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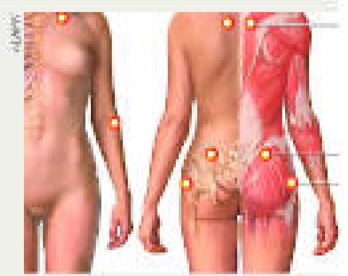

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At the heart of general practice since 1960

Practices forfeit QOF income over A&E plans

PCOs forced to extend deadline as practices face struggle with QP indicators worth over £4,000

EXCLUSIVE
By Madlen Davies

Practices are struggling with the new A&E indicators in the QOF, with almost a third missing the initial deadline to review casualty visits by their patients.

With £900 of lost income at stake for the average practice, some primary care organisations have been forced to issue a blanket extension to the deadline for practices to report on how their access arrangements might be a factor in avoidable A&E visits.

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GPs cannot cure all society's ills 15

LMC leaders said GPs felt A&E attendance rates were beyond their control

But other PCOs said they would hold fast to the 31 July cut-off for indicator QP12, and practices that had failed to meet it would miss out on the QOF cash.

LMC leaders are blaming the problem on workload, flaws with the indicator and the failure of some PCOs to provide practices with A&E attendance data, leaving GPs unable to conduct a practice review. They warned practices now face an uphill struggle to hit indicators QP13 and 14, together worth £3,210 to the average practice. These require practices to take part in external peer review of their A&E data and agree an action plan by the end of this month – then put that plan into practice by 31 March.

Who's hit the deadline?

- 29%: Proportion of practices that missed 31 July deadline
- 71%: Proportion that met deadline

Data from 28 PCOs collected by Pulse showed 29% of 2,331 practices failed to meet the 31 July deadline to produce their QP12 report, although the majority have now been granted an extension by their PCO.

Among the areas to grant extensions to all practices were NHS Walsall, NHS North West London and NHS Hertfordshire. However, NHS Birmingham cluster said the 15 practices that missed the July deadline 'will not qualify for the points associated with QP12'. NHS Bournemouth and Poole, where 20% of practices missed the deadline, said while some were permitted extensions 'a couple' were not and 'therefore will not be paid'.

Dr Nigel Watson, chief executive of Wessex LMCs, said there was 'a problem with practices getting the information, and once they looked at the data they struggled to see any patterns or draw any conclusions'. He added many GPs felt A&E attendance was beyond their control.

Dr Robert Morley, executive secretary of Birmingham LMC, said single-handed practices had struggled: 'Some practices might have decided it was not worth it, and they'll forfeit the funding.'

The Department of Health introduced the three new A&E indicators on a 12-month trial basis in April, to replace the scrapped QP prescribing indicators. For QP12, practices are required to focus their efforts on A&E attendances by high-risk older patients, children under 16 and frequent attenders. Their report must identify patterns and consider whether improved same-day access at the practice could reduce A&E visits.

NHS Employers said that as the three indicators followed on from each other, missing QP12 'could result in an inability to achieve QP13 and 14'.

@madlendavies

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CPD in this issue: 4.5 hours
Earn CPD for three articles in our Clinical section and our Commissioning feature

DH rethinks GP training levy fee

Government reconsiders plan for levy on all practices, after RCGP and GPC raise concerns over 'unintended consequences' of payments

By Helen Mooney

The Government has signalled a rethink over plans for all practices to pay a new levy for the training of doctors, after GP leaders said the proposal could lead to an 'exodus' of senior GPs.

The RCGP had warned that general practice could be destabilised if the Government pushed ahead, while the GPC said it was unfair to expect GPs to pay to train future doctors.

The plans originally stated that all healthcare providers should pay a levy for the education and training of doctors to replace current Department of Health funding for deaneries, but this is now being looked at again.

The levy was to be paid to the new local education and training boards – due to be authorised next month – but the Government said this month that in response to a 'diverse range of views' over the payment, work was now 'ongoing' into how the levy would work.

The DH rethink came after MPs on the Commons health committee said there was 'slender evidence of progress in converting this policy into a system that will work in practice' in their report into NHS education, training and workforce planning, published in May.

The DH response to the report, published this month, confirmed that more work needed to be done before 'firm proposals' on a levy could be put out for consultation.

The DH statement said: 'The [health] committee received a diverse range of views with regards to the proposal to raise the education and training budget through a levy on providers.

'This illustrates the complexity associated with the proposal and the need for detailed work.'

In its 2010 white paper *Equity and excellence – liberating the NHS* the Government stated that in future 'all providers of healthcare services' would be required to pay the levy that will replace the Multi Professional Education and Training budget that is currently paid to SHAs.

It said this would 'support the level playing field between providers', but the plans led to concern from GP leaders.

Earlier this year in written evidence to MPs, the RCGP warned the levy could have a drastic impact on GP practices.

It said: 'Such a system could have significant unintended consequences for small providers, including GP practices, who have previously not been required to pay for training.

'Such payments could cause an exodus of senior staff, destabilising the system as a whole.'

Dr Laurence Buckman, GPC chair, said he was 'pleased' the Government was reconsidering funding for medical training.

He said: 'GPs should not be charged for the privilege of training the next generation out of personal or practice income. We will await the outcome of their deliberations with interest.'

Dr Beth McCarron-Nash, a GP in St Columb Major, Cornwall, and former GPC negotiator with responsibility for training, said GP practices could not be treated the same as large hospital trusts.

She said: 'We are small businesses and it is different from being a very powerful provider – such as a foundation trust. The costs in general practice are extremely different.'

A DH spokesperson told Pulse it was still working on the detailed planning, and refused to say whether any levy would still apply to GP practices.

feedback@pulsetoday.co.uk

How levy row has developed

- **JUL 10** Government says 'all providers of healthcare services' will pay a levy to meet costs of education and training
- **DEC 10** DH consultation paper says implementation of the levy would be 'staged' with a notional levy preceding an actual one
- **JAN 12** In its policy paper *From design to delivery*, the DH notes there were concerns about 'potential side-effects' from levy
- **EARLY 12** RCGP warns MPs levy could have 'significant unintended consequences' for general practice
- **MAY 12** Commons health committee report says there is 'slender evidence of progress' in making levy something that will work in practice
- **SEP 12** DH signals rethink on who will have to pay levy and says work 'is ongoing'

Dr Beth McCarron-Nash: GPs should be treated differently

THE BIG INTERVIEW Watch Dr Beth McCarron-Nash speak about the training levy and other topics pulsetoday.co.uk/the-big-interview

The week in general practice

PCTs ask GPs to scrutinise consultant-to-consultant referrals **page 4**

GP leaders raise fears clinical commissioning could be 'diluted' by new health secretary Jeremy Hunt **page 6**

Think tank claims small business model for general practice is 'unfit for purpose' **page 10**

HPA accused of 'palming off' extra work on GPs **page 11**

CQC chair Dame Jo Williams announces she is stepping down from her role as head of the regulator ▸ pulsetoday.co.uk/politicalnews

Download of the week
Read the full report from the King's Fund that recommends changes to the 'cottage industry' of general practice ▸ pulsetoday.co.uk/downloads

The Big Interview
Watch The Big Interview with former GPC negotiator Dr Beth McCarron-Nash ▸ pulsetoday.co.uk/the-big-interview

BIG Question Are you happy with Jeremy Hunt as the new health secretary? ▶ pulsetoday.co.uk

150 public health QOF points loom

EXCLUSIVE

By Madlen Davies

Ministers have asked NICE to look at introducing a new public health domain in next year's QOF, as part of moves to ring-fence 150 points for preventing disease and tackling healthcare inequalities.

The new domain is being negotiated by NHS Employers and the GPC for introduction in April 2013.

Discussions are focusing on which indicators should be included, but the GPC is insisting the domain must be made up solely of existing QOF indicators shifted into the new public health section.

GPC deputy chair Dr Richard Vautrey said: 'Practice activity will remain unchanged. It shouldn't make it tougher. The QOF will continue to remain evidence-based.'

Dr Bill Beeby, the GPC's prescribing lead, insisted there was plenty of scope to redesignate enough existing QOF points: 'A lot of the QOF is already "public health" – looking at health interventions on a mass scale with the intention of producing long-term population gains. Such is the reasoning behind statins.

'If they are going to introduce other measures, there needs to be good science behind it, and that might stall some of the more vague ideas.'

But Professor Helen Lester, clinical QOF indicator development lead, predicted attention would focus on 'obesity, smoking, physical activity and alcohol'.

An NHS Future Forum report published in January made a strong case for tougher public health targets in the QOF, calling for GPs to 'make every contact count' in tackling these four big lifestyle risk factors.

The report said: 'Some incentives do not sufficiently target improved population health and wellbeing. The QOF rewards GP practices for keeping a register of obese patients. It does not go further and reward practices for supporting patients to eat more healthily, exercise more or access weight-loss support.'

A Department of Health spokesperson said the proposal for 15% of the QOF to be devoted to public health had been set out in a 2010 white paper: 'We have discussed this proposal with NICE, and NHS Employers are now consulting with the GPC about setting up the domain including which indicators will be included in April 2013.'

All indicators will pass through the NICE QOF advisory process.

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SEMINAR Last chance to book onto Diabetes and CVD Update 2012, London, 26 September pulse-seminars.com

ANALYSIS

Evidence GPs can change lifestyle is lacking

Nigel Praities
Deputy editor

There have been many calls for GPs to take a more active role in promoting better health, but it looks like this Government is getting serious.

The proposal to ring-fence a proportion of the QOF and devote it to public health is a significant shift in the direction signalled by the Government's 2010 public health white paper.

This said that at least 15% of the current value of the QOF should be devoted to 'evidence-based public health and primary prevention indicators' from 2013, with funding from Public Health England.

This was taken forward by the NHS Future Forum earlier this year, when it said GPs should be incentivised through the QOF to support patients to 'eat more healthily, exercise more or access weight-loss support'.

It emerged this week that the GPC and NHS Employers are now negotiating on which indicators will fall under this new domain – including existing ones on smoking and obesity.

The GPC insists the move will not mean any additional work, but it remains to be seen how the Government plans to ramp up the work that GP practices have to do in future years to persuade patients to modify their lifestyle. The latest proposals will have various lobby groups daydreaming of a raft of new indicators, but such calls should come with a health warning attached.

Interventions in patients with low levels of physical activity or problem drinking will involve a large number of patients, and the evidence that GPs can encourage lifestyle change is patchy at best.

As the recent analysis of the DESMOND trial in diabetes showed, even those who have an active interest in living more healthily need access to sustained support rather than simply a brief intervention after diagnosis.

A recent analysis cited the MRFIT trial in patients at risk of cardiovascular disease as an example of how interventions should be designed, with patients having two initial screening sessions and then 10 weekly group sessions and annual assessments to discuss managing their risk factors.

That will require a lot more investment than shuffling around a few QOF points.

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July 2012

Protest on commissioning

Dr Helena McKeown has resigned from her role as an RCGP commissioning champion in protest against what she branded 'covert rationing' and 'potentially dangerous practices' taking place in the NHS. The RCGP council member said she was 'too disillusioned with the reality' of commissioning to continue in the role: 'If we were truly able to commission to make best use of resources and not tie ourselves to constitutions with open-ended commitments that interfere with our role as a GP, I would be proud to be asked to continue.'

▶ Full story: pulsetoday.co.uk/commissioning-news

How we reduced our CCG spend on vitamin D ▶ page 36

LMCs condemn 'big hassle' as CCG crackdown sees GPs asked to scrutinise consultant-consultant referrals

REFERRALS

GPs asked to vet consultant referrals

EXCLUSIVE
By Jaimie Kaffash

GPs are being asked to scrutinise consultant-to-consultant (C2C) referrals as CCGs crack down on rising rates to cut spiralling costs.

NHS Oxfordshire has tasked GPs with challenging 'any onward consultant referral they feel is inappropriate', via a new system through which practices will receive electronic copies of all non-emergency C2C referral letters relating to their patients.

Similar schemes are being operated at Newcastle upon Tyne University Hospitals NHS Trust, where consultants must make 'direct communication' with GPs before a non-urgent C2C referral is made, and NHS Rotherham, where an audit showed GPs were unaware of 42% of C2C referrals.

The moves come after a surge in non-GP referrals, with Department of Health figures showing a 9% year-on-year increase in the first quarter of 2012/13.

In a letter to the Oxfordshire LMC, Emma Torevell, the associate director of QIPP delivery at NHS Buckinghamshire and Oxfordshire PCT cluster, said the scheme would task GPs with closely scrutinising referrals in a bid to cut costs.

Ms Torevell wrote: 'GPs need to be clear on the specific reason for onward referral, particularly given the apparently high level (and cost) of C2C activity in Oxfordshire. Having access to this information will enable those GPs who wish to, to challenge any onward consultant referral that they feel is inappropriate or could be managed differently.'

Dr Mary Keenan, medical director of Oxfordshire CCG, said: 'Broadly, the consultants seem to be accepting.'

But Dr Paul Roblin, chief executive of Buckinghamshire and Oxfordshire LMC, said the proposals were a 'big hassle' for GPs, and said the LMC would discuss alternative potential proposals this week: 'There is a logic to putting constraint on the ability of secondary care clinicians to refer outside their sphere of confidence and to avoid waste. But it does put extra work on GPs.'

Dr Michael Dixon, chair of the NHS Alliance, said: 'By far the faster expanding cause of referrals is C2C. In most cases, it is bona fide. But there are suspicions in some hospitals that this is fuelling an industry in payment by result tariffs.'

Dr Paul Flynn, deputy chair of the BMA's consultants committee and an obstetrics and gynaecology consultant on Abertawe Bro Morgannwg University's health board, said: 'A lot of PCOs have got themselves worked up about this. But I would question evidence that [C2C] are any more inappropriate than referrals by primary care.'

Meanwhile, Coastal West Sussex CCG is asking GPs to challenge trust gaming after evidence suggested commissioners were paying double the correct amount for outpatient appointments. In its 2012/13 QIPP delivery plan, the CCG said there was 'good evidence' that outpatient follow-up treatments were being charged as new outpatient appointments with the corresponding financial benefit to the trust. The CCG said closer GP monitoring of C2C referrals could help save £500,000 a year.
feedback@pulsetoday.co.uk

GPs are being tasked with tackling the spiralling costs of C2C referrals

How GPs are vetting C2C referrals

NHS Oxfordshire
All GPs must be sent electronic copies of C2C referral letters relevant to their patients

Newcastle upon Tyne University Hospitals Trust
Direct communication between consultants and GPs should be made in non-urgent situations, before referral is made

NHS Rotherham
All C2C referrals must be communicated to the GP

RED TAPE

Rules 'overwhelming'

The 'overwhelming' number of rules and regulations being produced around the new NHS framework is threatening to undermine CCGs' ability to redesign services, commissioning leaders have warned.

NHS Clinical Commissioners, a representative body for CCGs, said it was crucial that new commissioning organisations were involved in shaping how the reforms developed, and were not weighed down by red tape.

It urged the NHS Commissioning Board to involve GPs in the development of its draft module, which includes targets to promote integrated care and extend patient choice.

Dr Charles Alessi, interim chair of NHS Clinical Commissioners, said: 'Just at the time when CCGs are having to focus on their own authorisation, there are important commitments being made that potentially affect their ability to plan care in line with the local priorities they have identified.

'There are an overwhelming number of rules and regulations being produced at speed, which will have significant impact on commissioners. So it is essential they have the opportunity to help influence them.'

The body said it was collecting evidence from members, and planned to set out its views on the direction of the reforms in the autumn.

'There are an overwhelming number of rules and regulations.' Dr Charles Alessi

Mike Farrar, NHS Confederation chief executive, and member of the NHS Clinical Commissioners steering group, said: 'CCGs should not feel pushed to make speedy decisions without being given the opportunity to consider the full range of options available to help them transform local services and improve quality and value.'

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SERVICE PLANNING

Somatoform tool boost

Computer programs can predict the prevalence of patients with medically unexplained symptoms (MUS) at GP practices, but need more work before they can be used by commissioners to plan services, say UK researchers.

Their study found a model estimating MUS prevalence from GP records showed 'adequate goodness of fit' when compared with GP-observed levels, but they also found their estimates were hampered by GPs not always recording all patient symptoms in the patient's notes.

The researchers said this was the first study to look at developing computer models to estimate the prevalence of MUS in general practice. It did this by looking at symptoms recorded by 17 GP practices – such as anxiety, stress, psychiatric referrals and asthma – in 'consecutive consulters'.

The researchers found the models had a c-statistic of 0.70 and 0.76, suggesting both had a 'reasonable ability to distinguish cases from non-cases'.

The Government announced last year that the Improving Access to Psychological Therapies programme would receive £400m in additional funding through 2014/15 to extend it to new groups, such as those with MUS.

Dr Shane Gordon, a GP in Tiptree, Essex, and clinical commissioning co-lead at the NHS Alliance, said: 'This is a potentially highly productive area of work.

'Not only do we need good models of prevalence, but also good methods to identify specific patients and evidence-based interventions to reduce any inappropriate use of health resources.'

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Date of Preparation: August 2012. CHGBI/CHNIQ/0072/12

References: 1. Ferguson SG and Shiffman S. The relevance and treatment of cue-induced cravings in tobacco dependence. Journal of Substance Abuse Treatment 2009; 36: 235-43. **2.** Durcan MJ *et al.* Efficacy of the nicotine lozenge in relieving cue-provoked cravings. Presented at the 5th European SRNT. Padua, Italy. 2003.

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Copperfield: Nobody notices when we're right
▶ page 18

Fears Hunt may 'dilute' reforms

GP commissioners urge new health secretary not to take his foot off the pedal with reform plans

By Gemma Collins

GPs have raised fears over the future direction of clinical commissioning under new health secretary Jeremy Hunt, amid questions over his suitability as Andrew Lansley's replacement in the Cabinet.

Following the announcement that Mr Lansley had been removed from his post as part of Prime Minister David Cameron's reshuffle, leading GPs voiced concerns that Mr Hunt may 'dilute' clinical commissioning.

Despite the wave of criticism Mr Lansley faced from the profession over his handling of the reforms, GP commissioners praised the architect of the controversial Health and Social Care Act and insisted Mr Hunt had a lot to prove.

