had a fragility fracture since 1 April 2012.
- Patients aged 50+ who have had fragility fractures since April 2012, who have also had Read codes added to demonstrate osteoporosis and a DXA scan proving osteoporosis. All three criteria are required to qualify for the register. Details of qualifying codes for each are listed below.

The two valid codes for fragility fractures

- N331M – fragility fracture due to unspecified osteoporosis
- N331N – fragility fracture.

Valid osteoporosis codes (only needed for those aged 50-74)

- N330.% (excluding N3305, N3307, N3308, N3309, N330A, N330D)
- N3312
- N3313
- N3316
- N3318 to N331B
- N331H to N331M – fragility fracture due to unspecified osteoporosis

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- NyuB0
- NyuB1
- NyuB8

Valid DXA scan codes (only needed for those aged 50-74)

To be valid, a DXA scan Read code either:

- has to suggest that the patient is osteoporotic in the rubric and therefore the Read code does not need a numeric value, or
- has to be a Read code that does have a numeric and that numeric must be -2.5 or worse.

DXA scan codes suggesting osteoporosis, but with no need for a T-score value

- 58E4. – forearm DXA scan result osteoporotic
- 58EA. – heel DXA scan result osteoporotic
- 58EG. – hip DXA scan result osteoporotic
- 58EM. – lumbar DXA scan result osteoporotic
- 58EV. – femoral neck DXA scan result osteoporotic.

DXA scans with a T-score value, where the T-score value must be worse than -2.5

- 58E2. – forearm DXA scan T-score
- 58E8. – heel DXA scan T-score
- 58EE. – hip DXA scan T-score
- 58EK. – lumbar spine DXA scan T-score
- 58ES. – femoral neck DXA scan T-score.

OST2 and OST3

All patients who are then classified as being in the osteoporosis register must be offered a bone-sparing agent – one of four specified drug families. OST2 looks at the 50- to 74-year-olds, and OST3 looks at the 75-and-over age group.

There are catches galore in the osteoporosis rules. For example, see the list of 'non-valid' bisphosphonates below as defined by the rulesets.

Full details are available in the online version of this article at tinyurl.com/cxcyde6.

PULSE Learning

1 CPD hour

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OST2 (three points, 30-60%)

This indicator requires that patients aged between 50 and 74 with all three of the criteria listed above should have been prescribed a bone-sparing agent in the six to 12 months before the reference date.

OST3 (three points, 30-60%)

This indicator requires that patients aged 75 and over, whose sole criterion is a code for a fragility fracture, should have been prescribed a bone-sparing agent in the six to 12 months before the reference date.

Valid bone-sparing agents

- Bisphosphonates – didronel, alendronate or risedronate only
- Raloxifene – a selective oestrogen receptor modulator, for women only
- Teriparatide
- Strontium ranelate.

Non-valid bone-sparing agents

- Disoduim pamidronate
- Sodium clodronate
- Zoledronic acid
- Ibandronic acid
- Denosumab.

Exception-coding osteoporosis patients

The easy option (for OST2 only) is the use one of the three 'global' exception codes:

- 9hP. – exception reporting: osteoporosis quality indicators
- 9hP0. – excepted from osteoporosis quality indicators: patient unsuitable
- 9hP1. – excepted from osteoporosis quality indicators: informed dissent.

Exception coding patients from osteoporosis treatment (for OST2 and OST3)

There are also various Read code options for each of the four categories of valid drugs used under OST2 and OST3.

Bisphosphonate exception codes – persisting

- 14LT. H/O – bisphosphonate allergy
- ZV14K [V] – personal history of bisphosphonate allergy.

Bisphosphonate exception codes – expiring

- 8I3e. – bisphosphonates declined
- 8I6R. – bisphosphonates not indicated
- 8I7E. – bisphosphonates not tolerated
- 8I2V. – bisphosphonates contraindicated.

Raloxifene exception codes – persisting

- 14La. H/O – raloxifene allergy.

Raloxifene exception codes – expiring

- 8I6p. – raloxifene not indicated
- 8I7P. – raloxifene not tolerated
- 8IEH. – raloxifene declined
- 8I2l. – raloxifene contraindicated.

Teriparatide exception codes – persisting

- 14Lb. H/O – teriparatide allergy.