They warned that he had to support GP commissioners and not become a 'puppet' health secretary, as details emerged that he has opposed reconfiguration of a hospital in his constituency and expressed support for homeopathy on the NHS.

Jeremy Hunt: new health secretary 'has a lot to prove'

Dr Mike Dixon, chair of the NHS Alliance, interim president of NHS Clinical Commissioners and a GP in Cullompton, Devon, said clinical commissioning could be 'diluted' by the new health secretary.

'Andrew Lansley was the most ferocious advocate for GP commissioning that we ever had,' he said.

'I am concerned that a secretary of state who doesn't have a tough grasp might give into the vested interests that oppose GP commissioning.'

Dr Dixon added: 'My real fear is that the secretary of state might dilute GP commissioning and that we might end up with dispirited reforms. I hope he doesn't give in.'

Dr Peter Swinyard, chair of the Family Doctor Association, and a Swindon GP, said Mr Hunt faced an 'enormous challenge'.

'Andrew Lansley was a competent man who understood the health service, even if people didn't like him,' he said.

'Jeremy Hunt has a lot to prove. It will be interesting to see if he goes in a different direction and brings bigger changes or if he is just a puppet. I hope he is not a placebo health secretary.'

Dr Paul Charlson, a sessional GP in East Yorkshire and close adviser to Mr Lansley as chair of Conservative Health, admitted: 'It was time for a change.'

But he added: 'With a change of face, the dynamic can change. There will be a different relationship that can improve the situation or make it worse.'

Hunt on the NHS

Reconfiguration

'If the PCT really does want to close the community beds at Haslemere, they had better be ready for a fight.'

Speaking against bed closures in his Surrey constituency, 2010

Homeopathy

'It is your view that homeopathy is not effective, and that people should not be encouraged to use it as a treatment. I am afraid that I have to disagree with you.'

Letter to constituent sceptical about homeopathy, 2007

Abortion

In 2008, he voted for the time limit on abortion to be reduced from 24 to 12 weeks.

The new ministerial line-up is completed by former Liberal Democrat health spokesman Norman Lamb, who replaces Paul Burstow as minister for care services, Dr Daniel Poulter, a former obstetrician, and Anna Soubry – who replace health ministers Simon Burns and Anne Milton respectively.

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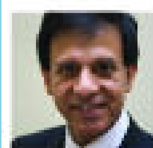
GP VIEWS

Reaction to Jeremy Hunt's appointment



'We need a health secretary who listens, who does not force change on the basis of ideology and who halts the elements of the reforms that the profession is directly opposed to.'

Dr Chaand Nagpaul, GPC negotiator

'Like any other new minister, he will wish to make his mark, but in no way should a reshuffle indicate a change in policy or direction.'

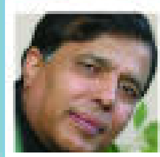
Dr Charles Alessi, NAPC chair and interim chair of NHS Clinical Commissioners

'The appointment provides a fresh opportunity for doctors and the Government to work together.'

Dr Mark Porter, BMA chair

'Among other things, we will be seeking Mr Hunt's support for increased recruitment and retention of GPs and extension and enhancement of GP training.'

Dr Clare Gerada, RCGP chair



'His NHS track record is nothing to be proud of. But it is in his interest as well as ours that we sit down around the negotiating table.'

Retired GP Dr Kailash Chand, who was appointed BMA deputy chair this week

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Prescribing Information

DECAPEPTYL® SR 3mg, DECAPEPTYL® SR 11.25mg and DECAPEPTYL® SR 22.5mg

Presentation: Powder for suspension for injection. Vials for all preparations contain an overage to ensure the licensed dose is administered. *Decapeptyl SR 3mg*: Triptorelin acetate 4.2mg. *Decapeptyl SR 11.25mg*: Triptorelin acetate 15mg. *Decapeptyl SR 22.5mg*: Triptorelin pamoate 28mg. Triptorelin acetate and triptorelin pamoate are bioequivalent. **Uses:** Treatment of locally advanced, non-metastatic prostate cancer, as an alternative to surgical castration, and treatment of metastatic prostate cancer. As adjuvant treatment to radiotherapy in patients with high-risk localised or locally advanced prostate cancer (Decapeptyl SR 3mg, 11.25mg and 22.5mg). **Dosage and Administration:** Decapeptyl SR 3mg: One intramuscular (i.m.) injection every four weeks (28 days). *Decapeptyl SR 11.25mg*: One i.m. injection every 3 months. *Decapeptyl SR 22.5mg*: one i.m. injection every 6 months. *Additional dosing information*: No dosage adjustment necessary in the elderly. The injection site should be varied periodically. Inadvertent intravascular administration must be avoided. **Contraindications:** Hypersensitivity to LHRH, its analogues or any other component of the medicinal product. **Precautions and Warnings:** Long-term use of LHRH agonists is associated with an increased risk of bone loss and may lead to osteoporosis and increased risk of bone fracture. Particular caution in patients with risk factors for, or established osteoporosis is necessary. Rarely, LHRH agonist treatment may reveal the presence of a gonadotroph cell pituitary adenoma. Mood changes, including depression have been reported. Patients with known depression should be monitored closely during therapy. Initially, Decapeptyl SR, like other LHRH agonists, causes a transient increase in serum testosterone levels. As a consequence isolated cases of transient worsening of signs and symptoms of prostate cancer (tumour flare) and cancer related (metastatic) pain may occasionally develop during the first weeks of treatment and should be managed symptomatically. During the initial phase of treatment, consideration should be given to the additional administration of a suitable anti-androgen to counteract the initial rise in serum testosterone levels and the worsening of clinical symptoms. As with other LHRH agonists, isolated cases of spinal cord compression or urethral obstruction have been observed. Careful monitoring is indicated during the first weeks of treatment, particularly in patients suffering from vertebral metastases, at risk of spinal cord compression, and in patients with urinary tract obstruction. After surgical castration, Decapeptyl SR does not induce any further decrease in testosterone levels. From epidemiological data it has been observed that patients may experience metabolic changes (e.g. glucose intolerance), or an increased risk of cardiovascular disease during androgen deprivation therapy (ADT). Patients at high risk for metabolic or cardiovascular diseases should be carefully assessed before commencing treatment and their glucose, cholesterol and blood pressure adequately monitored during ADT at appropriate intervals not exceeding 3 months. Administration of triptorelin in therapeutic doses results in suppression of the pituitary gonadal system. Normal function is usually restored after treatment is discontinued. Diagnostic tests of pituitary gonadal function conducted during and after discontinuation of therapy with LHRH agonists may therefore be misleading. **Interactions:** Drugs which raise prolactin levels should not be prescribed concomitantly as they reduce the level of LHRH receptors in the pituitary. When Decapeptyl SR is co-administered with drugs affecting pituitary secretion of gonadotropins, caution should be exercised and it is recommended that the patient's hormonal status be supervised. **Pregnancy and Lactation:** Not applicable. **Undesirable effects:** Very common: Asthenia, hyperhidrosis, back pain, paraesthesia in lower limbs and hot flush. Common: Nausea, fatigue, injection site erythema, injection site inflammation, injection site pain, injection site reaction, oedema, musculoskeletal pain, pain in extremity, dizziness, headache, erectile dysfunction and loss of libido. Rarely, cases of anaphylaxis and hypersensitivity have been reported. Prescribers should consult the Summary of Product Characteristics in relation to other side effects. **Overdosage:** No human experience of overdosage. **Pharmaceutical Precautions:** Do not store above 25°C. Reconstitute only with the suspension vehicle provided. Decapeptyl SR is a suspension, therefore once reconstituted it should be used immediately. **Legal Category:** POM. **Basic NHS cost:** Decapeptyl SR 3mg £69.00 per vial. Decapeptyl SR 11.25mg £207.00 per vial. Decapeptyl SR 22.5mg £414.00 per vial. **Marketing Authorisation Numbers:** Decapeptyl SR 3mg: PL 34926/0002. Decapeptyl SR 11.25mg: PL 34926/0003. Decapeptyl SR 22.5mg: PL 34926/0013. **Marketing Authorisation Holder:** Ipsen Ltd, 190 Bath Road, Slough, Berkshire, SL1 3XE, UK. Tel 01753 627777. Date of preparation of PI: December 2011.
Ref: UK/DECD8632a (6m Adjuvant licence)

Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard
Adverse events should also be reported to the Ipsen Medical Information department on 01753 627777 or medical.information.uk@ipsen.com

1. Heidenreich A et al. Guidelines on Prostate Cancer. European Association of Urology 2011.
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3. Botto H et al. 3rd International Symposium on Recent Advances in Urological Cancer Diagnosis and Treatment. 1992. Paris: 107-110.
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* At NHS list price and licensed posology.
Date of preparation: January 2012. DECD8621b

The unwell returning traveller ▶ page 31

Warning over patient notes plan

Medical defence experts say plans to give patients online access mean GPs will have to use layman's terms

By Madlen Davies

GPs may need to omit important clinical information and switch to using lay language in patient notes if the Government presses ahead with plans to give patients online access to their records, medical defence experts are warning.

Patient notes could become less useful as doctors feel the need to leave out information – such as differential diagnoses – that might distress patients, the Medical Protection Society said.

The MPS also warned of the potential for GP workload to increase and for 'enormous strain' on the doctor-patient relationship in its response to the Department of Health's consultation on plans to give patients online access to their health records by 2015.

'It will be a big cultural change for clinicians to use patient-appropriate language,' said the MPS's formal consultation response. 'Clinicians will have to consider the need to inform and reassure patients [to avoid] an increase in consultations to explain records to worried patients.'

Government plans will see patients access records online by 2015

It called for a category of sensitive information that would be protected from online viewing – 'for example, where there are issues in mental health, sexual health, child protection and counselling'.

Dr Stephanie Bown, director of policy and communications at the MPS, said it was vital to preserve the primary purpose of medical records – communication between health professionals to ensure high-quality care: 'Greater patient access to records may impact on the content, with the need for doctors to use patient-friendly language and consider omitting entries that may cause distress.'

The MPS said it supported giving patients greater access to their health information and digital routes to their GP – but warned there was a risk of unrealistic expectations.

'Greater online access to health professionals comes with consequences, such as use of clinician time,' the response said. 'The aspiration that patients will be able to contact their health team electronically for "routine support" may lead patients to expect their emails will be answered straight away.'

Dr John Etherton, a GP in Rottingdean, East Sussex, said the changes could be 'a nightmare': 'Putting it into layman's terms will mean a duality of entry that will increase our workload. We can't omit differential diagnoses. We'll be treading on thin ice.'

@madlendavies

The DH's proposals

- **Lead GP to organise direct access to records for any patient requesting it**
- **GPs must arrange online appointment booking and a secure email system for patients to contact their practice by 2015**
- **Repeat prescriptions and test results to be online**

Source: Department of Health. *Power of information*. 2012

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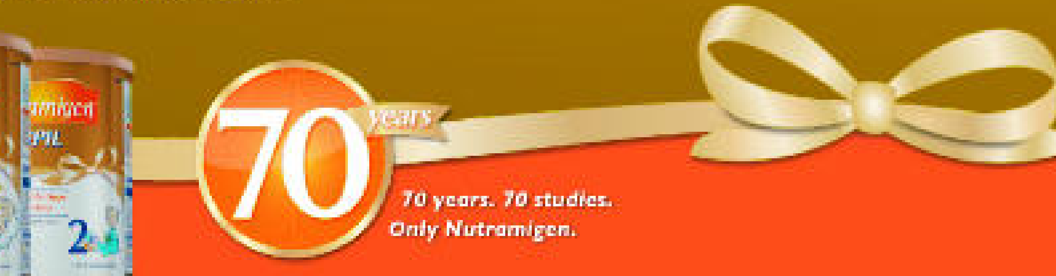

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RCGP hits back at C&B plans

The RCGP has hit back at Government plans to force GPs to refer through Choose and Book, saying the 'cumbersome' system needs radical improvement.

As Pulse first reported in May, the plans could force practices to adopt 'labour intensive' methods, such as calling around hospitals to book appointments themselves, if they refuse to use the system.

But in its official response to the Department of Health's consultation on expanding patient choice – *Liberating the NHS: No decision about me, without me* – the RCGP called for 'radical improvements to the speed and reliability' of the 'cumbersome' electronic booking and referral system.

The college said the DH's plan to publish statistics on Choose and Book uptake to encourage its use 'fails to tackle the root cause of low levels of participation in some places'.

It said the proposal to make Choose and Book an information and booking system for patients, through NHS Choices, would threaten GPs' gatekeeper role and generate 'extra costs and unnecessary, possibly harmful procedures'.

The college's response also warned that offering patients a free choice of provider could increase costs and health inequalities, make local commissioning of services more difficult and lead to patient disappointment.

IN BRIEF

Ca results go electronic

GPs are set to receive their patients' bowel cancer screening results electronically.

Full story ▶ pulsetoday.co.uk/practicenews

Free diabetes risk tests

Health boards in Wales are to offer free diabetes and stroke risk tests in pharmacies.

Full story ▶ pulsetoday.co.uk/practicenews

Revalidation criticised

An independent study has criticised the 'lack of clarity' in proposals to introduce revalidation, which has led to 'inertia and tension'.

Full story ▶ pulsetoday.co.uk/politicsnews

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ABRIDGED PRESCRIBING INFORMATION

Inactivated Influenza Vaccine (Split Virion) BP

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

For a complete list of undesirable effects please refer to the Summary of Product Characteristics. **Package quantities and basic NHS cost:** Single dose prefilled syringes in single packs, basic NHS cost £6.59; packs of 10 single dose prefilled syringes, basic NHS cost £65.90. **Marketing authorisation holder:** Sanofi Pasteur MSD Limited, Mallards Reach, Bridge Avenue, Maidenhead, Berkshire, SL6 1QP. **Marketing authorisation number:** PL 6745/0095

Legal category: POM. Date of last review: April 2012

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

UK15944 c 07/12

How will commissioning affect my income?
▶ page 34

GP model 'not fit for purpose'

King's Fund says 'cottage industry' style general practice must change to offer more services

By Jaimie Kaffash

The small business model of general practice is 'not fit for purpose' and should be replaced with larger, more federated practices, concludes a report from an influential think tank.

The King's Fund report suggests practices should delegate more work to nurses, commit to using more technology and set themselves up in more accessible locations, such as supermarkets.

The report – *Transforming the delivery of health and social care* – presents the 'case for change' in the NHS and says commissioners should stop focusing on 'quick fixes' and embrace wholesale reform of services to make them more integrated and more like other service industries.

Published this month, it singled out variation between GP practices for particular criticism, saying the 'cottage industry' model is not serving patients' needs.

The criticism came after a major investigation by the King's Fund into general practice last year urged the Government to encourage commissioners to drive up quality in general practice – using tools such as balanced scorecards and local audits.

Dr Rosemary MacRae: GPSIs negate need for practices to federate

Authored by King's Fund chief executive Professor Chris Ham, director of policy Dr Anna Dixon and adviser to the chief executive Beatrice Brook, the report also said the shift in services from hospitals to the community would require the adoption of new ways of working, including better use of email and telephone consultations and training more GPs.

The report concluded: 'In many parts of the NHS, general practice still resembles a cottage industry in which family doctors as independent contractors run small businesses that are isolated from each other and constrained in the range of services they are able to provide.

'Primary care in the UK is more firmly established than in many other countries and provides a wider range of care than at any time in the evolution of the NHS. Despite this, there is evidence of wide variations in the quality of care and inequities in the distribution of GPs. If the aim is to tackle these variations and to deliver more care out of hospital, the current cottage industry model of general practice is not fit for purpose.'

The authors also recommended more practices should be opened in locations convenient for patients, such as supermarkets, following on from Sainsbury's attempt to open surgeries in its stores. They added: 'Larger practices are also able to make use of the specialist expertise of some GPs, thereby reducing the use of hospital services where clinically appropriate.'

Dr Clare Gerada, RCGP chair, said: 'GPs have worked together across organisations for many years. If the NHS stood still enough we would have developed our provider role more to share staff, expertise and resources. What we need to focus on is the care we provide, not the structures that we provide it in. The King's Fund would do well to examine hospital practice in as much detail as they examine GP practice and maybe acknowledge the central role that GPs have in the NHS - not constantly have snipes at us.'

Dr Rosemary MacRae, a GP in St Helens, Merseyside, also rejected the conclusions: 'The establishment of GPSIs allows practices to benefit from local expertise without losing themselves to federations.'

feedback@pulsetoday.co.uk

King's Fund recommendations

- Need for larger practices offering more services
- Better use of technology such as email and telephone consultations
- Encourage more self-care
- More GPs need to be trained to avoid a shortage
- Adopt more innovative practices – for example, greater use of nurses
- Deliver care in more convenient settings such as supermarkets

Source: King's Fund

MORE ONLINE
Read the full report
pulsetoday.co.uk/downloads

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 Meda Pharmaceuticals Ltd.

MEDA

Scottish health secretary replaced

Nicola Sturgeon has been replaced as Scottish health secretary after being handed a key role in overseeing Scotland's impending push for independence from the UK.

Ms Sturgeon, who is also deputy first minister, has been appointed cabinet secretary for infrastructure, investment and cities spending, taking over from Alex Neil, who in turn replaces her as health secretary.

Her key policies in her term as health secretary, which began in May 2007, included orchestrating talks over a 'more Scottish' GP contract, currently under discussion with the Scottish GPC.

Scottish first minister Alex Salmond hailed her 'substantial achievements' in the post, but said the changes had been made to assist Scotland in preparation for the referendum on independence in 2014: 'Nicola Sturgeon has demonstrated what can be achieved when Scotland has responsibility for its own affairs. She has delivered record low waiting times and protected the NHS from the creeping privatisation of the UK Government.'

Dr Mary Church, a GP in Glasgow and former joint chair of the Scottish GPC, said on the social networking site Twitter that she was 'very sad' to see Ms Sturgeon move from health.

'She will be very difficult to replace,' she said.

Don't miss the Diabetes and CVD Update 2012 on 26 September in London
▶ pulse-seminars.com

HPA accused of 'palming off' extra work on GPs

By Gemma Collins

GPs have accused the Health Protection Agency (HPA) of 'palming off' work on them by demanding extensive medical reports on patients.