Teriparatide exception codes – expiring

- 8I6q. – teriparatide not indicated
- 8I7Q. – teriparatide not tolerated
- 8IED. – teriparatide declined
- 8I2m. – teriparatide contraindicated.

Strontium exception codes – persisting

- 14LW. H/O – strontium ranelate allergy
- ZV14H [V] – personal history of strontium ranelate allergy.

Strontium exception codes – expiring

- 8I3h. – strontium ranelate declined
- 8I6V. – strontium ranelate not indicated
- 8I7H. – strontium ranelate not tolerated
- 8I2Y. – strontium ranelate contraindicated.

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You can see how confusing the coding of osteoporosis is. I recommend that a couple of people in your practice take charge of osteoporosis coding, or many patients are likely to be missed.

Peripheral arterial disease

This new disease area has four indicators:

PAD1 (two points)
This requires merely a register of all patients with peripheral arterial disease.

PAD2 (two points, 40-90%)
Patients with PAD who are not on warfarin are required to be offered aspirin or clopidogrel (not dipyridamole) within the previous 12 to 15 months.

PAD3 (two points, 40-90%)
PAD patients' last blood pressure reading (within the last 12 to 15 months) is ≤150/90mmHg.

PAD4 (three points, 40-90%)
PAD patients' last total cholesterol value within the last 12 to 15 months is ≤5.0mmol.

Valid codes for PAD
These include most of the expected codes such as:
- G73. – other PAD
- G73z. – PAD not otherwise specified
- G73z0 (intermittent claudication) and G73zz (not otherwise specified)

Some codes, like G7310 (Buerger's disease), are not included.

PAD exception codes – expiring
- 9hS. – exception reporting: PAD quality indicators
- 9hS0. – excepted from PAD quality indicators: patient unsuitable
- 9hS1. – excepted from PAD quality indicators: informed dissent.

It will be useful to ensure that anyone with a diagnosis of PAD who is put on anti-hypertensives also has a hypertension code added, so they'll score twice over for their blood pressure management.

Smoking

SMOK5 (25 points, 50-90%)
This replaces SMOK3, and now requires that all patients with the following nine diseases are asked their smoking status every 15 months:
- coronary heart disease
- stroke/transient ischaemic attack
- diabetes
- chronic kidney disease stages 3-5
- hypertension
- asthma
- chronic obstructive pulmonary disease
- psychosis
- PAD.

Smoking status is to be recorded annually unless the patient is a 'never smoker' or has three consecutive years of annual 'ex-smoker' codes.

SMOK6 (25 points, 50-90%)
This now replaces SMOK4 ('smoking cessation advice given'). The previous quick noting of 'smoking cessation advice' is no longer enough. Smoking patients with any of the diseases above now need to be offered 'a record of an offer of support and treatment in the preceding 15 months'.

Two criteria for 'scoring' SMOK6

1. Evidence of an offer of referral to a stop-smoking service adviser:
- 8CAL – smoking cessation advice (the indicator we've used previously, which still counts)
- 8HTK. – referral to stop-smoking clinic
- 8HkQ – referral to NHS stop-smoking service
- 8H7i. – referral to smoking cessation adviser
- 8IAj. – smoking cessation advice declined
- 8IEK. – smoking cessation programme declined
- 9N2k. – seen by smoking cessation adviser
- 13p50 – practice-based smoking cessation programme (give the start date)
- 9Ndf. – consent given for follow-up by smoking cessation team
- 9Ndg. – declined consent for follow-up by smoking cessation team.

2. Evidence of pharmacological intervention
- 745H.% – smoking cessation therapy
- 8B3f. – nicotine replacement therapy provided free
- 8B2B. – paid for nicotine replacement therapy
- 8B3Y. – over-the-counter nicotine replacement therapy
- du3..% – nicotine prescribed products (lozenges, gum and patches)
- du6..% – bupropion
- du7..% – more nicotine products
- du8..% – varenicline
- 8IEM. – smoking cessation drug therapy declined.

Note that every valid code for the second criterion of SMOK6 requires the patient to be on a smoking cessation product, except the last Read code option. This last code is very likely to be the most frequently used in this situation.

SMOK7 (11 points, 50-90%)
This was Records 23, but is now transferred to the smoking ruleset. All patients aged 15 or older have to have smoking status documented, and for this indicator, it must have been recorded in the previous 27 months.