Practices in Devon have complained to their LMC after receiving numerous requests from their regional HPA, demanding 80-page reports and interview questionnaires about patients with an infection.

The RCGP said the row was indicative of a national problem.

GPs said the requests were adding to their increasing workload, while Devon LMC said that, although GPs are required to notify the HPA of the disease, they are under no obligation to complete any additional reports.

In its latest newsletter, Devon LMC said: 'Given the enormous workload under which most practices are straining, Devon LMC would advise that the usual response should be to decline to accept this unfunded work.'

Dr Andrew Sant, executive vice chair of Devon LMC, told Pulse he had been told of four cases where GPs had been asked to interview a patient for a second time, contact relatives and write an extensive report.

He said one GP was asked to complete an 80-page report on a patient with hepatitis E: 'Doctors have a duty to notify the HPA of the disease, but asking them to get in touch with the family and fill out an 80-page report is not what they are contracted to do. It is a money-saving exercise on behalf of the HPA to get GPs to do their work.'

The LMC acknowledged that an amendment to the regulations in 2010 meant GPs were obliged to provide more information about patients than before, but said the latest demands were not within GPs' remit.

Dr George Kassianos, a GP in Bracknell, Berkshire, and RCGP immunisation lead, said the issue was a national one.

'The workload is slowly creeping up,' he said.

An HPA South West spokesperson said: 'The HPA sometimes asks GPs for additional information about patients. However, we do not expect them to undertake substantial additional work that is not directly related to their patients' care.

'The South West (South) Health Protection Unit has worked with [Devon] LMC to resolve its concerns after a small number of patient questionnaires were sent to a GP in error.'

feedback@pulsetoday.co.uk

Dr George Kassianos: infection reports workload creeping up

It is a money-saving exercise on behalf of the HPA to get GPs to do their work

Dr Andrew Sant, Devon LMC

Aggressive BP control not helpful in diabetes

Aggressive blood pressure control in patients with diabetes does not reduce mortality and could be harmful in some cases, warn UK researchers.

Data from more than 120,000 patients with newly diagnosed type 2 diabetes over 15 years found that keeping blood pressure below 130/80mmHg was not associated with better survival rates, compared with those on less intensive treatment.

Researchers from Imperial College London and the University of Leicester also found an almost threefold increased risk of death from any cause in patients with systolic blood pressure below 110mmHg, compared with those with a blood pressure of between 130-139/80-85mmHg.

The study, published in the *BMJ*, used data from patient records from 422 practices.

The researchers concluded: 'It might be advisable to maintain blood pressure between 130-139/80-85mmHg, supported by other therapeutic and lifestyle interventions, to improve cardiovascular outcomes.'

Controversial maternity care guidance shelved

Specialists are to review controversial new guidance on maternity services, after it came under fire for exerting pressure on women to give birth at home and refuse pain relief to cut costs.

The Royal College of Obstetricians and Gynaecologists (RCOG) report said GPs should encourage 'normal' births and urge women to avoid caesarean sections, inductions and epidurals.

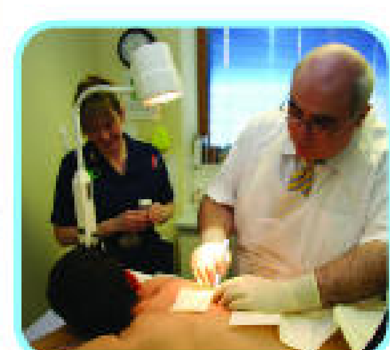
But an RCOG spokesperson said the college had removed the report from its website after claims that putting pressure on women to give birth at home could lead to birth trauma and medical complications.

The report, which also encouraged GP practices to assume more antenatal care to cut costs, will be reviewed by the college.

Cathy Warwick, chief executive and general secretary at the Royal College of Midwives, which co-produced the document, said: 'Saving money is only valid if it is associated with better outcomes.'

Invitation

GP Commissioners & GP providers should work hand-in-hand...
20th September 2012, Cobham, Surrey



Contractual and Clinical Pathways

Recent NHS changes have focused attention on GPs working as commissioners of NHS care, but there is now a growing realisation that the changes have also created opportunities for GPs to work together as providers.

While commissioners can go some way to modifying contractual pathways, it is providers who can best create meaningful change within clinical pathways. Many GPs have an interest in influencing clinical pathways rather than taking part in contracting.

GP provider groups in Surrey

In Surrey since 2006, four groups of GPs (EDICS, EDICS Leatherhead, MEDICS and PIMS) have been working together to provide NHS services for a population of nearly 300,000, creating bespoke clinical pathways for patients based upon the Map of Medicine.

Management Model

This model is structured around locally owned and operated services, clinically led by GPs and consultants working together and supported by sophisticated back-office functions. The server-based information systems link all clinic sites and enables reporting via SUS. A dedicated patient support line is available to help patients with their choice and to support them throughout their referral pathway.

This model has enabled local GPs and consultants (often in 'chambers') to work together and to take charge of developing local out-of-hospital services in tandem with hospitals. As a result, in Surrey, the provider landscape has changed considerably.

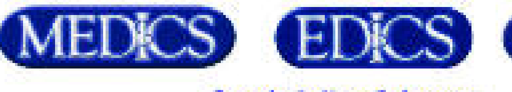
AQP Status

In July 2012, the group was awarded AQP (Any Qualified Provider) status by the NHS. This accreditation enables the group to extend their reach and to deliver or support a range of NHS services further afield - provided they are delivered in the prescribed manner and to the standards defined by AQP. In this form of contract, the group will receive NHS funding for 'the whole patient pathway'. Consequently, for the first time, NHS commissioners and patients will be able to compare whole-system care within different types of provider environments.

AQP will enable the group to share their experience to help other local GP provider groups to develop and to support them until they can obtain AQP accreditation of their own.

The GP groups are holding an event on the evening of 20th September in Cobham, Surrey. If you are interested in attending and hearing of the potential for GP and consultants to work together as a provider group under AQP arrangements, then please register at:

www.edicsevents.com or email: register@edicsevents.com



Interlink Care Solutions

New study finds patients stepped down from LABA treatment 70% more likely to need oral steroids

ASTHMA

LABA step-down reduces control

By Emma Wilkinson

GPs should weigh up the risks of stepping down long-acting ß-agonist (LABA) treatment in patients with controlled asthma as it may result in a loss of disease control, concludes a new analysis.

In what the authors called the first analysis to look specifically at stepping down LABA therapy, they found patients who stepped down were 68% more likely to need oral steroids, plus suffered a significantly reduced quality of life.

US researchers analysed five randomised trials that compared stepping down LABA treatment with no change in therapy and found it resulted in fewer symptom-free days, compared with continued use.

Research suggests patients stepping down LABA use have reduced asthma quality of life scores

Current British Thoracic Society and SIGN guidelines recommend asthma treatment is stepped down once control is achieved to prevent 'over-treatment', but this new analysis raises doubts over whether this advice should be followed for LABAs.

The meta-analysis looked at nearly 700 patients over the age of 15 with mild to moderate asthma that was well controlled with a combination of inhaled steroids and LABAs equivalent to step 3 of the guidelines.

Stepping down LABA therapy significantly reduced asthma quality of life scores by an average of 0.32 points, asthma control scores by 0.24 points and symptom-free days by 9%, compared with those on continuous therapy.

Although researchers were unable to analyse exacerbation rates, patients stepping down LABA therapy were also 68% more likely to report any use of oral steroids compared with those who were on continuous therapy.

The risk of withdrawing from the studies due to a lack of efficacy or asthma control was also trebled in the stepping-down group, compared with those on continuous therapy.

There was no statistically significant difference in the frequency of non asthma-related adverse events between those stepping down LABA therapy and those with no change in treatment.

The authors concluded their data showed stepping down LABA therapy may not be advisable for all patients.

Study leader Dr Thomas Casale, professor of medicine at Creighton University in Nebraska in the US, said: 'Both physicians and patients should be aware of the possible implications of our study and make the most appropriate individualised decisions in constructing asthma treatment plans.'

Change after stepping down LABA therapy

-9%
Symptom-free days

+68%
Risk of oral steroid use

-0.36
Quality of life

Source: *Ann Intern Med* 2012, online 27 August

Dr Kevin Gruffydd-Jones, a GP in Box, Wiltshire, and member of the education committee of the Primary Care Respiratory Society, said a pilot study done in his own surgery had shown similar results, with patients requesting to be back on LABA therapy within two weeks of discontinuing treatment.

He said: 'Stepping down is a reasonable approach and we don't do enough of it, but the main priority should be getting people off high-dose inhaled steroids.

'We should also attempt to step down LABA treatment - but as this shows, that may be much more difficult [to achieve].'

***Ann Intern Med* 2012, online 27 August**

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Adverse events should be reported. Reporting forms and information can be found at www.yellowcard.gov.uk. Adverse events should also be reported to Dermal.

CPD TIP OF THE WEEK

Using trigger points in fibromyalgia

Being tender on any of the trigger points identified in the American College of Rheumatology fibromyalgia diagnostic criteria is significant, according to an updated CPD module. It outlines the 18 trigger points recommended, but the author states none of the points are any more sensitive in predicting the likelihood of underlying fibromyalgia. Even a single-point tenderness has a diagnostic accuracy between 75% and 89%, so if several are painful on palpation, GPs should feel confident to make the diagnosis. But the author recommends an initial order, beginning with the front of the patient with the lateral epicondyles and the second costochondral junction.

ONLINE CPD
See the Key questions on fibromyalgia module at pulse-learning.co.uk

▶ page 22

DIABETES

Intensive blood glucose control 'raises fall risk'

Tight glycaemic control trebles the risk of hip fracture in older patients with type 2 diabetes, say researchers.

Their study analysed glycaemic control in more than 900 patients with diabetes admitted to a large Singapore hospital with hip fracture and matched them with controls with diabetes seen for other reasons in the same hospital clinic.

The patients had an average age of 77, and the use of insulin and sulfonylureas was similar between cases and controls.

The five-year study found that HbA$_1$c levels of less than 7% (9.6mmol/l) were significantly associated with a risk of hip fracture three times higher than those with an HbA$_1$c of more than 8% (11.6mmol/l).

The authors concluded: 'Some guidelines suggest physicians should consider aiming for less stringent HbA$_1$c targets when managing frail older adults. Even when treating to targets of HbA$_1$c less than 8%, close monitoring is essential to prevent episodes of hypoglycaemia.'

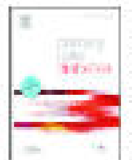
Dr Alan Begg, a GP in Montrose, Angus, and co-editor of the *Practical Diabetes* journal, agreed that very tight glycaemic control – especially if done quickly – was not a good thing.

He said: 'HbA$_1$c targets don't need to change, but clinicians need to beware the risks of too tight glycaemic control and assess on an case-by-case basis.'

***J Am Geriatr Soc* 2012 60:1493-7**

DIABETES

Practice nurse clinics 'improve diabetes control'



Patients with type 2 diabetes managed at practices with nurse-led diabetes clinics have significantly better glycaemic control than those who do not receive nurse-led care, say Danish researchers.

Their observational study looked at data from 193 GP practices and nearly 13,000 patients between 40 and 80 years of age, and studied the association between HbA$_1$c and the level of care.

Three-quarters of GP practices surveyed had a practice nurse, and in 61% that nurse provided individual consultations for patients with diabetes.

In practices with well-implemented nurse-led clinics, 75% of patients had a HbA$_1$c measurement performed during the 190 days of the study. The mean number of patients with an HbA$_1$c of 8% (11.6mmol/l) or more was 17.2.

This compared with the equivalent figures of 68% (20.8mmol/l) in practices with no practice nurses, and 72% (17.6mmol/l) in practices with practice nurses who did not provide specialist diabetes consultations.

Cholesterol levels were also lower in practices with nurse-led diabetes clinics, compared with non-nurse practices.

The authors concluded: 'The results suggest that involving nurses in type 2 diabetes care is associated with improved quality of diabetes management.'

***Primary Care Diabetes* 2012; 6;221-8**

GUIDELINE ROUND-UP

AF guidelines include new anticoagulants

European guidelines on atrial fibrillation have been updated to recommend first-line use of novel oral anticoagulants such as dabigatran.

The drugs offer better efficacy, safety, and convenience compared with oral anticoagulation with vitamin K antagonists such as warfarin for most patients, state the European Society of Cardiology's updated recommendations.

European Society of Cardiology, August 2012

Calcitonin banned on safety grounds

Drug safety advisers have banned the use of calcitonin in the treatment of osteoporosis because of an increased risk of cancer with long-term use.

In its monthly newsletter, the MHRA said all intra-nasal calcitonin sprays will now be withdrawn from the European market.

MHRA *Drug Safety Update*, August 2012

Scottish warfarin checklist

Scottish experts have launched their guideline on best practice in use of anticoagulants, including advice on treating patients during pregnancy.

The recommendations from the Scottish Intercollegiate Guidelines Network include a checklist for information patients should be given before starting treatment with warfarin and other vitamin K antagonists.

SIGN clinical guideline 129, August 2012

COUGH

Gabapentin could benefit chronic cough

Gabapentin could be a useful option in otherwise treatment-resistant chronic cough, say researchers.

Their small randomised controlled trial showed the drug resulted in an improvement in cough-specific quality of life, severity and frequency, compared with placebo. The study of 62 adult patients without respiratory disease or infection found the drug was well tolerated during the 10-week course, although 31% of patients on gabapentin reported nausea and fatigue – mostly managed through dose reduction – and 10 patients dropped out of the study.

The Australian researchers calculated a number needed to treat of 3.58 to produce a clinically meaningful improvement in cough-related quality of life, and said the effects could be due to inhibition of the urge to cough within the cerebral cortex.

There was no difference between the drug and placebo in cough reflex sensitivity, urge to cough or laryngeal dysfunction.

With further studies to back up the findings, gabapentin could be 'a viable alternative to current chronic cough treatment', especially in those for whom other treatments have failed, the researchers concluded.

***Lancet* 2012, online 28 August**

CVD

'Intensive' programmes improve CVD risk

Intensive lifestyle interventions in high-risk patients can lower cardiovascular mortality by up to a fifth, conclude UK researchers.

The systematic review of five trials looked at data from more than 31,000 patients who were free of CVD at baseline, but were identified as at high risk by a validated risk score. The authors looked at the affect of various lifestyle interventions in these patients and found the effect on CVD mortality ranged from 7.4% over six months to a 22% reduction over five years. They found those who had undergone the most intensive interventions experienced the greatest reductions in CVD risk and mortality.

The authors cited the MRFIT trial as an example of a more intensive intervention, where patients had two initial screening sessions and then 10 weekly group sessions and annual assessments to discuss how to manage their risk factors.

They concluded that a more 'aggressive' approach was needed in primary care to manage patients identified as at high risk of CVD: 'The findings of this review highlight the importance of targeting individuals at higher risk of CVD who have the most to gain in terms of absolute reduction in CVD risk and where the best evidence for improvement is shown.'

Study author Professor Kamlesh Khunti, professor of primary care diabetes and vascular medicine at the University of Leicester and a GP in the city, said: 'Patients have the risk score assessments, but don't implement all the changes that are needed. I think what GPs and nurses can do is actively do the risk score assessments and then aggressively manage the risk factors.'

***J R Soc Med* 2012;105;348-56**

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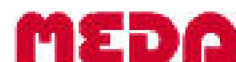
Pfizer Vaccines



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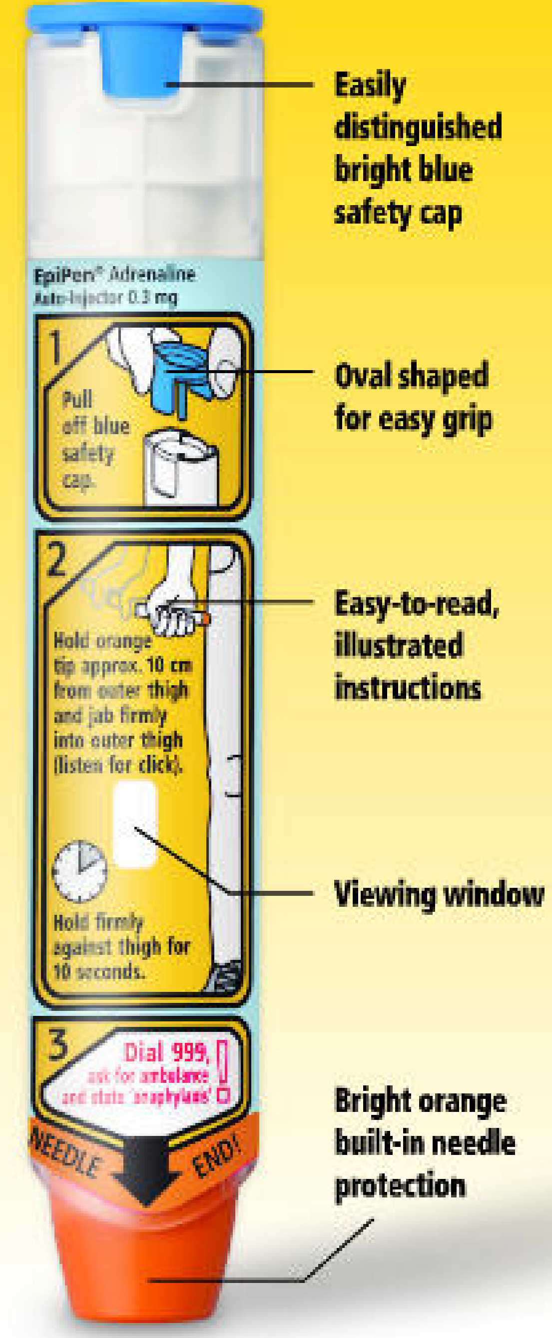
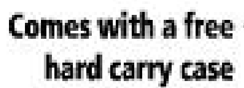


MEDA Pharmaceuticals Ltd would like to announce the approval of their improved EpiPen® (adrenaline) auto-injector.

Additional design features have been incorporated that will enhance patient safety, such as automatic needle protection and a viewing window for patients to check the integrity of the adrenaline solution. **Patients can be reassured that the administration technique remains exactly the same.**

The improved **EpiPen®** (adrenaline) auto-injector will be available from September 2012 and should be prescribed in exactly the same way as the current device. Stocks of the old device will gradually be phased out. There is no need for patients to replace or exchange the original **EpiPen®** (adrenaline) auto-injector before their next scheduled repeat prescription.

Support materials for patients and healthcare professionals will be available for the improved device.



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Presentation: EpiPen delivers a single dose of 0.3mg of adrenaline BP 1:1000 (0.3ml) in a sterile solution. EpiPen Jr. delivers a single dose of 0.15mg adrenaline BP 1:2000 (0.3ml) in a sterile solution. 1.7ml of adrenaline remains in the auto-injector after activation. **Indications:** For immediate self administration in the emergency treatment of allergic anaphylactic reactions. Anaphylaxis may be caused by insect stings or bites, foods, drugs and other allergens as well as idiopathic or exercise-induced anaphylaxis. **Dosage:** ADULTS: Self administration of 0.3mg adrenaline (EpiPen) intramuscularly. CHILDREN: The appropriate dosage may be 0.15mg (EpiPen Jr) for children 15-30kg body weight and 0.3mg (EpiPen) adrenaline for children >30kg body weight, or at the discretion of the physician. EpiPen should only be injected into the anterolateral aspect of the thigh through clothing if necessary. A second injection with an additional EpiPen may be administered after about 5 – 15 minutes if indicated. As EpiPen is designed for emergency treatment, the patient should always seek immediate medical attention even if symptoms have disappeared. **Contraindications:** There are no absolute contra-indications to the use of adrenaline in a life threatening situation. **Warnings and precautions:** Avoid the risk of inadvertent intravascular injection. DO NOT INJECT INTO THE BUTTOCKS. Accidental injection into the hands or feet may result in loss of blood flow to the affected areas. If there is an accidental injection into these areas, advise the patient to go immediately to the nearest emergency room or hospital casualty department for treatment. Patients must be instructed in the proper use of EpiPen. Use with extreme caution in patients with heart disease and those taking digitalis, mercurial diuretic or quinidine. The effects of adrenaline may be potentiated by tricyclic antidepressants and monoamine oxidase inhibitors. Adrenaline should be used in pregnancy only if the potential benefit justifies any potential risk to the foetus. **Side effects:** May include palpitations, tachycardia, sweating, nausea and vomiting, respiratory difficulty, pallor, dizziness, nervousness and anxiety. Cardiac arrhythmias may follow administration of adrenaline. Overdoses of adrenaline may cause cerebral haemorrhage or arrhythmias. For a complete list of warnings and side effects, you should consult the Summary of Product Characteristics. **Legal category:** POM **Package quantity and basic NHS price:** EpiPen and EpiPen Jr. are available as single unit doses at £26.45 each or as a twin pack of 2 Auto-Injectors at £52.90. **Product licence number:** EpiPen Auto-Injector PL 15142/0245. EpiPen Jr. Auto-Injector PL 15142/0246. **Marketing authorisation holder:** Meda Pharmaceuticals Ltd, Skyway House, Parsonage Road, Takeley, Bishop's Stortford, CM22 6PU. Tel: 0845 4600000 **Date of preparation of prescribing information:** February 2012.
UK/EPI/12/0037

UK/EPI/12/0053 September 2012

GPs cannot cure all society's ills

Driving while using a mobile phone is illegal. Driving blindfolded without access to the gears or the break would be sheer lunacy.

But that is what GP practices are, in effect, being asked to do under the latest quality and productivity (QP) indicators introduced into the QOF in a bid to reduce A&E attendances.

As we reveal this week, nearly a third of practices have fallen at the first hurdle – either requesting an extension or completely missing the deadline to hold a practice meeting to review the reasons for A&E attendances by their patients.

GP leaders in some areas are blaming PCTs' failure to provide the A&E attendance data that would underpin practices' review meetings – though they also acknowledge some apathy among GPs about the thankless task they have been given.

If all of this sounds familiar, that's because exactly the same issues bedevilled the QP indicators on referrals, prescribing and emergency admissions last year, with PCTs failing to provide key data and, as a result, practices struggling to maintain their QOF income.

From the start, the rationale for these indicators was flawed. The academic literature on ever-increasing A&E attendance rates is scant, but what there is indicates that to make a real difference deep-seated socioeconomic problems, transportation issues, GP out-of-hours provision and the location of NHS services would all have to be addressed.

GP practices can tinker round the edges of this huge problem, but how can it be fair to expect them to effect real change when they do not have access to the multifaceted levers that could make a difference?

Nigel Praities
Deputy editor

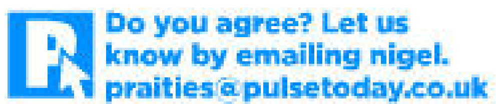
The emerging evidence of problems with this year's A&E indicators follows on from statistics showing only 72% of practices achieved maximum income for the QP prescribing indicators last year. This raises uncomfortable questions for GPC negotiators who have agreed to targets that sit poorly with the raison d'être of the QOF.

The QOF was meant to be a strictly evidence-based mechanism to incentivise good practice in the care of patients – yet it's increasingly being used to tie GPs' income to the hopeless task of attempting to change patients' wayward behaviour.

Further evidence for this disturbing trend comes from the news that the Government is planning to ring-fence 15% of QOF points for public health indicators – so GPs can look forward to seeing more of their earnings tied to a responsibility to cure society of ills ranging from obesity to excessive drinking.

Holding GPs accountable for things they have little means of controlling will only alienate and further demotivate the profession.

The reach of primary care is broad, but not ubiquitous. GPs are not gods, and they cannot cure all ills with a wave of their magic stethoscope. The sooner ministers realise this, the better.



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It's only because GPs care so much that patient complaints hit us hard

Forget all the so-called pearls of wisdom from industry, says **Dr Barry Moyse** – the key is to listen to our patients

Even if I say so myself, I am really good at dealing with patients' complaints. I can see all sides of the problem without fear or favour, thoroughly explore the issues without letting my feelings get in the way and effortlessly work towards a resolution fair to all parties. But when it comes to the complaints about me, I wonder: who do these people think they are? How dare they make me feel so low?

There was an 8.2% increase in written complaints made against GP practices in 2011/12, with nearly 55,000 received ('Complaints against GPs up by 8.2%', pulsetoday.co.uk/news). This must be set into context – only 35% concerned clinical problems, and most of the rest were over alleged poor communication, attitude or administration. Crucially, only one in three was upheld. And consider the numbers of patients who didn't complain: in 2006, the NHS Information Centre estimated that there were nearly 30,000 consultations in each typical surgery.

GPs are still among the most trusted and appreciated professionals and patients continue to attend in ever larger numbers. More complaints are, at least in part, an inevitable consequence of rising numbers of consultations. According to a report by Deloitte in May, if the pattern of GP consultations remains unchanged there could be a total of 433 million practice consultations annually by 2035.[1]

I do not believe that anyone goes into medicine to do a bad job, but a vocation is a double-edged sword – it is precisely because we care that even a single complaint can make so many of us question our worth. If two-thirds of patient complaints fail, that is a lot of GP misery for nothing.

I am not suggesting we should effectively ignore all patient feedback – from time to time we can learn lessons from a minority of genuine complaints. But a rise in the number of remarks about our practice is only to be expected if we run more consultations.

In our brave new consumerist society, complaining is positively encouraged and, whether we like it or not, general practice services are seen as just another part of it. There is a management theory that describes complaints as 'pearls of great price' that enable a business to learn and grow. This is true, but only to a point.

General practice cannot set itself apart entirely from consumer society. Practices are, after all, small businesses that are often in competition to attract patients.

But we are not making tins of beans, we are dealing with complex and unique individuals using systems and techniques that can never be perfect. And even the very best members of our profession are mere imperfect beings striving to be professional. We are not employed by Tesco (yet), nor are we in the nuclear power or civil aviation business – so why do these other industries inspire so many of the ideas used by managers and media commentators to target our profession?

Service makes a difference

The solution for improving general practice is simple: listen to your patients. In 1998 I joined a small practice that had consistently failed to build up a decent list size. The village was close enough to a large town for patients to have a wide choice of practices and, unfortunately, there had been long-term illness in the team, which added to the failure to thrive.

I was determined to raise the practice's profile without actually advertising and made a point of telling every new patient to get in touch directly if they encountered any problems. If we did not know why they were unhappy, how could we change? There were other factors to the practice's improvement over the next few years, but I am happy to say list growth was one of them.

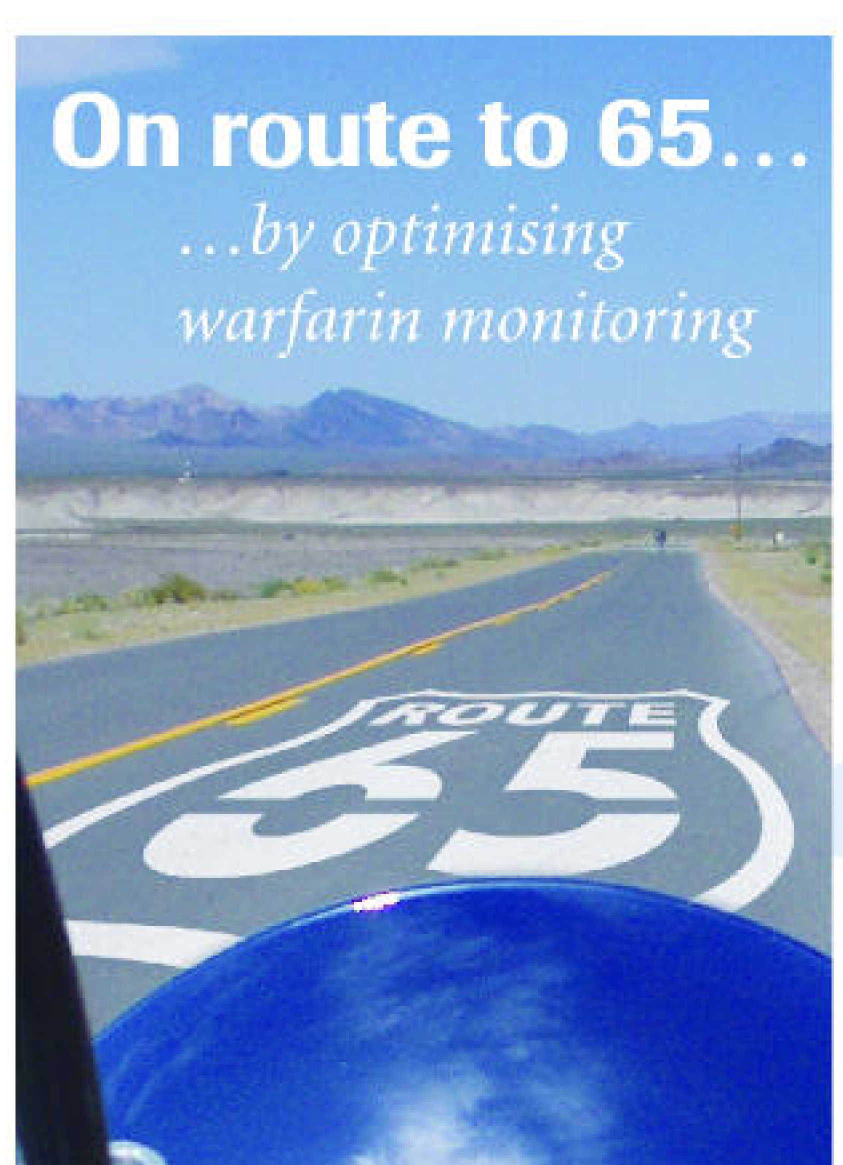
We have all experienced good, bad and indifferent service in our own lives. Who has not been frustrated when trying to contact a helpline 'presently experiencing a high volume of calls'? Who has not sat in a dispiriting waiting room, studiously ignored by staff who seem to be having a great time without worrying about you?

By the same token, a promptly answered telephone call or an email from someone who sounds interested in helping us can make all the difference. Why should general practice be any different? I think most practices and practice managers understand this. An efficient, productive practice is a happier place to be a GP as well as a better place to be a patient.

Dr Barry Moyse is a GP in Taunton and assistant medical secretary of Somerset LMC

Reference

1 Deloitte. *Primary care: today and tomorrow*. 2012. pulsetoday.co.uk/documents/45R5159/0/120508+Primary+care+-+Today+and+tomorrow.pdf (accessed 4 September 2012)



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

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Pulse Seminar

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Why are GP leaders so thin on the ground?

Lack of GPs on CCG boards and low female numbers on professional bodies show we're not getting enough support, writes **Dr Clare Gerada**

In recent weeks, I've been struck by two reports in Pulse: the fact that the GPC no longer has any female or sessional GP negotiators on it, and the lack of GPs on CCG boards. The two stories are different, but share the same theme: poor representation of GPs is a cause for concern for the profession's future.

Like most GPs, I went into my profession to make people better – not to be a manager or a politician. But at a time when GPs are meant to be in the driving seat of healthcare, it is ironic that GPs – especially women – are conspicuous by our absence on CCG boards.

Are GPs uninterested in commissioning? Can women not rise to the challenge? I think not. It's that we are too busy doing the day job, alongside what we do as homemakers and parents.

Reflecting on the extra responsibilities given to us by the health act, I wonder if the fundamental things such as the remuneration offered, the time commitment needed or simply not wanting to let our patients down could be holding us back.

GPs are being expected to take on new roles and play an active part on CCGs, yet still carry out the most important job of caring for our patients – without sufficient extra support or resources.

A recent report on representation in leadership roles looked at why more women are not putting themselves forward for bodies such as CCGs.[1] Senior female clinicians talk about coming up against two sets of barriers to leadership progression: role conflict and 'structural' barriers; and individual and organisational 'mindsets'.

The lack of GPs on CCG boards seems to result from the first set of obstacles – role conflict and structural barriers. GPs operate in 10-minute time frames, and so for us lengthy CCG meetings mean valuable time away from our consultations.

Things need to change so we're not forced into an either/or situation of having to choose whether to be a GP or a leader, when we're perfectly able to be both things. We know from the enthusiasm generated by our own RCGP Centre for Commissioning and the recent RCGP project around sessional GPs and commissioning that GPs want to get involved. GPs are key to making this new NHS work, and it is imperative we have a major role.

We also need to look at the 'mindsets' that stop women being accepted into leadership. We want to be good role models for those we work alongside and for future generations of GPs. It may be that this is a bigger problem for women than for men – while a practical problem like remuneration holds everyone back, a problem like poor representation targets specific groups – such as female GPs.

Our practice population is also very different and more diverse than it was even 10 years ago. General practice is changing and we need to change with it if we are to properly represent our patients.

Overall, we need more investment in our leadership skills and more practical support in our practices if we are to lead from the front rather than be bystanders. But for women, the investment must be not just practical, but professional. If there are no female figures in the profession, who can you look up to? Perhaps it is time for you to 'be the change you want to see'.

Dr Clare Gerada is the chair of the RCGP and a GP in south London

References

1 NHS Midlands and East. *Releasing potential: women doctors and clinical leadership*. 2012. tinyurl.com/c259oun

Actimel is a probiotic drinking yogurt containing the probiotic strain *Lactobacillus casei* DN-114 001. Actimel has been researched for more than 15 years with **28 publications of clinical studies.** It has been shown to reduce the incidence[1,2] and duration or severity[3-5] of acute and infectious diarrhoea and to significantly reduce the incidence of AAD and CDAD in a clinical study in older hospitalised patients (over 50 years old) during a course of antibiotics and for one week after.[6] **WGO practice guidelines** report, "*One study indicated that* ***L. casei* DN-114 001** *is effective in hospitalized adult patients for preventing antibiotic-associated diarrhea and C. difficile diarrhea*"[13] and in the "*prevention of acute diarrhea*" there is "*suggestive evidence that...* ***L. casei* DN-114 001**... *[is] effective in some specific settings*".[13] A number of UK hospitals have integrated Actimel into their *C. difficile* management plans.

Activia is a probiotic yogurt containing the probiotic strain *Bifidobacterium lactis* DN-173 010. Activia has been researched for more than 15 years with **17 publications of clinical studies.** Studies have shown Activia can help reduce IBS-related bloating[7] and distension.[8] **NICE guidelines** state, "*There is fair evidence to show that some probiotics (single or combination) give a significantly greater improvement in global symptoms of IBS than placebo*"[14] and **Map of Medicine** states, "*Some specific strains, such as* ***Bifidobacterium lactis* DN-173 010** ... *have clinical trial evidence of efficacy for bloating [and] distension*".[15]

* Based on studies using two bottles/pots consumed daily.

‡ Abdominal bloating and distension are part of digestive discomfort.

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Studies have shown Activia may help reduce digestive discomfort,[7-9] including bloating[7‡]

Activia contains the exclusive probiotic strain *Bifidobacterium lactis* DN-173 010

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For more information, please visit **www.probioticsinpractice.co.uk**

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Information for Healthcare Professionals

Nobody notices when we're right

ILLUSTRATION: DAVID BRADLEY/RTG

Copperfield tries to fill his appraisal folder with positive stories – and comes up with three measly examples of making patients feel better

One of the nice things about working at the coalface of primary care is that, in the right light and with a bit of imagination, we can sometimes make out something in the rock formation that looks exactly like the health secretary's face, which we can then legitimately attack with a pickaxe.

One of the less nice things about being a GP, though, is that our sweat and toil is routinely met with indifference by most punters.

It's not that I'm doing this job to elicit gratitude, of course. It's just that it's embarrassing when my appraiser, having waded through this year's 'complaints' section of my appraisal folder, finally reaches my 'compliments' file and is obliged to invert it and give it a hopeful little shake. I'm not bitter, though. I don't blame the patients.

Why would they thank me? I spend most of my working life persuading them to start/persevere with/recommence statins and antihypertensives, to reduce their cardiovascular risk.

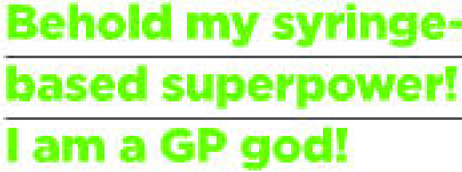
Preventing a cardiac event is less tangible than defibrillating a patient out of one, and so is unlikely to trigger any outpouring of thanks – particularly when those efforts leave my pill-poppers with aching muscles, bloated ankles and limp sex lives.