SMOK8 (12 points, 40-90%)
This has the same score criteria as SMOK6, except that the 'record of an offer of support and prescription' must be within the preceding 27 months.

Dr Simon Clay is a GP and QOF lead in Erdington, Birmingham

MORE ONLINE

For a complete analysis of all the 2012 QOF changes together with all Dr Clay's disease-specific QOF help documents, spreadsheet summary aide-memoires and other collated QOF resources, go to tinyurl.com/cxcyde6

Dr Ollie Hart and **Dr Andy Hilton**
explain how they were asked to use their skills as GPSIs to reshape local care for back pain

Dr Ollie Hart: scheme has saved an average of 80 appointments a month

How we cut direct referrals for back pain to nothing

The problem

It is well recognised that spinal pain, with or without nerve root irritation, is one of the most common conditions encountered in primary care. Most people recover spontaneously by six weeks. However, a significant proportion (3-10% depending on the study) develop chronic problematic long-term pain. The main risk factors for developing chronic back pain are psychosocial factors, such as fear or avoidance of movement, depression and a 'catastrophising attitude' towards the pain. Back pain accounts for significant costs for both healthcare and society – estimated to be around £12.3bn a year in the UK.[1]

As GPSIs in musculoskeletal medicine, we were asked by clinical commissioners locally – then Central Sheffield Consortium, now Sheffield GP Commissioning Consortia – to look at this problem. Access and provision of service was inequitable across the city for this condition, with variable waiting times and quality of physiotherapy. We were also influenced by a musculoskeletal service framework released in 2006,[2] and the Arthritis and Musculoskeletal Alliance document, *Standards of care for back pain*.[3]

It was clear from the evidence base that early intervention for musculoskeletal conditions could prevent the progression to persistent problematic pain. We felt applying best practice could significantly improve the quality of patient care, and reduce progression to chronic back pain.

Figures for referrals to secondary care surgical spinal teams before our initiative were around 100 a month with a conversion to surgery rate of 20%. It was felt we could achieve savings in this area, as spinal surgery is only indicated for persisting nerve root compression.

What we did

The initial work between 2008 and 2009 came down to two main approaches.

First was the production of a local pathway. We convened a stakeholder group from primary care, physiotherapy and secondary care, and we drew up a patient-centred pathway that took into account best evidence and local consensus. We did this with a mix of a couple of large group workshops, with smaller email and face-to-face groups to debate areas of contention.

We made a few key changes:

- We created a specification for a physiotherapy-led spinal team that would act as the first point of referral from primary care. These would be led by a specialist physiotherapist in spinal pain, and allow access to a variety of skills including acupuncture, manipulation and pain management approaches. We requested that all non-urgent spinal referrals pass through these teams, as opposed to direct referral to hospital surgical spinal teams.
- We specified standard maximum timescales for patients to be seen once they are referred – one week for severe pain, two weeks for standard pain levels.
- We recommended that GPs use the STarT back screening tool to help stratify risk of chronicity (an evidence-based, simple nine-question tool designed for primary care).
- We organised access to MRI for these spinal teams.
- We specified that all cases being considered for surgical intervention (with nerve root pain) be discussed at a surgical multidisciplinary team meeting where case history and MRI are considered by a team including a surgeon, physiotherapist and pain specialist.

We then went on to set up a website, sheffieldbackpain.com. The process of developing the site created a common goal for the group, and helped to focus our advice on written and video formats for patient information leaflets, assessment tools and education materials for professionals and patients.

We launched the new website and pathway as part of a learning event for GPs on musculoskeletal issues. We printed flyers, posters and cards for practices, and followed up with letter and email updates to remind people about use of the pathway.

In 2011, as a result of local audit and the report of the STarT trial,[4] we made some significant updates to the pathway and referral processes. We realised that despite clear approval of the pathway by primary care, secondary care was getting the same number of referrals. In two out of three cases for all referrals to any specialty, GPs were not highlighting psychosocial risk factors for chronic pain and made very little use of the STarT back tool. The physiotherapy team also requested we include neck pain.

We amended the pathway so that all non-urgent referrals passed through spinal physiotherapy teams, and all referrals included a STarT score. Physiotherapy teams would only accept patients with a medium or high risk on the STarT score, unless problematic pain persisted beyond six weeks despite a low score.