Besides, if they were going to reward me with a bottle of Bolly, they wouldn't know when to give it, exactly – at least not until cardiovascular risk predictors become so advanced that they can specify the precise date that, on account of my heroic actions, something didn't happen. Or, to put it another way, we GPs all too seldom make people feel better.

Spare me the fluffy guff about 'care not cure' or I'll be obliged to vomit. I understand all that. But sometimes, real doctors need real results. Patient walks in ill. Patient walks out better. That sort of thing. How often does that happen? I can think of only three specific situations:

1 Ear wax. This is a gift. The patient is helplessly deaf and distressed. The diagnosis is made in an instant. And the treatment is safe, simple and leads to an immediate and complete cure. Behold my syringe-based superpower! I am a GP god! Hear me cure! So what do we do? We delegate the job to nurses. Are we insane?

2 Pulled elbow. Dad has accidentally pseudoparalysed junior's arm by swinging him around in a parenty way. He's anticipating a permanently disabled child and a grilling from social services. You perform a mystical manipulation. There's a



frisson as the traumatised toddler screams. Then dad's face transforms from 'you heartless monster' to 'you miracle worker' as the monoplegic moppet makes that Lazarus-like recovery, or at least his subluxed radial head does. Awesome.

3 Polymyalgia. Doesn't really count as it involves steroids and a time lag of couple of days. Still bloody impressive, though.

Have I missed any? Nope. That's it. No wonder job satisfaction's at rock bottom.

Our spectacular triumphs are a trickle against a flood of well-intentioned futility. Our rescue fantasies are overwhelmed by the mundane reality of the day job.

Our hopes are dashed against… hang on a sec, just shine your torch over there, would you? Can you see that?

Pass the pickaxe.

Dr Tony Copperfield is a GP in Essex. You can email him at tonycopperfield@hotmail.com

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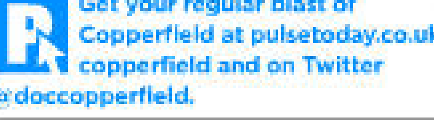

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Date of preparation: April 2012 AHOMA120160

GMS practices often do the same job as PMS for less cash

LETTER OF THE WEEK

From Dr Peter Swinyard
Chair of the Family Doctor Association
Swindon
via pulsetoday.co.uk

As you report in your story, 'PMS could disappear as GPC begins single contract talks with Government', (pulsetoday.co.uk/news), PMS local contracts become illogical next year when all contracts will be held by the NHS Commissioning Board.

Where PMS contracts have stimulated a better service, there must be continuing funding to support this – but we also need equitable funding to allow GMS practices to offer the same standard of service for the same money.

In many areas, GMS has become the poor relation and the GMS practices think they are doing the same job as their PMS neighbours for less money.

There is much to play for here – if all practices became GMS3, the PMS practices that suffered from the downsides of a local contract would again enjoy national negotiating rights via the GPC.

But we must preserve a system to take account of the 'unusual' practices, such as those catering for students or the homeless, which cannot make a living on GMS.

Is it too much to hope that there will be a levelling-up in a time of financial disasters?

Many GMS practices feel they have become the poor relation of PMS

● **From Dr Sean Kennedy**
Glasgow
via pulsetoday.co.uk

I work in a GMS practice and I cannot say I have enjoyed the negotiated increased workload and reduced pay in recent years.

I am not naive – I do not think PMS has necessarily done better. But some practices have opted out of nationally negotiated contracts with the GPC. They may or may not want back in, but I do not see why it is a given that they would choose this.

The GPC is arguing and negotiating for this, but they are an interested party.

Has anyone asked PMS practices what they want?

If I were cynical I would think that we are seeing the quid pro quo with the GPC getting what they want in return for calling off the industrial action.

Complaints will always be demoralising

From Dr Sidappa Gada
Ipswich
via pulsetoday.co.uk

It's not pleasing to see that complaints against GPs are increasing ('Complaints against GPs up by 8.2%', pulsetoday.co.uk/news).

Managing a budget, managing the QOF, dealing with increasing patient demands, 10-minute consultations, watching your referrals, working within the remit of CCGs, dealing with the CQC, preparing for revalidation: in today's world, there are too many pressures on GPs.

I agree with the LMC secretary's comment that primary care is seen more in line with a consumer society.

But we need to dissect the complaints and try to go to the root of the problems. This will keep the increase in complaints in check.

Complaints in any sector at any level, to any personnel, are demoralising.

● **From Dr John O'Malley**
Wirral, Lancashire
via pulsetoday.co.uk

The most interesting figure in your story about complaints is not the increase – it is that only one complaint in three is upheld.

Taken in the context of the total number of interactions and the increasing customer mentality, this is a reflection of the high standard of care seen in primary care today.

Side-effects of statins are a real issue

From Dr Graham Edlin
St John's Wood, London
via pulsetoday.co.uk

Despite all the claims that the side-effects of statins are rare, study after study comes up with a 60-70% discontinuation rate ('Statin non-adherence "major problem" in diabetes patients', pulsetoday.co.uk/news).

In most of the original studies, as NICE has commented, there was a three-month off-label run-in. All possible entrants to the trial were asked to take an unlabelled drug for three months, which was in fact the trial statin.

This was ostensibly to check compliance with the trial instructions, but only about a third of prospective entrants were then prepared to continue into the trial proper.

No record is kept of the discontinuation reasons, but this is why NICE commented on the statin trials.

You cannot say for sure that the discontinuation was due to adverse effects of the drug, but it looks very likely.

We should also note that in the Heart Protection Study, the relative risk reduction of 23% means just two fewer events per 100, over 10 years, even in a high-risk group.

Discontinuation rates for statins may be as high as 60-70%

Has Gerada ditched RCGP tools?

From Dr Gerard Bulger
Tristan Da Cunha, St Helena
via pulsetoday.co.uk

I was surprised by a detail in your recent story on who would be revalidated first ('GP leaders to be among first doctors revalidated', pulsetoday.co.uk/news).

Is Dr Clare Gerada really using Excel to store details of all her CPD?

Does this means she finds the RCGP revalidation tools as nasty to use as the rest of us?

Poor turnout was down to a noble few

From Dr David Brownridge
Kidderminster, Worcestershire
via pulsetoday.co.uk

So only one in 10 GPs took pensions action on June 21 ('Official figures show only 10% took pensions action', pulsetoday.co.uk/news)?

Well, congratulations to that noble 11.2%!

To quote the Bard: 'The fault, dear Brutus, is not in our stars, but in ourselves, that we are underlings.'

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 3DB. Let us know where your practice is situated. Feedback may be edited

Can a salaried GP be a true practice rep?

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

I have a question about Pulse's recent story on the number of salaried GPs involved in commissioning ('Less than a quarter of salaried GPs involved in commissioning', pulsetoday.co.uk/news).

CCGs are 'member organisations' and the members are the practices.

But many GP partners are not really involved with CCGs, and there is only a requirement locally for one GP to represent each member practice.

So I'm not clear why the member practices would want to be represented by a salaried GP rather than one of the partners, and would be interested in the thinking behind this. After all, would a salaried GP have the power to commit the employing practice to plans put forward by the CCG?

Why would I do this for no pay?

From Anonymous
via pulsetoday.co.uk

As a salaried GP, I would not want to be involved in commissioning unless I was remunerated for my time.

I get paid significantly less than a partner and accept this lower pay in return for not having these types of responsibilities.

I am flexible and take on extra duties outside of what is expected of me, but to expect me to give up many hours of my free time to attend meetings for free is unrealistic and unfair.

Time public knew about funding cuts

From Dr Thomas Reichhelm
West Malling, Kent
via pulsetoday.co.uk

After reading your story on LES funding cuts affecting practices ('LES funding cuts push practices to the brink', pulsetoday.co.uk/news), I wondered – isn't it time we alerted the public to all this?

After years of being bashed by the press, surely it is now time to hit back and tell the full story about the cuts, the rationing imposed through the back door and the ways in which we are being set up to fail under clinical commissioning.

● **From Dr Julian Bashforth**
Liphook, Hampshire
via pulsetoday.co.uk

LES cuts represent a further reduction in GP practice funding at a time when practices are expected to do more and more as work is shifted from secondary care to primary care.

I agree most LES work should be universally provided, but these LES cuts represent a genuine loss of income for practices. The cuts also come on top of years of effective pay cuts and rising practice expenses.

Who's in your top 50?

We published our Top 50 GPs list last week, and our Top 20 Non-GPs
Go to pulsetoday.co.uk/top50 to see the list and have your say

Practices will go to wall in pay squeeze

From Dr Richard van Mellaerts
Kingston, Surrey

I am delighted to read that Dr Laurence Buckman and the GPC are pushing for a rise of several per cent to the current GP contract ('GPC pushes for pay uplift of "several per cent"', pulsetoday.co.uk/news).

Practice expenses have risen inexorably over the last few years, and the treasury's reluctance to give any meaningful increase to practice funds is causing increasing difficulties for practices.

Pay freezes, recruitment freezes and staff redundancies are now becoming common, as well as falling profits. With the reduction in LES funding becoming more widespread, the time approaches when practices will go to the wall.

The new health secretary has an opportunity to prove that he takes NHS general practice seriously and values the services that we provide by ensuring the ongoing financial stability of our practices and pushing for a reasonable and fair uplift from the Treasury.

Statin dose, efficacy and side-effects

From Mr Rakesh Kantaria
Medical leader, cardiovascular medical affairs, AstraZeneca UK

The results from the study on the adverse event reporting system (AERS), mentioned in your recent story on statins, suggest that adverse event reporting rates differ, with higher relative risk rates for rosuvastatin than for other statins ('High-potency statins "raise risk of muscle damage"', pulsetoday.co.uk/news).

But AERS cannot be used to calculate the incidence of an adverse event. The study design did not differentiate between the different doses of the available statins.

In contrast to the authors' assertions, AstraZeneca's view is consistent with the generally accepted opinion that there is no evidence for linking statin potency, and corresponding efficacy in reducing LDL-cholesterol, with myalgia and muscle- and tendon-related adverse events.

In contrast, there is a wealth of evidence linking statin dose with myalgia not explored in this study.

Rosuvastatin has been shown to be generally well tolerated and is available at the lowest dose in the UK. AstraZeneca is concerned that the failure of the study authors to acknowledge the low overall absolute risk of muscle and tendon adverse events may lead to unnecessary worry and concern for healthcare professionals and their patients.

AstraZeneca supports fully the efforts of the medical community to advance understanding of dyslipidaemia, but wishes to highlight the limitations of this particular study.

No rush on statin-CCB alert

From Dr Peter McEvedy
Blyth, Northumberland
via pulsetoday.co.uk

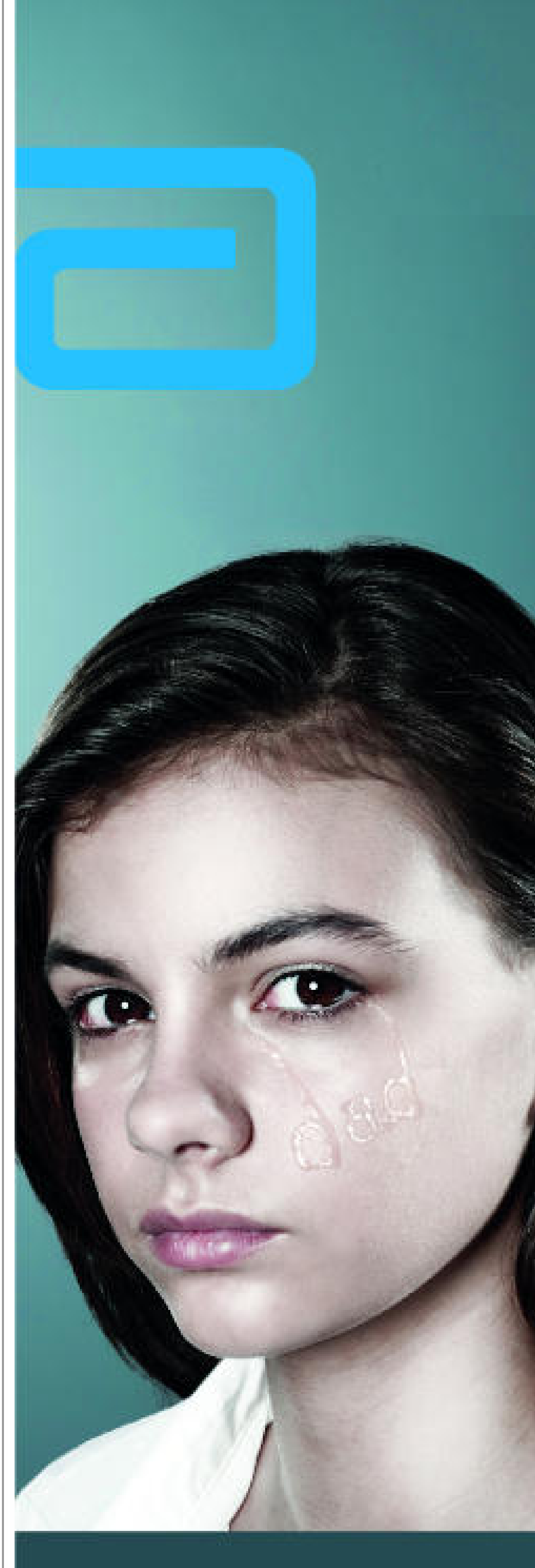
You're lucky, Dr Copperfield – your practice has just 104 patients affected by the MHRA warning over amlodipine combined with simvastatin at 40mg or above ('A nightmare in 20 questions', pulsetoday.co.uk/blogs).

We have over 200 patients on both amlodipine and simvastatin at our practice.

Thoughts run to nifedipine – not too expensive, but likely to cause side-effects – or atorvastatin, which we have been avoiding but has just come off patent. We have been advised by our cardiologist that this is not urgent, though.

● **From Dr David Simpson**
Stockbridge, Hampshire
via pulsetoday.co.uk

Has anyone measured the increase in CVD risk by reducing simvastatin 40mg to 20mg? I'm sure other statins will be found to have the same risk given time. If the increase in CVD morbidity outweighs the myositis risk, we should not change these tablets.



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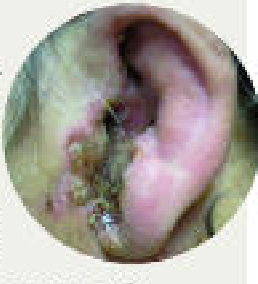


KEY QUESTIONS

Irritable bowel syndrome

Consultant gastroenterologist Dr Anton Emmanuel tackles GP Dr Julian Spinks's questions on diagnostic criteria, red flags and elimination diets

1 We've been taught that irritable bowel syndrome (IBS) was a diagnosis of exclusion. Now we are told that it is a symptomatic diagnosis – what are the diagnostic criteria?

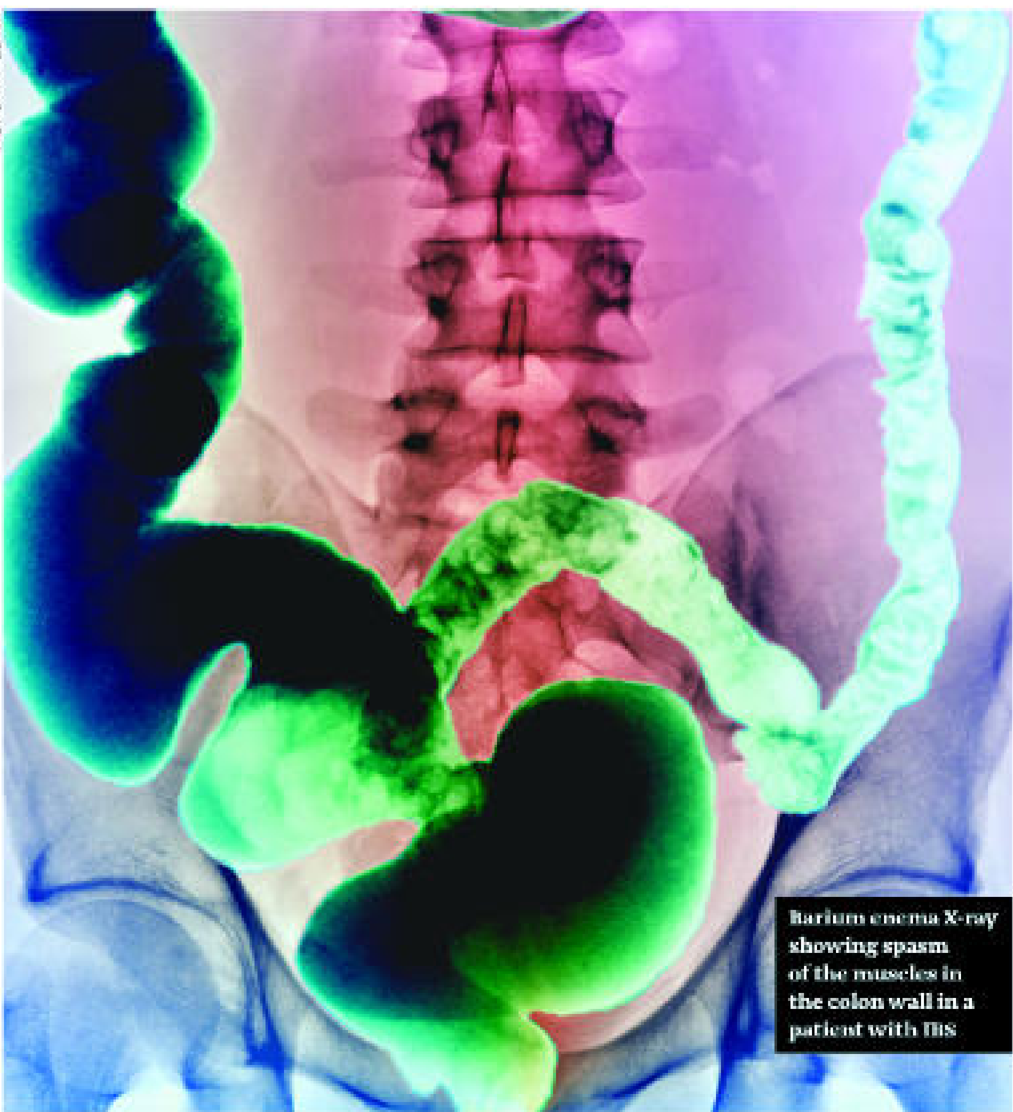
It is critical to exclude organic disease when patients present with symptoms of IBS – in this way, IBS is still a diagnosis of exclusion. In particular, you need to exclude colorectal cancer, ovarian cancer and coeliac disease. After this, the primacy of symptoms is critical, as is making a positive diagnosis, rather than saying: 'Well, tests are normal, so I suppose this is just IBS.' So from this perspective, it is a symptomatic diagnosis.