The secondary care and physiotherapy-led spinal teams agreed to bounce back referrals that fell outside the agreed pathways and also agreed to stratify the care that patients received according to the risk score on the STarT tool (high-risk patients receiving 'psychologically informed physiotherapy' that addressed barriers and fears).

We designed a concise referral form, with mandatory sections in bold, to facilitate collection of our minimum data set.

Lessons learned

Despite achieving good buy-in from GPs, we learned that in this case it required mandated use of the STarT tool to ensure all patients had a bio-psychosocial assessment communicated in referral information. We also learned we needed misdirected referrals bounced back to achieve full compliance with agreed pathways. However, a certain level of trust is required before the local health community accepts such directive strategies.

The physiotherapy teams have concerns that only 70% of all referrals bounced back to referrers are returned. However, this may reflect the natural history of spinal pain, where many cases settle spontaneously.

Outcomes

Our pathways now ensure that all patients (>95%) are referred having received a bio-psychosocial assessment. This allows easier triage to appropriate treatment from first physiotherapy appointment. It also allows GPs to reassure patients unlikely to need further treatment. Patients have reported high levels of satisfaction at this approach, and physiotherapy teams find it efficient.

Physiotherapists report a skew to more complex cases and a trend towards reduced overall referrals (although six months in it may be too early to tell). This suggests using the STarT tool is helping to select patients with higher need, and ensuring that those who are likely to recover spontaneously remain managed in primary care.

Direct secondary care referrals have reduced to zero – saving on average 80 appointments a month. Using the multidisciplinary team approach generally halves the number of patients being referred to surgical teams from physiotherapy services, and has increased surgical conversion rates from 20% to 50%. It has also allowed faster access to surgical treatment for patients in severe pain. It will require re-audit of the whole system to assess the change in numbers of referred patients, but initial estimates suggest this approach has at least halved the number of referrals to surgical outpatients – saving more than 40 new appointments a month.

The website has attracted significant use – averaging 100 visitors a day with more than 5,000 regular users (patients who have visited more than five times). The PCT has funded expansion of the site to include problems with the hip and knee, foot and ankle, hand and elbow, and shoulder.

The future

The next steps are to work with local academic institutions to study the effects of self-care websites on patient outcomes. While we have anecdotal evidence of patient benefit, it would be important to quantify the value of such approaches, so as to assess their importance in a commissioned model of care. Research suggests these benefits to patients, of website information and tools, may be enhanced by peer support while accessing sites. We intend to include research questions that assess this.

Dr Ollie Hart and Dr Andy Hilton are both GPSIs in musculoskeletal medicine in Sheffield

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4 Hill JC, Whitehurst D, Lewis M et al. Comparison of stratified primary care management for low back pain with current best practice (STarT Back): a randomised controlled trial. *Lancet* 2011;378:1560-71.

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Dallam Lane Medical Centre, Warrington,
Cheshire, WA2 7NG.
Tel: 01925 572 334
or email warr-pct.dllmc@nhs.net.
For further information please call
Angela Bonney on 07811 768103

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(probable future partnership)

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

Closing date 31st May 2012.

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

GP Partnership opportunity from August 2012 (experienced or newly qualified)

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We are looking for an enthusiastic GP to join our friendly and supportive team of partners and salaried doctors providing care for around 11,000 patients from our purpose built surgery.

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A sense of humour and a "can do" attitude are essential!

Informal visits welcome.
Applications with CV by email to:
Chris Gebel, Practice Manager, North Swindon Practice

Chris.Gebel@nhs.net
Tel: 01793 707896

Closing date: Friday 15th June 2012

Salaried GP with a view to Partnership

Number of sessions negotiable - minimum of four.

Due to retirement, we are looking for an innovative, enthusiastic individual to share our commitment in providing high quality healthcare in a friendly long established GMS Practice.

List Size: 7,500
High QOF Achiever
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For more information, arrange an informal visit or for applications please forward your C.V. to: Grainne Rodriguez, Practice Manager, Silver Springs Medical Practice, Beaufort Road, St Leonards on Sea, TN37 6PP.
Email grainne.rodriguez2@nhs.net

Closing Date 31st May 2012

SALARIED GP

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(From October 2012)

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- *Ideally 8 sessions a week working over 5 days however we would consider less for the right candidate*
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Dorothy Pluck on 01442 892465 or Jenny Stevens on 01442 892466
Email: dorothypluck@nhs.net or jennystevens@nhs.net

Closing date 22nd June 2012

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Very friendly 3 partner practice. 6000 patients. family practice with very low turnover of staff and patients.

Own premises, purpose built Health Centre.

We are looking for someone able to commit to an equal share in the responsibilities, workloads and rewards.

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Tonge Fold Health Centre
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Bolton BL2 6DY

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Southam, Warwickshire CV47 2YG
Email Julie.Robson@gp-M84009.nhs.uk

Closing date for applications 1st June 2012

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St Andrews Health Centre
London E3 3NS

We are looking for enthusiastic GP's who are interested in being part of our rapidly growing team at St Andrews GP Surgery and Walk In Centre. Our aim is to deliver high quality primary care which integrates with the local community while providing a supportive and enjoyable place to work.

St Andrews Health Centre will be moving into a brand new building at the end of June and we are looking to recruit two new full time GP's to join us.

We offer a salary of £75,000 p.a. and opportunities in leadership and professional development.

Application forms can be downloaded at eastendgp.co.uk. Please return completed application forms to carole.mccluskie@nhs.net by May 17th 2012.
Interviews will be held on May 24th.

If you require further information please contact Ian Jackson our Practice Director on ianjackson1@nhs.net

College Street Medical Practice, Long Eaton, Derby / Nottingham border

8 Session Salaried General Practitioner with the view to partnership opportunity

College Street Medical Practice is a friendly and proactive PMS training practice looking for a flexible, enthusiastic and motivated Doctor to complement our clinical team and deliver high levels of quality care.

- *7,000 patients*
- *SystmOne*
- *High QOF achiever*
- *2 x Nurse Practitioners plus nursing team*

Interested candidates, please send CV with covering letter to, Jacob Cooke, Practice Manager, College Street Medical Practice, 86 College Street, Long Eaton, Nottingham, NG10 4NP.
Email: jake.cooke@nhs.net

Closing date: 31st May 2012
Interview date week commencing 11th of June 2012
Anticipated start date August 2012 or sooner

Tudor House and Rectory Road Medical Practice

GP LOCUM NEEDED

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

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- Emis-LV, moving to EMIS web in July 2012
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We require an additional GP to cover 6 sessions per week, salary & benefits negotiable.

One day per week as duty doctor 8 am – 6-30 pm, the other 2 days would be 8:30 – 5 : 30 with share of special clinics/agreed visits/ admin work, etc,.

The Practice is close to the A46 Evesham bypass which has good links to the M5 and surrounding areas.

Please Email CV, details and any enquiries to anthea.stewart@nhs.net

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Contact James Cusack (Partner) or Diana Kirk (Practice Director)
E-mail: James.Cusack@gp-c84029.nhs.uk
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Lombard Medical Centre, 2 Portland Street,
Newark, Notts NG24 4XG
Tel: 01636 702363
www.lombardmedicalcentre.co.uk

Closing Date for applications: 30/05/12
Interview Date: 20/06/12

FULL OR PART-TIME SALARIED GPs

Tudor Surgery is a close-knit practice situated in the market town of Nantwich, South Cheshire.

We are seeking two or more Salaried GPs to cover a total of 14 sessions from July 2012. We are happy to consider job shares or other innovative proposals to support a satisfying work-life balance.

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The successful applicants will be computer literate with good written and oral communication skills. They will practice evidence-based medicine, prescribe cost-effectively and be keen to be involved in reflective practice. Time will also be allowed to lead on specific areas of the QOF.

Annual Salary: £6,000 – £8,500 per session
(depending upon experience) plus MDDUS cover.

If you wish to join our enthusiastic team please apply with CV and covering letter by email or to:
Dr Keith Malone, Tudor Surgery, Church View PCC, Beam Street, Nantwich CW5 5NG.
Tel 01270 610686.
Email: keith.malone@gp-n81090.nhs.uk

Closing date 31-5-2012

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in Goring by Sea is a friendly, supportive training 7-doctor PMS practice by the sea in West Sussex with the following exciting job opportunities:

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Closing date: 23rd May 2012

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Or email ccampbell@nhs.net for further information

Informal visits welcome

Closing date for applications 31st May, with Interviews 30th June 2012

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• Six partners (4.6 WTE) • Highly skilled nurses
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• Involved in PBC • High QOF achievers
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• Many DESs including Substance Misuse.