The symptoms of IBS are formalised in the Rome III diagnostic criteria (see box, right).[1] These criteria are well recognised, but are complex and too unwieldy for clinical practice. Essentially, the symptoms are abdominal pain, altered bowel function (consistency and frequency) and a temporal association between those two factors.

2 Other than the main IBS symptoms, what items in the medical history would it be useful to ascertain?

Patients report a wide range of symptoms that could usefully be included in a history, such as: bloating, passage of mucus, pelvic pain, headache, fibromyalgia-type pains, backache and fatigue. Upper-gut symptoms – for example indigestion and reflux – often coexist with IBS symptoms and so should also be noted. Ask about the severity of these symptoms, taking account of the most intrusive aspect of their symptoms.

The absence of 'red-flag' symptoms in any history – see question four. Stress exacerbation is typical, but not pathognomonic. Similarly, the absence of nocturnal symptoms is typical, but not always reported. Meal exacerbation of symptoms is also frequently reported.



Barium enema X-ray showing spasm of the muscles in the colon wall in a patient with IBS

Rome III diagnostic criteria for IBS[1]

Recurrent abdominal pain or discomfort at least three days a month in the past three months, associated with two or more of the following:
- **improvement with defaecation**
- **onset associated with a change in frequency of stool**
- **onset associated with a change in form (appearance) of stool.**

Symptoms are often intermittent, with flare-ups lasting from two to four days, with periods of remission in between.

Women present to healthcare professionals with IBS symptoms more readily than men, so you may need to ask men more probing questions in order to take a full history.

3 Are there any basic investigations that would be useful to diagnose IBS and should we request investigations like ultrasounds and sigmoidoscopies?

I often see patients – usually younger patients – being over-investigated, while others, such as those over 40 who are presenting with IBS for the first time, are under-investigated. In a younger patient, investigations should be kept to a minimum.[3]

But there are some basic investigations that I would recommend. Do a blood screen, including FBC (looking for anaemia, high white blood cell or platelet count). A coeliac antibody screen is also sensible.

If the patient presents with discomfort related to eating a fatty meal, an abdominal ultrasound may reveal gallstones or biliary disease.

Diarrhoea may require a stool analysis or faecal elastase test to exclude chronic pancreatitis if there is a history of gallstones or alcohol misuse. When considering endoscopic procedures, remember that the yield of lower gastrointestinal endoscopy in constipation is low. In diarrhoea, sigmoidoscopy or colonoscopy with biopsies is wise.

4 It is inevitable that GPs worry about missing a more serious diagnosis, such as bowel or ovarian cancer. What are the red flags to look for?

The NICE and British Society of Gastroenterology guidelines[1,2] both recommend further investigation of:
- rectal bleeding in the absence of anal symptoms
- unplanned weight loss

- a family history of colorectal cancer
- a sudden change in bowel frequency
- dysphagia
- vomiting
- anaemia
- loss of appetite.

These symptoms are especially noteworthy in patients over the age of 50. It is fairly common to see minor bleeding from the anus and this does not preclude the diagnosis of IBS, but further investigation may still be warranted to rule out more serious diagnoses, particularly if the blood is dark red.

Also be aware that bloating and distension in IBS fluctuates during the day and night, while bloating in a patient with ovarian cancer does not.

5 Many patients put their IBS down to food allergies or intolerances. Are there any proven links between certain foods and IBS, and should we advise elimination diets?

Eating can often make the symptoms of IBS worse, but there is currently no proven link to any specific food allergy. Keep in mind that IBS is distinct from coeliac disease.

Patients do subjectively report intolerance, often citing several foods as culprits, but firm supportive evidence is still lacking. Formal elimination diets are useful, but these are hard to do effectively without professional dietetic input – a scarce resource.

Your patient may have already attempted to manipulate their diet to relieve symptoms. This can lead to unusual, nutritionally inadequate diets. You may find excessive intake of fruit, caffeine and dietary fibre – especially insoluble cereal fibre – which may be compounding the problem. Reducing intake of these foods can often help.

Recently, a diet low in foods that produce intestinal gas and liquid – the low FODMAPs diet – has become popular, and it has an increasing evidence base.[4]

6 What are your thoughts about using herbal and traditional medicines in IBS?

The evidence base for traditional medicines is slim. The percentage response above placebo tends to be below the magic 10% that is required for formal endorsement. We also do not know which factors predict a good response to such interventions.

Gut-focused hypnotherapy has a strong evidence base, but it is not readily available.[5] As for acupuncture and herbal therapies, the evidence base is, again, slim, and often contradictory. But a few patients find these therapies reduce symptoms. In these cases, remember that such therapies are generally quite safe and so can be used if patients feel there is an improvement.

7 Anxiety and other psychological factors are often linked to IBS. Would you recommend talking therapies and, if so, are there any that are better than others?

Talking therapies are undoubtedly clinically effective and they are cost-effective in the longer term, compared with conservative and drug therapies. Cognitive behavioural therapy is particularly effective. Exposing the links between stressors and symptoms is often helpful for the patient.[6]

Rarely, formal psychological therapies may be needed. These patients are often long suffering and have many symptoms. The chronicity of symptoms can be a further source of stress, and psychological discussions that are not handled sensitively can leave the patient feeling as though they have brought their symptoms on themselves.

Dr Anton Emmanuel is a consultant gastroenterologist at University College Hospital in London
Dr Julian Spinks is a GP in Strood, Kent

This article was produced in collaboration with the British Society of Gastroenterology (BSG), a professional organisation focused on the promotion of standards in gastroenterology and hepatology within the UK. The BSG has produced guidance designed to aid emerging CCGs to commission an effective gastrointestinal and liver disease service. For more information and to download the guidance, go to: bsg.org.uk/clinical/general/commissioning-report.html

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Review the published evidence at www.probioticsinpractice.co.uk
Information for Healthcare Professionals.

HEALTH AFFAIRS

WHAT'S NEW IN

Diabetes

An update from GP and diabetes hospital practitioner Dr Chris McDonald

1 Intensifying glycaemic control in type 2 diabetes may cause more harm than good

In the 1990s, two trials – the DCCT in type 1 diabetes and the UKPDS trial in type 2 – found that strict glycaemic control significantly reduced the risk of complications.

But control of hyperglycaemia has to be balanced against the risk of hypoglycaemia, which is associated with its own morbidity.

A recent Cochrane review looked specifically at the impact of intensive glycaemic control – defined as an HbA$_{1}$c target of below 9.6mmol/l (7%) – on peripheral neuropathy, which has tended to be a secondary outcome in the large prospective trials.

It concluded that in patients with type 1 diabetes, this translated to a 53% risk reduction for developing neuropathy after five years compared with those receiving standard care – and a threefold increase in hypoglycaemic events.

But in patients with type 2 diabetes there was less than a 1% reduction in the risk of developing neuropathy, but a similar rate of hypoglycaemic events.

Of course, the effect on other clinical outcomes has to be taken into account when determining the risk-benefit ratio of intensifying glucose control, but peripheral neuropathy is a serious complication that should not be overlooked and the risk associated with hypoglycaemic events is substantial.

There is a fairly clear benefit in type 1 diabetes, but the effect is much less impressive in type 2 and adds to increasing evidence that lowering glucose too far can be counterproductive.

Callaghan B, Little A, Feldman E et al. Enhanced glucose control for preventing and treating diabetic neuropathy. *Cochrane Database System Rev* 2012;CD007543

2 NICE guidance on preventing diabetes

There is little doubt that treating pre-diabetes early and aggressively can dramatically reduce the risk of developing the disease.

The latest study – published in *The Lancet* in June – compared lifestyle intervention, metformin or placebo in 1,990 patients with impaired glucose tolerance. Six years later those patients whose blood glucose levels had dropped to normal when tested at least three times in that period were up to 70% less likely to have diabetes than those on placebo, irrespective of how that drop was achieved.[1]

The following month, NICE published its public health guideline on preventing diabetes – it is essentially *The Lancet* paper put into guideline form.[2]

In short, it recommends GPs use an electronic risk assessment tool to search their lists for people with diabetes risk factors and invite them in to test their HbA$_{1}$c.

Anyone with an HbA$_{1}$c of 42-47mmol/l (6-6.4%) is classified as high risk and should be offered an intensive lifestyle change programme with annual GP reviews to check progress. Those whose risk remains high despite participation in these programmes should be offered metformin.

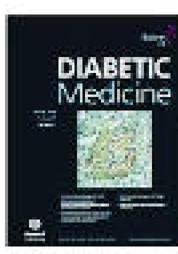
I think the main questions to ask are:

- Treating pre-diabetes works, but in how many patients? It's worth looking at appendix D of the guidance: *Gaps in the Evidence*. It states there is a lack of evidence on the effectiveness and cost-effectiveness of lifestyle change programmes in preventing or delaying type 2 diabetes at the cut-offs recommended.
- Who is going to provide these intensive lifestyle programmes? Most GP practices certainly don't have these skills or resources.
- How effective is metformin in these patients? It is 18% at 10-year follow-up according to a 2009 meta-analysis, compared with 34% for lifestyle and diet change. So lifestyle is preferable as a first option, but in clinical practice how many of our patients will be successful?
- And when is metformin going to get a license for this indication?

My personal view is that this is an ambitious document with a laudable aim, but we need the resources to make it work.

Also, it amounts to being a screening programme and we need the evidence to justify it.

1 Perreault L, Pan Q, Mather K et al. Effect of regression from pre-diabetes to normal glucose regulation on long-term reduction in diabetes risk: results from the Diabetes Prevention Program Outcomes Study. *Lancet* 2012;379:2243-51
2 NICE. Preventing type 2 diabetes – risk identification and interventions for individuals at high risk. July 2012;PH38



3 Polypharmacy in care home residents with diabetes

As GPs, we are well aware of the number of medications an older patient accrues as new comorbidities develop.

And although we know all patients should have regular medication reviews – one aim of which should be to discontinue unnecessary treatments – in my experience this doesn't happen as often as it should in older patients, particularly in some care homes.

A study published last year looked specifically at the issue of polypharmacy in patients with diabetes living in care homes.

It is a relatively small study – looking at medications taken by 75 residents with diabetes in care homes in the Coventry area – but its conclusions are useful.

The researchers found 84% of these patients were taking four or more medications – meeting the definition of polypharmacy – and more than a third were prescribed eight or more.

A high proportion of residents were taking drugs for cardiovascular disease prevention, which the authors suggested might be entirely inappropriate in a population with limited life expectancy.

Antiplatelet drugs were being taken by 59% of the patients – including aspirin, clopidogrel and dipyridamole – and 41% were on statin therapy.

These reviews would take time and a decision to stop any medication needs careful consideration – it's certainly not valid to assume all secondary care prevention drugs have no value in older patients and can all be stopped.

They also looked at 18 residents (24% of the total) whose monthly drug costs were over £101 per month – largely due to special-order liquid preparations.

The cost implications are of less interest to me and I disagree with one conclusion of this otherwise useful paper – that liquid specials could be replaced with crushed tablets.

This is not a licensed use and I wouldn't be comfortable recommending it, especially when residents are often given their medication by healthcare assistants rather than nurses.

Gadsby R, Galloway M, Barker P et al. Prescribed medicines for elderly frail people with diabetes resident in nursing homes – issues of polypharmacy and medication costs. *Diabet Med* 2012;29:136-9

4 Concerns over hyperglycaemia with statins

A 2010 meta-analysis first raised the suggestion that statin therapy was associated with a slightly increased risk of new-onset diabetes.[1] Although the odds ratio was just 1.09, it was statistically significant and clinically important given the extent of statin prescribing. Treatment of 255 patients with statins for four years would result in one new diagnosis of diabetes.

Then last year an analysis of five trials including 32,752 non-diabetic patients taking statins for almost five years found that 8.2% went on to develop diabetes.[2] This analysis is the first to suggest a dose-dependent effect. Patients on intensive statin therapy – simvastatin 80mg or atorvastatin 80mg – were 12% more likely to develop new-onset diabetes than those on moderate-dose therapy such as simvastatin 20mg or 40mg, atorvastatin 10mg or pravastatin 40mg.

Fortunately, the MHRA has produced some useful advice for GPs on the issue.[3] An association between statin use and new-onset diabetes is supported by evidence. But the risk appears to be mainly in patients already at increased risk of developing diabetes. Raised fasting blood glucose at baseline is a key factor and may be enough to identify those at risk. Other risk factors include a history of hypertension, raised triglycerides and raised BMI at baseline. There is limited evidence to support a further increased risk with high-dose atorvastatin or simvastatin, but it is not possible to exclude any statins from having risk. But the overall benefits of statins strongly outweigh any risks, including in those at risk of diabetes and those with diabetes.

1 Sattar N, Preiss D, Murray H et al. Statins and risk of incident diabetes: a collaborative meta-analysis of randomised statin trials. *Lancet* 2010;375:735-42
2 Preiss D, Seshasai S, Welsh P et al. Risk of incident diabetes with intensive-dose compared with moderate-dose statin therapy: a meta-analysis. *JAMA* 2011;305:2556-64
3 MHRA. *Drug Safety Update* 2012;5:A2

Dr Chris McDonald is a GP in Aberdeen and a hospital practitioner in diabetes

Competing interests None declared

TEVA UK

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The extended online version of this article has an update on bariatric surgery and diabetes remission

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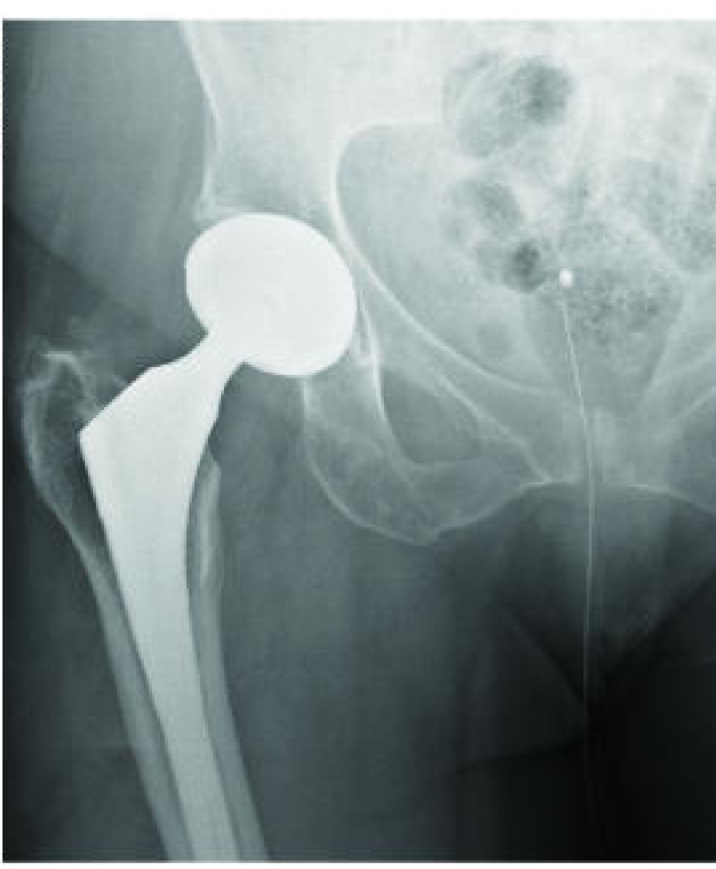
POST-OP PROBLEMS

Orthopaedic surgery complications

Orthopaedic consultants Mr Stephen Cannon and Mr Rej Bhumbra continue our series with a discussion of possible complications after orthopaedic surgery



Pressure on inpatient beds continues to increase and so do the numbers of patients undergoing day-case and short-stay procedures.

Patients who are going to have day surgery should be selected carefully – for example, if they have had a difficult post-operative course in the past, a scheduled inpatient admission should be facilitated.

The most important aspect of identifying any post-operative complication is suspecting it in the first place. Try to obtain as much information about the operation as possible from the patient and the discharge documentation.

It can be difficult to determine how a set of symptoms may evolve, and if you're not sure then erring on the side of caution and referring is rarely criticised. If the patient does warrant hospital review, it is best to re-refer to the surgeon who did the operation if at all possible.

General orthopaedic complications

- *Pain* is the most common post-operative complaint. Inadequate or ineffective analgesia is a problem if the local anaesthetic or hospital-administered stronger opiates have worn off and this has not been anticipated by the discharge team. Pain that is out of proportion to the surgical insult or recalcitrant to increasing analgesia warrants review by the surgical team as well as the anaesthetic unit.
- *Nausea* can be quite debilitating postoperatively. It should be managed swiftly with either antiemetics or a reduction in the opiate analgesia.
- *Fever* is important to recognise in the

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Are your patients finding effective medicines hard to swallow?

Swallowing difficulties can affect 70 to 90% of older people.[1] So, many of your patients over the age of 60 may be having trouble swallowing tablets and capsules.[2] It may not have crossed your mind to ask them, and they probably won't tell you! So what could be happening to the medication you prescribed?

Some may not be taking it at all, meaning repeat visits to you or even worse, potential hospitalisation.[3] In fact 30% of emergency admissions amongst older people are related to medication (including non-compliance and omission of drugs) and more than 50% of these are preventable.[4]

Others may try to comply by crushing tablets or opening capsules, unknowingly changing the pharmacokinetics. This might render the medicine inactive, or as in the case of sustained releases tablets, deliver the whole dose at once risking a potential increase in Adverse Drug Reactions.[5,6]

There is a simple solution. Guidelines recommend that you should ask your patients if they can swallow medicines. If they can't, you could consider prescribing an alternative formulation, like an oral liquid.[7]

For more information on this topic visit **www.rosemontpharma.com**

References: [illegible]

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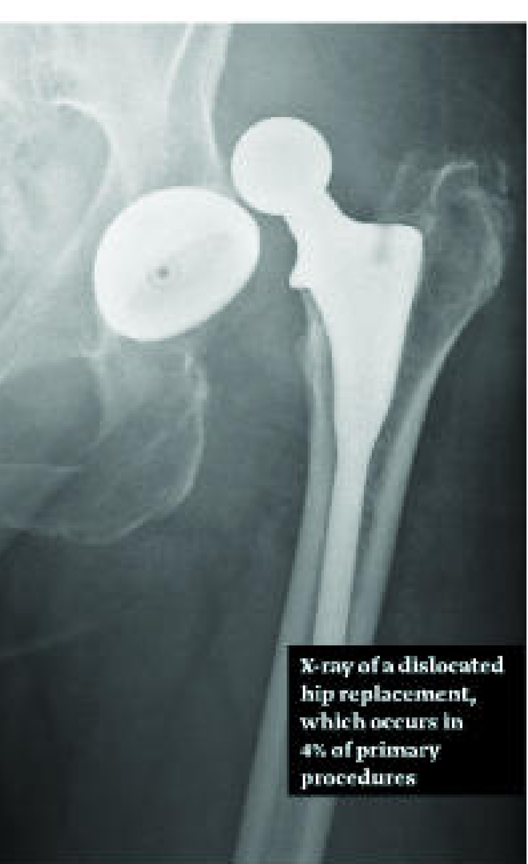
X-ray of a dislocated hip replacement, which occurs in 4% of primary procedures

post-operative period. Documentation of the temperature is helpful because the timing and extent of the fever can help determine its cause. It is fairly common for patients to have a low-grade, non-specific fever within 24 hours. Infections specific to the surgical site can also happen within 24 hours of surgery, but this is less common. Look for infections such as pneumonia (aspiration or atelectasis), UTIs (especially if there has been tract instrumentation) and thromboembolic disease. In a patient with no other pre-operative morbidities, you'll need to consider whether a fever is a reaction to drugs, blood products, intravenous lines or the physiological response to both an anaesthetic and the operation.

- *Haemorrhage or haematoma formation* presents with pain, swelling and bloody wound discharge. If the application of a pressure dressing does not control the discharge, prompt referral should be made. For knee, foot and hand surgery, elevation can be a very important way to control both haematoma formation and pain. Improperly applied dressings can externally increase the compartment pressure, producing swelling and pain – the dressings should be removed urgently. Significant pain with exacerbation on passive stretching of the digits is a hallmark of compartment syndrome, and this is an orthopaedic emergency.
- *Neurological deficits*, especially post-operative paraesthesia over and just around a surgical scar, are common. The effects of local anaesthetics or regional blocks will need to have diminished before a patient will be discharged. If a specific procedure will result in an anticipated neurological loss, the patient should have been informed appropriately. Any unexpected persistent neurological deficit should be alerted to the operating team.
- *Thromboembolic disease* can be difficult to diagnose clinically. Assessment of risk factors is just as important as the clinical signs. Combining a risk-scoring system with D-dimer results can have a negative predictive value, but obtaining blood tests and further imaging does usually necessitate referral. The presence of one or more of the following warrants urgent referral for a chest CT pulmonary angiogram to exclude a pulmonary embolism:
  - shortness of breath
  - chest pain
  - haemoptysis with or without a tachycardia.
- *Infections* can be caused by any breach in the skin and the presence of metalwork can increase the susceptibility. Superficial infections tend to present earlier and are more obvious than the deep-seated infections. Deeper infections can present with pain, swelling, fever or loss of function. Either way, establishing a causative organism and early treatment is the goal. Early involvement with microbiological services and liaising with the community care teams and dressing units is essential to optimise wound management. Deeper infections require infection eradication, with surgery and antibiotics or long-term control suppressive therapy in resistant cases.
- *Ischaemia of the extremities*, especially in patients with pre-existing vascular insufficiency, is a significant post-operative complication. Dressings should be applied to facilitate distal skin inspection for both colour and capillary refill. The inadvertent use of circumferential dressings, critical swelling, iatrogenic vascular injury or even digital tourniquet retention, are all limb threatening. Skin colour, state, capillary refill and the presence of pulses all require careful assessment. A painful, early dusky white digit, later dark, is suggestive of an arterial injury, while a blue, then purple, congested skin appearance may indicate that poor venous drainage is preventing appropriate perfusion.

Procedure-specific complications

Arthroscopy

After reabsorption of the intra-articular

A hot, immobile joint urgently needs investigation

saline used in surgery and a reduction in the pain and swelling, most patients recover well.

- *A hot immobile joint* with or without systemic symptoms of fever urgently needs investigating to exclude an infective arthropathy. This may present immediately or early in the post-operative period.
- *Non-remittance of symptoms* such as stiffness, pain and instability, and an inability to access physiotherapy to improve joint range of motion and power presents later, but should be detected either in the GP surgery or in the outpatient post-operative review. Patients should be encouraged to have periods of mobilisation if post-operative instructions recommend it to prevent stiffness. But note that frozen shoulder in particular is now being managed more often by radiological services – using ultrasound-guided needle hydrodistension – rather than with day surgery. Patients will often require more than one treatment, so an immediate

29

Some UK hospitals are using this probiotic yogurt drink in those at risk of antibiotic-associated diarrhoea and *C. diff*-associated diarrhoea...

...could it help your at risk antibiotic patients too?

Probiotics have been shown to help restore the balance of gut bacteria disturbed by antibiotic use.[1,2] Actimel is a probiotic yogurt drink, containing ***Lactobacillus casei* DN-114 001***, which has been **shown to support the body's immune system in numerous clinical studies**[3]. In one clinical study older hospitalised patients (over 50 years of age) drinking Actimel daily† during a course of antibiotics and for one week after showed significantly reduced incidence of antibiotic-associated diarrhoea and *C. difficile*-associated diarrhoea.[4] **WGO Practice Guidelines** report "Recent research has indicated that *L. casei* DN-114 001* is effective in hospitalised adult patients for preventing antibiotic-associated diarrhoea and *C. difficile* diarrhoea"[5] Some hospitals near your practice have already started integrating it into their *C. difficile* management plans.

Visit www.probioticsinpractice.co.uk to see the evidence for yourself and register for a new RPS accredited CPD e-learning module on probiotics, the immune system and gut microbiota.

Information for Healthcare Professionals

* *Lactobacillus casei* DN-114 001/CNCM I-1518 (*L. casei* Danone)

† Two bottles consumed daily.

References: 1. De La Cochetiere MF et al. *Microb Ecol* 2008;56:395–402. 2. O'Toole PW and Cooney JC. *Interdiscip Perspect Infect Dis* 2008; 175–285. 3. Danone Research. Clinical studies – Actimel publications. Available online at: www.studies.danone.com (accessed August 2011). 4. Hickson M et al. *BMJ* 2007;335:80. 5. World Gastroenterology Organisation Practice Guideline. Probiotics and Prebiotics; May 2008. Available online at: www.worldgastroenterology.org/probiotics-prebiotics.html (accessed August 2011).

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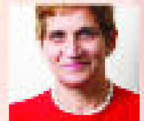

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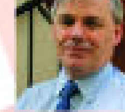

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*Free for Pulse Learning subscribers
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27 non-remittance of symptoms after one injection is not indicative of failure.

Foot and ankle surgery

Extensive bony operations are now being conducted by foot and ankle teams as day surgeries, in addition to the traditional distal toe deformity corrections, neuroma divisions or first metatarsal realignments. Patients will often be discharged in plaster of Paris or fibreglass casts. Written plaster care instructions, with points of contact and weight-bearing status, should all have been given to the patient.

- *Swelling with subsequent pain* is common in the foot – especially in the warmer seasons – as it is the most dependant part of the limb. This presents in the early post-operative period, and immobilisation and elevation are very important in the initial post-operative window to reduce distal oedema and maintain the vascularity of the cut skin edges.
- *Wound infection* should be suspected early, given the location of the wound and skin bacterial load, and a low threshold for wound inspection should be adopted. Taking swabs and having those results available early can guide management.

Hand and wrist surgery

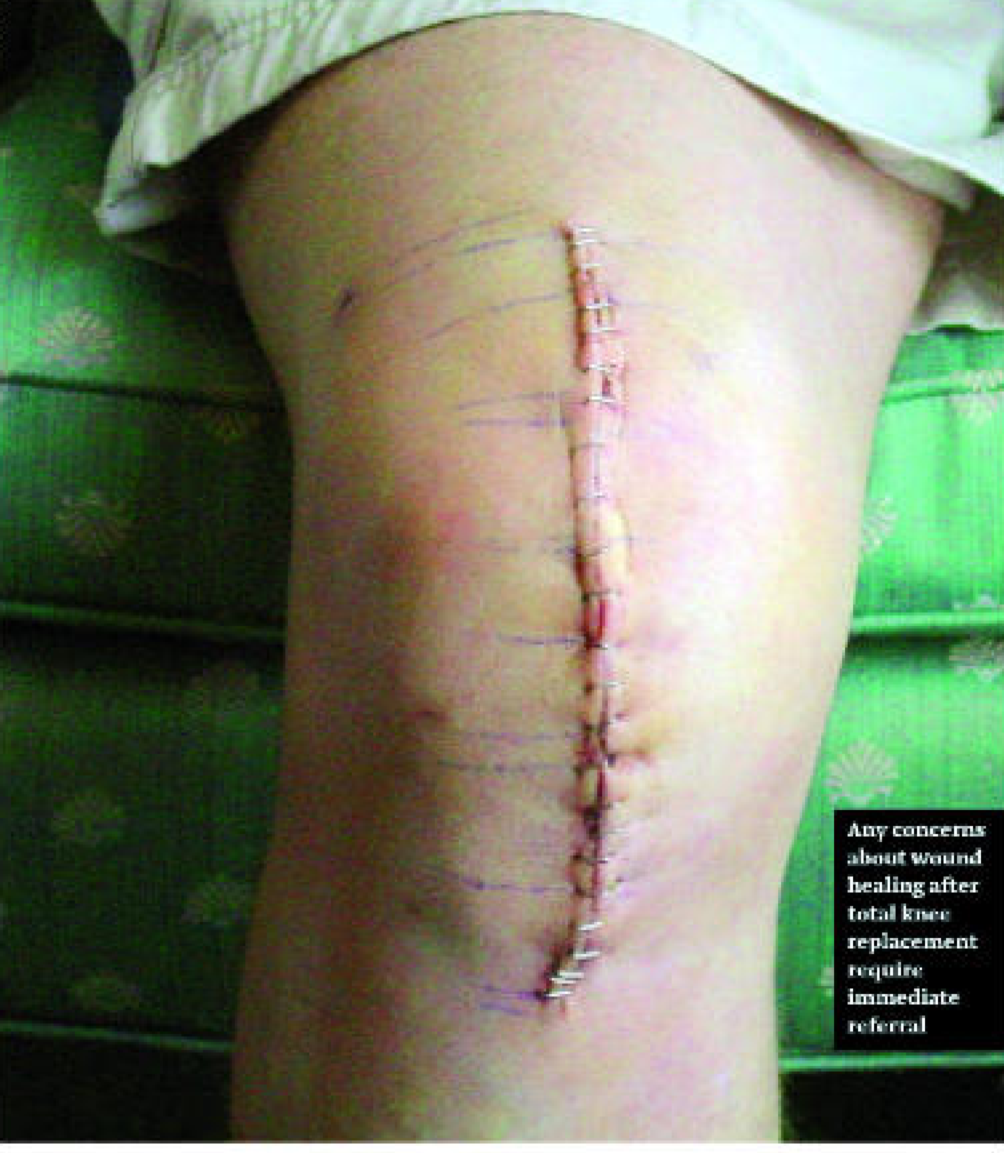
- *Wound ooze* is not uncommon, as the upper limb has a rich blood supply. Reassurance is all that is usually required.
- *Wound breakdown* is less common than wound ooze, but any questions of pain, ooze, and neurological or vascular dysfunction need a complete examination of the affected area. Tourniquet use is common in the extremities and problems associated with their use are well documented. These include prolonged neurological deficits, skin degloving, pain and secondary vascular compromise.

Total hip replacement

Enhanced recovery programmes following hip and knee arthroplasty are now in place in many units, both in the NHS and in the private sector, which aim to discharge some hip replacement patients between four and six days post-operatively.

In hospital, patients will be given antibiotics, which are usually completed by the point of discharge. But patients also require anticoagulation for around six weeks post-operatively. This can involve sub-cutaneous injection of heparin, but is often oral anticoagulation, with thromboembolus-deterrent stockings. Many patients will be asked to partially weight-bear for the first six-week period until reviewed, particularly if they have had uncemented components.

- *Wound haematoma* occurs commonly because of immobility and continuing anticoagulation. Progression of the haematoma requires discussion with the appropriate orthopaedic unit. Similarly, any delay in wound healing – particularly if there is concern regarding deep infection – requires urgent re-referral.
- *Deep vein thrombosis* in patients after hip replacement is now virtually unheard of, but general dependent oedema is not uncommon. If in doubt, Doppler ultrasound is a useful investigation.
- *Acute chest pain*, particularly following Valsalva manoeuvre, is likely to be due to pulmonary embolism.
- *Dislocation* occurs in approximately 4% of primary hip replacements, usually in those patients who have had a posterior approach. Acute dislocation requires urgent referral. The classical signs are acute hip pain with a shortened externally rotated limb.


Any concerns about wound healing after total knee replacement require immediate referral

Total knee replacement

As mentioned earlier, total knee arthroplasty is now the subject of an enhanced recovery programme, often resulting in discharge between the third and the fifth post-operative day. Patients are on anticoagulation only for 10 days and this is usually given by subcutaneous injection for the early period of outpatient care.

- *Failure of the wound to heal* is the main concern after knee replacement. Any continuing discharge or other concerns about wound healing require immediate referral back to the orthopaedic surgeon to consider revision and lavage of the wound.
- *Stiffness* should be avoided by encouraging the patient to flex to 90°. Immobilisation of the knee can sometimes be helpful over a short period of time. Patients who are not flexing to 90° during the initial six-week period should be referred to the local physiotherapy department or orthopaedic surgeon.
- *Arterial and venous compromise of the lower limbs* is often concomitant in patients with knee replacements, as patients are usually elderly. And this can be exacerbated in the early post-operative period due to dependent oedema. Concerns about DVT – specifically pain and swelling with painful dorsiflexion of the foot – should prompt a diagnostic Doppler ultrasound.

Mr Stephen Cannon is a consultant orthopaedic surgeon and Mr Rej Bhumbra is a locum consultant at the Royal National Orthopaedic Hospital, London

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Further reading

- NICE. Surgical site infection. Oct 2008. CG74.
- NICE. Hip disease – replacement prostheses. January 2003. TA2.

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1 in 4

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

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

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

* The need for a second dose is currently unknown

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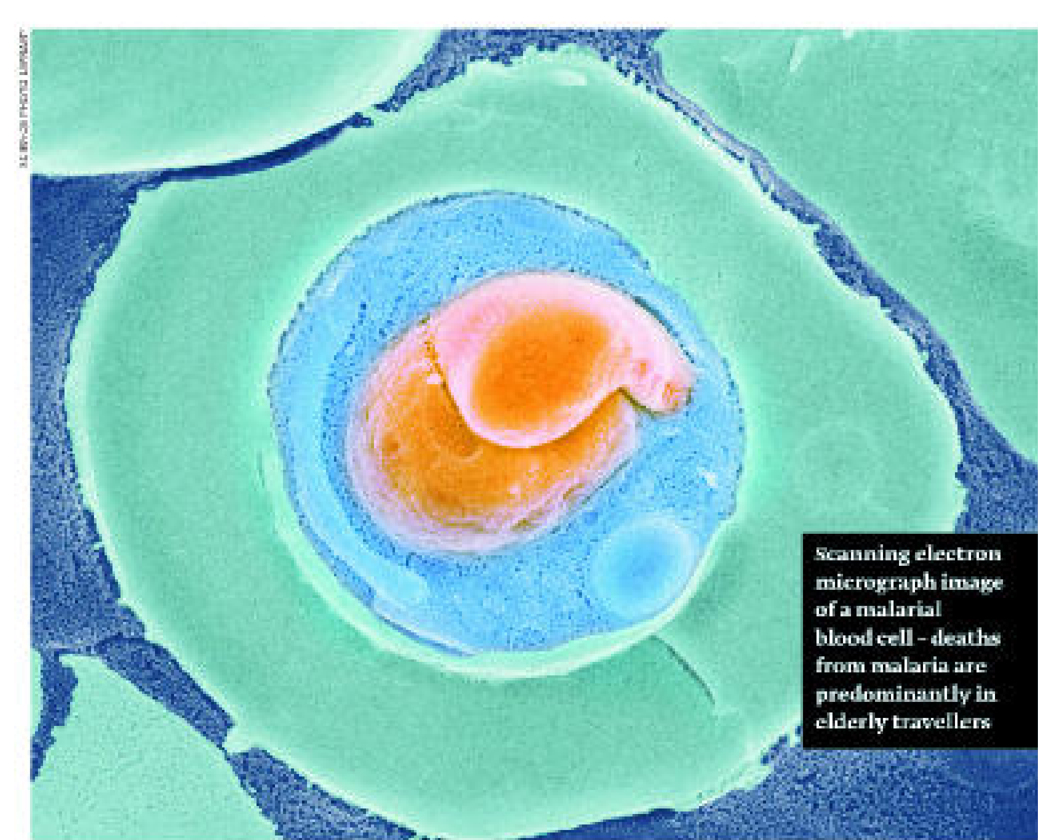
UK15206a c 06/12

TEN TOP TIPS

The unwell returning traveller

Travel medicine specialists Dr Ron Behrens and Bernadette Carroll offer tips on how to manage the returning traveller who feels unwell



Scanning electron micrograph image of a malarial blood cell – deaths from malaria are predominantly in elderly travellers

1

Ask about reasons for travel, activities and precise dates.