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

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6 Session Salaried General Practitioner

College Street Medical Practice is a friendly and proactive PMS training practice looking for a flexible, enthusiastic and motivated Doctor to complement our clinical team and deliver high levels of quality care.

- 7,000 patients
- SystmOne
- High QOF achiever
- 2 x Nurse Practitioners plus nursing team

Interested candidates, please send CV with covering letter to, Jacqui Cooke, Practice Manager, College Street Medical Practice, 86 College Street, Long Eaton, Nottingham, NG10 4NP. Email: jacqui.cooke@nhs.net

Closing date: 31st May 2012.
Interview date week commencing 11th of June 2012
Anticipated start date August 2012 or sooner

DALEFIELD SURGERY

Salaried GP

4 sessions per week
Potential for partnership

Dalefield Surgery is an expanding practice that requires a motivated salaried GP with view to partnership

- *Progressive GMS practice – list size 5,700*
- *2 partners , 1 salaried GP, 1 Nurse Practitioner*
- *Excellent Management, Nursing and Support staff*
- *Maximum achieving QOF*
- *Vision INPS system*

Please send CV to Mrs Marie Bryan, Practice Manager,
Dalefield Surgery, Avondale Health Centre,
Avondale Street, Bolton. BL1 4JP
Or e-mail: marie.bryan@nhs.net

Closing date for applications 31st May 2012
Interviews to be held Monday 11th June 2012

TRAINING PRACTICE, KENT
Winterton Surgery, Westerham

GP wanted for 4-8 sessions, replacement partner, starting early September

5 partners, [4.25WTE], with salaried assistant. GMS practice, with dispensing, working from two sites, list size 8,200.
Well established, semi-rural, close to London, airports and the coast! We can adapt to the right person! No sense of humour required!

Please send CV with covering letter to Mrs M. Dickinson-Stapley, Winterton Surgery, Market Square, Westerham, Kent TN16 1RB or email to margaret.dickinson-stapley@nhs.net

Closing date 18th May

SALARIED GP

Six sessions per week - £48,000
plus MDU contribution & pension

6 weeks holidays plus one week's study leave
East Barnet/Southgate borders

Enthusiastic, committed GP required for small supportive practice

To start as soon as possible

Fully staffed, EMIS LV Paperlight, High QOF Achiever, GMS Practice, No OOH, 3100 patients

Send CV to: Jacqui Perfect (Practice Manager) Jacqui.perfect@nhs.net

www.oakridgemedicalpractice.co.uk

Closing date for applications: Friday 25th May 2012

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

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

Amman Valley Practice, Ammanford SA18 1EG

Salaried GP required

Gateway to the Black Mountain
Varied and diverse workload
Opportunity to develop clinical interests in a supportive and innovative team
4 or 8 sessions, commencement summer 2012

Closing date: May 28th 2012

Informal enquiries welcome
All enquiries and CVs to the Practice Manager
Helen.Fender@gp-w92610.wales.nhs.uk

RARE G.P PARTNER OPPORTUNITY

Close to home but far from being the UK.
A thriving private family practice in JERSEY.
FME work available.
Low overheads, high income, low tax.
Work to live in an Island of opportunities.
Arguably the best schools, beaches & climate in the the UK.

Apply to Dr. Sarah Kennea
7 David Place Medical Practice, St. Helier, Jersey, JE2 4TD
Email: dr.sarah_kennea@me.com Tel: 07797810570

DOCTORS/GPS REQUIRED

PULBOROUGH MEDICAL GROUP

SALARIED GP POSITION

Established and friendly 9 doctor training practice with 12,400 patients, fully computerised using the SystmOne clinical system.
We are looking for a salaried GP to work 6 sessions per week.
Specialist skills welcomed particularly in Minor Surgery.
However enthusiasm and motivation equally important.

Start date: beginning of August 2012
Interview date: Wednesday 23rd May

Enquiries and applications with CV and covering letter by Friday 18th May to Alan Bolt, Managing Partner, Pulborough Medical Group, Spinn Close, Pulborough, West Sussex RH20 1FG.

PMG is committed to excellence in patient care and investment in their people.

WORSLEY MANCHESTER

We are a friendly, high achieving 3 doctor practice looking for an enthusiastic salaried GP to join us, with a view to partnership.

+ 6/8 sessions negotiable. + 7 weeks annual leave. + EMIS PCS paperlite. + GMS List size 5800. + Excellent QOF. + Medical students. + Excellent nursing and support staff.

For further information, please contact practice manager, Sangeeta Ganvir on 0161 790 8621 or sangeeta.ganvir@nhs.net

HARLEY STREET DOCTORS LTD.

Doctors required UK-wide for mobile insurance medicals, especially in the following areas:
London, Bournemouth, Southend, Chelmsford, Reading, Southampton, Leics., Lincs., Cambs., Herts., Dorset, Dundee & Aberdeen
Please email your CV to: peter@harleystreetgroup.co.uk or call on 020 7224 0030

Kingsfold Medical Centre, Preston

SALARIED GP REQUIRED

WITH A VIEW TO PARTNERSHIP
9 sessions per week

• GMS practice • Approximately 4000 patients
• EMIS LV • High QOF achievement
• Nurse led Chronic Disease Clinics

Please apply with covering letter and CV to: Sangeeta Chikhalikar
Kingsfold Medical Centre, Woodcroft Close, Penwortham, Preston PR1 9BX
Telephone - 01772 909128
Email: Sangeeta.chikhalikar@gp-p81181.nhs.uk
www.kingsfoldmedicalcentre.co.uk

Full - Time Salaried GP
London NW10

We are looking for a Full-Time Salaried GP Willesden, London NW10

Start date 1.7.2012.

Computerised with Emis.
Friendly 6 Partner Practice,
List size approx 10,000.
8 Sessions per week including on call + late evenings on alternative weeks.
No weekends (OOH).
With at least 2 years Clinical Experience.
Preferable qualified for contraception services MRCGP, 6 weeks annual leave, (includes 1 week study leave).
We encourage Team work and good Communication.
Visit to the Practice, Welcome.

For more information please contact:
Dr D Durica or Practice Manager - Patsy Campbell.
Patsy.campbell@nhs.net
Tel 0208 459 5550 ~ Fax 0208 451 7268
Or apply with CV with handwritten letter
Dr S Ramdahen & Partners, The Medical Centre, 144 - 150 High Road, Willesden London NW10 2PT

Closing date for applications – 31.5.2012

Doctors required UK-Wide for Insurance medicals.

dc life

...is growing. Join our panel of doctors who provide Insurance Medicals.

• Adhoc or sessional work • Training provided
• Excellent remuneration • Full administrative support

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

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

Surrey/Sussex Border
Salaried GP (Full time)

We are a friendly and progressive PMS Training Practice with a list of 15,000 patients on 2 town sites near Gatwick.

We are looking for a candidate who is motivated, committed to clinical excellence, teamwork, and is willing to work with immigration detainees.

Salary range £71,158 - £81,158 (FTE) based on experience

For further information or to arrange an informal visit please contact Christine Stickle on 01293 658814 or via email christine.stickle@nhs.net

www.saxonbrook.co.uk

Hertfordshire, Whitwell Surgery

Full Time Partner / Salaried GP

part time / job share considered

GP required to join well organised and established small friendly practice.

- Salary negotiable
- 2500 patients
- Consistently high QOF achievement
- Purpose built premises
- EMIS LV
- Excellent admin & clinical support

Informal visits welcome.

To apply please send CV & covering letter to: Beverley Sheaver, Practice Manager, Whitwell Surgery, 60 High Street, Whitwell, Hitchin, Herts SG4 8AG. 01438 871398 beverley.sheaver@nhs.net

Spilsby Surgery - Salaried GP

Spilsby Surgery is looking for a whole-time or substantive part-time salaried doctor to join their friendly innovative team from August 2012. We are committed to delivering patient centric care within the beautiful setting of the Lincolnshire Wolds, an Area of Outstanding Natural Beauty that offers affordable property and good schools.

We are a high performing surgery that has been at the centre of innovative practice over the last 20 years. We have led within our locality on the care of patients with LTC and been at the forefront of developing new clinical roles within primary care. We offer a mixed skills nursing team with an excellent management and support structure. We are fully engaged and participate in the local Clinical Commissioning Group and have striven to see the opportunity this may afford us in providing more local services to our patients. The practice is committed to undergraduate and postgraduate education.

We are looking for a doctor who is committed to primary care in the 21st century and offer an attractive financial package to the successful candidate.

We welcome meeting all prospective applicants at the surgery so that we can convey our passion and vision for the practice moving into the future.

For further information or an informal discussion, please contact:

Mrs Jeannie Bee, Executive Partner
Tel: 0844 477 3309 Email: jeannie.bee@lpct.nhs.uk
Spilsby Surgery, Bull Yard, Simpson Street, Spilsby, PE23 5LG

Closing date for applications is Thursday 31st May

LOCUM AGENCIES

COURSES & CONFERENCES

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

EDITOR'S CHOICE

Don't believe CCGs can't achieve

Forget the negativity – our CCG has transformed mental health services, says Dr John Orchard

We have heard so much negativity from all corners of the profession towards CCGs it is time to redress the balance.

Here in Hardwick CCG in Derbyshire, the most underfunded CCG in the most underfunded CCG cluster, we have plenty to smile about.

First, we have brought together enthusiastic, creative health professionals with a can-do approach keen to share ideas that improve patient care.

Second, we have a fantastic lean management team who share our goals.

Third, our local trusts have all undergone an epiphany and now see our views as important.

Dr John Orchard: GP commissioners can do things differently

What we can clearly see is a major opportunity to move our patients from their perennial position as the lost tribes of Derbyshire to the first beneficiaries of the new Health and Social Care Act. So what has really changed? Psychodynamic psychotherapy was a major bone of contention with a long waiting list of direct GP referrals in the south of the county and no service in the north. What was this expensive service doing? Apparently, seeing the same people, regularly, for up to five years. Surely, this is general practice? Extensive public consultations have been followed along with constructive meetings with therapists. The result is service re-design with these aims:

- Early assessment of each individual who reaches tier 4, by a psychotherapist who can signpost them to the therapy most likely to help.
- A commitment to step down services to return patients to primary care as a goal.
- Equity of access to all types of therapy across the county rather than a postcode lottery.

This has been a painful learning exercise, but the process has resulted in new energy and focus for all parties.

Dr John Orchard is a GP in Alfreton, Derbyshire, and a board member of Hardwick CCG

MORE ONLINE
Read the rest online at pulsetoday.co.uk/comment

OFF DUTY

We're working at a time of huge stress for GPs. How many of us recommend exercise to help stressed-out patients, then jump in the car on the way to a home visit? There is a growing body of evidence that exercise can help depression and anxiety. Perhaps we should be tapping into that, setting a good example to our patients.

▶ pulsetoday.co.uk/off-duty

WHAT YOU'VE BEEN SAYING

▶ pulsetoday.co.uk/forum

"It is often said each generation recycles the mistakes of its predecessors."
... on face-to-face consultations by GPs being 'no longer sustainable'

"Lansley is a firm believer in transparency – except for himself."
... on the Government blocking the release of the NHS risk register

"Look what striking did for the miners."
... on doctors' ballot on industrial action over pensions

GPs TO BE

What it means to be a GP

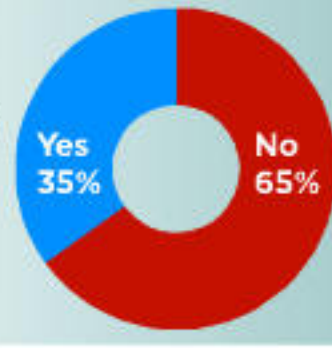
I am sometimes asked what a GP does. If you ask a politician, a GP is someone who attends meetings and commissions care. If you ask a journalist, he is someone who plays a lot of golf with his stockbroker. If you ask a hospital specialist nurse, then he is someone who needs instruction...

GPs TO BE
Read the full post
pulsetoday.co.uk/gps-to-be

THIS WEEK'S POLL

Is self-care the answer to the NHS efficiency drive?
Vote at ▶ pulsetoday.co.uk/polls

Last week's poll
Are GPs ordering too many lab tests?



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