Diagnosis of travel-related illnesses relies on a detailed travel history including where the patient travelled (country and region), reasons for travel (visiting relatives or business trip) what they did (such as swim in lakes, visit a game park or have local sexual contacts).

Also ask about precise dates of travel to include or exclude infections based on their incubation period and time to presentation. The dates of onset and duration of symptoms, along with details of pre-travel immunisations and compliance with prophylaxis, are valuable.

Be alert to illness that can rapidly be fatal or a danger to the public.

The priority is to rule out infections that can rapidly be fatal such as malaria or meningitis, or infections that are a threat to public safety such as viral haemorrhagic fevers.

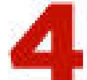
Viral haemorrhagic fevers are extremely rare, but anyone who presents with an unexplained fever within three weeks of a visit to an area in sub-Saharan Africa where cases are reported (rural central and west Africa) should be isolated while under investigation – particularly if there is a history of contact with body fluids of an infected person or animal.

Look for patients at high risk of malaria.

Any patient presenting with unexplained fever or flu-like illness should be asked for a history of travel to avoid missing a diagnosis of malaria.

Over 95% of infections with *Plasmodium falciparum* occur within two months of leaving an endemic area, but most occur within 10 days. Symptoms are usually non-specific and include malaise, fever, and occasionally rigors.

Patients who travelled to visit family and friends are at an eight-fold higher risk of having malaria than others. Deaths from malaria are predominantly in older travellers and travellers who have been on 'winter sun' holidays, particularly in the Gambia.[1]



Don't overlook common health problems.

Health problems common in the general population occur in travellers too. Headaches, malaise, viral respiratory infections and fevers are frequent in travellers and are not always tropical infections.

32

Methylprednisolone BP 4%

50+ years and still going strong

Pfizer

Working together for a healthier world

5 Consider other symptoms to identify the cause of a fever.

The cause of fever in an unwell returned traveller may be difficult to identify and not always have a precise aetiology.

Consider enteric infection (typhoid and paratyphoid) if the patient presents with fever and abdominal pain, particularly after a visit to the Indian subcontinent. A history of fever, rash and recent travel to South East Asia may be due to dengue fever. Consider Rickettsial infection in a traveller who has a fever and skin rash following safari in southern or east Africa. If there is no obvious organ involvement – for example pneumonia, skin sepsis or rash – and the patient is acutely unwell, admission to hospital would be wise.

6 Consider exposure to STIs.

Sexual contact in developing countries exposes travellers to tropical infections such as chancroid, lymphogranuloma venereum, granuloma inguinale (donovanosis), and syphilis. HIV seroconversion illness may present with generalised flu-like symptoms of fever, sore throat, lymphadenopathy, generalised rash, muscle and joint pain and pneumonia, usually two to six weeks after exposure.

7 Conduct stool microscopy and culture in patients with diarrhoea.

Traveller's diarrhoea is the most frequent infection occurring during travel. Most episodes last two to three days, but 1-4% of episodes will persist for four weeks or longer. The initial investigation consists of stool microscopy and culture, but in around half of cases no pathogen will be identified. *Giardia lamblia* is occasionally identified as the cause of persistent diarrhoea in travellers returned from India or Pakistan. Other parasitic causes of diarrhoea include *Entamoeba histolytica* and *Cryptosporidium parvum*. Enteric infections can trigger a post-infectious irritable bowel syndrome with long-term sequelae in 1-4% of patients.

8 Identify skin infections in returned travellers.

Schistosomiasis presents with an urticarial rash, fever and eosinophilia, and a history of fresh-water exposure in Africa four to eight weeks earlier.[2] Cutaneous myiasis is more frightening – the patient who has returned from sub-Saharan Africa or Latin America may describe a boil-like lesion where movement of the larva of the tumbu or bot-fly can be felt.

Vaseline under an occlusive dressing placed over the lesion asphyxiates the larva, forcing it to move on to the skin. Cutaneous larva migrans, tungiasis, scabies and other parasites are less common and require specific topical therapy.

9 Refer unexplained eosinophilia for further investigation.

Unexplained eosinophilia (greater than 0.5%) in a symptomatic returned traveller requires further investigation for a helminthic infection.

If they do not have atopy, investigation – starting with a search for ova in the stool and then serological testing for other helminths and trematodes – might help explain the raised count. This can be simply done as an outpatient in a specialist centre.

10 Seek specialist advice if unsure.

Advice can be sought from infectious and tropical diseases centres including the Liverpool School of Tropical Medicine on 0151 705 3100, The Royal Liverpool University Hospital on 0151 706 2000, and the on-call tropical medicine registrar (24-hour service) at the Hospital for Tropical Diseases London via the University College London Hospital Switchboard on 020 3456 7890 or 0845 155 5000.

Dr Ron Behrens is a consultant physician in tropical and travel medicine and Bernadette Carroll is a research fellow at the Hospital for Tropical Diseases, London

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1 Checkley A, Smith A, Smith V et al. Risk factors for mortality from imported falciparum malaria in the UK over 20 years: an observational study. *BMJ* 2012;344:e2116
2 Johnston V, Stockley J, Dockrell D et al. Fever in returned travellers presenting in the UK: recommendations for investigation and initial management. *J Infect* 2009;59:1-18

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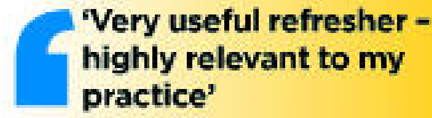

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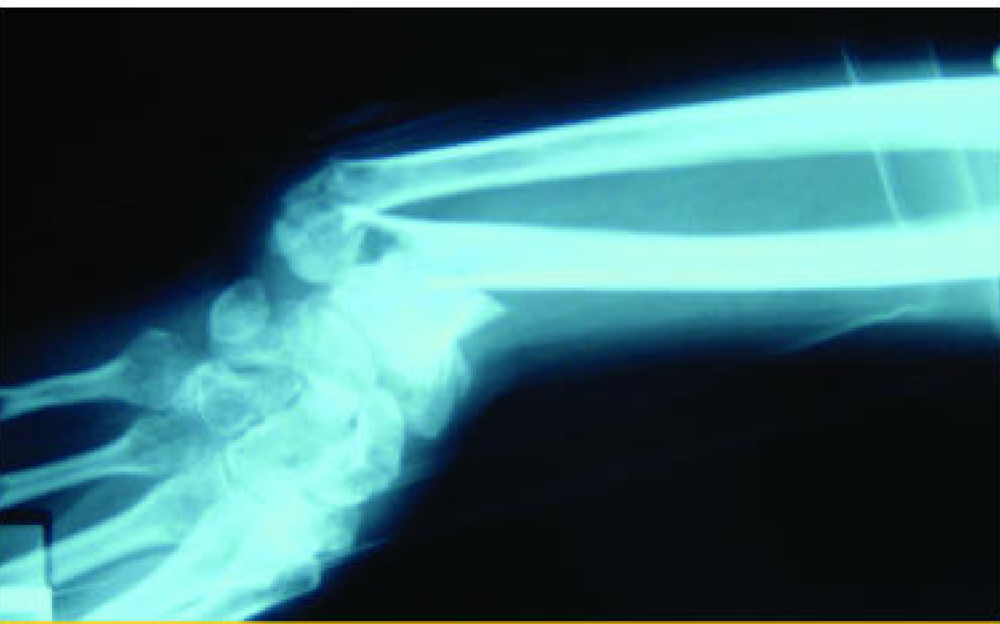

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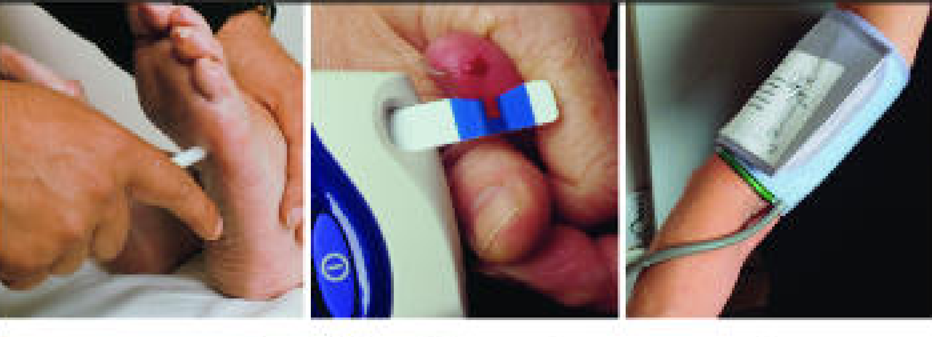

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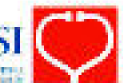

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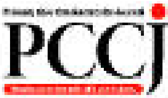

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Sally Sidaway explains how to make the most of CCG work
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Dr Isabel Hodkinson explains how her CCG handled an increasingly common problem
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How will commissioning affect my income?

Sally Sidaway answers key questions about the impact of working for a CCG on both personal and practice income

From April 2013, CCGs will be firmly established, with many GPs holding active commissioning roles – from officer posts to ad hoc work. All parties need to fully understand the implications of a GP taking up a CCG post so that both the GP and the practice are protected against negative financial consequences.

How will my partnership profit share be affected?

GPs taking up CCG posts will usually continue to be involved in their practice.

There are three possible ways to adapt profit share when a partner is absent for a number of sessions:

- partnership profit share will be reduced in line with the reduction in sessions worked
- full profit share will remain and the first tranche of percentage share will be from income earned from the CCG
- a mixture of these two solutions.

In any instance, your practice accountant must ensure the accounting treatment is transparent and fair.

What are typical backfill costs?

The costs of filling in for the absent partner's time will need to be taken into consideration when negotiating rates of pay with the CCG.

Geographical variation will exist but, for a two day per week CCG post, consider the following options for backfill:

- **Locum GP** Average sessional rates might be in the order of £250 (seeing 18 patients). Visits may be additional, or an increased overall rate paid for a full duty session. Whole-day rates may be more favourable. For a two-day absence, costs could be, at minimum: (£250 x four sessions) = £1,000 x 52 weeks = £52,000 per annum
- **Salaried GP** Geography will affect salary rates, but – for example – a salaried GP may expect to earn between £8,500 and £9,000 per session (London weighting to be considered). For a two-day absence (including on-costs) expenditure could be: (£9,000 x four sessions) = £36,000, plus employer's superannuation at £5,040 and employer's national insurance at £4,968 = £46,008 per annum

An additional amount for non-clinical duties carried out by the absent GP should also be considered.

What about reducing my profit share to pay for my time?

If a GP reduces profit share in exchange for CCG hours, it can be difficult to calculate the worth of each contribution. No two practices are the same; the loss of profit for a GP absent for four sessions will differ from practice to practice.

The quantification of loss of practice earnings when negotiating rates must be considered in collaboration with the practice accountant. A figure for profit per session from your practice accounts must be calculated and should reflect items that may not vary with sessions, such as net property revenue and seniority.

Loss of personal earnings or the costs of backfill for work carried out in practice time must be calculated, too. The aim is that neither an individual GP nor a practice should suffer financially from a GP taking up a CCG post.

LMCs will support GPs in these negotiations, both those involved in commissioning and those who continue to run practices with reduced commitment of some GPs.

How might commissioning affect my employment status?

A GP taking up a CCG role must understand what this will mean to their individual position.

HMRC employment status law is clear, and it should be assumed that an 'office holder' of a CCG will normally be classed as employed and taxed under PAYE. Non-office holders carrying out ad hoc work will also need to be considered in light of the legislation.

Usually these GPs will be regarded as

'employees on flexible terms' by HMRC. Detailed guidance on the factors that HMRC will consider is now available on the Department of Health website.

It may be possible for GPs to make a case for the income to be treated as self-employed, but this will need to be agreed with HMRC on a case-by-case basis and your accountant will be able to advise.

What are the implications for my personal finances?

There are broadly four areas where a change of employment status will affect a GP's personal finances.

1 **Tax** Earnings will be taxed under PAYE by deduction at source from monthly salary. Income tax rates will be based on individual total taxable earnings from all sources. CCG earnings will be taxed at the same rates whether they are classed as employed or self-employed. Employed earnings will be taxed on a GP's self-assessment tax return, with credit given for any tax deducted at source. Under PAYE, the appropriate tax code will need to be applied. Your accountant should liaise with HMRC to ensure this is correct.

2 **Expenses** The rules for tax relief on expenses for an employee are different from those for the self-employed. Tax relief will be given where expenses are incurred wholly, exclusively and necessarily for the purposes of the salaried engagement. Mileage to and from CCGs is not allowable. CCGs are likely to pay mileage allowance for travel for CCG purposes. Changes in circumstance may affect overall business mileage percentages that a GP is entitled to claim. If other expenses are incurred, a GP should take advice on the tax relief available.

3 **National insurance** There is a difference in how national insurance is paid on employed earnings compared with self-employed earnings. As an employee there will be two tranches of national insurance payable:

- Class 1 employer's national insurance – payable by employer
- Class 1 employee's national insurance – payable by deduction at source from employee.

National Insurance contributions are higher under employed status and are shared by both employer (CCG) and employee (GP). Applying 2012/13 rates, the additional burden on a gross salary of £150,000 compared with the same level of self-employed earnings is:

- additional total National Insurance payable by employee of £910
- additional employer's National Insurance of £19,667.

Clearly the bulk of the additional cost lies with the CCG as the employer, not with the employed doctor.

4 **Pensions** From April 2013, all CCG earnings for GPs will be fully superannuable under the NHS pension regulations, assuming the CCG is an NHS employing authority. It will not be possible to choose whether this income is superannuated.

> **It may be possible to make a case for self-employed status**

GPs who have applied for fixed protection and have ceased making pension contributions will need to ensure the terms of the fixed protection are adhered to. GPs in this position should take advice from their independent financial adviser. Responsibility for the 14% employer's element of superannuation lies with the CCG. Employee and added-years contributions will be paid by the GP by monthly deduction at source.

The CCG post is treated as employed service and will be lodged in NHS pension scheme records as 'officer' service. At present, on retirement either the GP will receive a separate officer pension for the CCG post or an adjusted GP pension (in which some or all officer service is treated as if it were a GP service). Of the two, the GP will receive whichever pension is calculated to be the higher sum.

GPs working in an employed post will continue to have all these earnings superannuated, but they may see a reduction in cost for the employer's element of the superannuation, now payable by the CCG.

They may also pay employee contributions at a lower-tier rate on these earnings, resulting from the way their earnings are now split. There will be no adverse effect on the pension, assuming total pensionable earnings remain constant. Practices will need to ensure new partnership share agreements are lodged with the NHS Commissioning Board.

Will working for a CCG affect my seniority entitlement?

> **Seniority entitlement could drop to 60%**

For GPs taking up CCG posts, there could be a detrimental effect on full seniority entitlement. Pensionable earnings from employed CCG posts will not be taken into consideration when eligibility for full seniority is measured. It is possible that a GP will see seniority entitlement reduced from 100% to 60%, and in rare situations seniority entitlement may be lost. The situation for individual GPs will differ, so it is advisable to seek advice from your accountant. Seniority may also need to be brought into negotiations with CCGs to ensure rates of pay are set with consideration for all factors.

Should I change my partnership agreement?

Partnership agreements should be checked to ensure enough flexibility to allow a partner to take up a CCG post and to retract permission if the situation does not work out from a practice point of view.

If you think yours needs to change, consult a lawyer.

Sally Sidaway is a director of medical services at RSM Tenon and a member of the Association of Independent Specialist Medical Accountants

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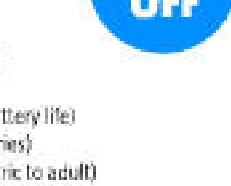

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How we reduced our CCG spend on vitamin D

Dr Isabel Hodkinson explains how reducing the number of specials prescribed in her CCG brought them in £700,000 under their forecasted spend

The problem

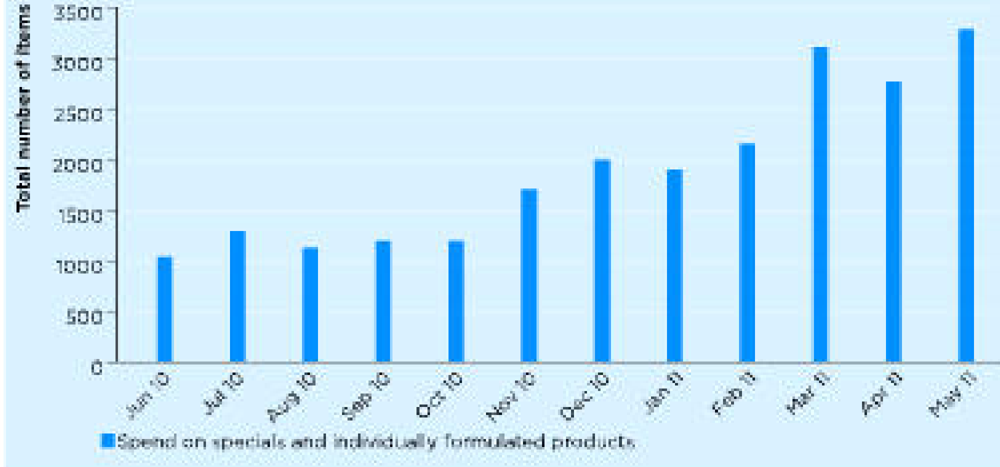
Our local guidelines group published vitamin D guidance in November 2010, but it was not until September last year that commissioners realised how much pressure prescriptions for vitamin D were putting on our budget.

Up until August 2011, our projections showed we would come in on our £28.8m annual prescribing budget. But by September, we were given projections that showed by the end of the financial year – if we didn't do anything about it – we would be overspent by £2m on prescribing (including vitamin D) and by the end of the year this group would take up 7% of our entire budget.

The initial analysis found that this was largely being caused by an increase in specials, which rose by 88% in cost terms and by a staggering 213% in the number of items prescribed between June 2010 and May 2011.

For many specials – around 53% in September 2011, for example – ePACT data does not enable us to tell what the prescriptions were for. But 50% of our identifiable items were for vitamin D. Detailed analysis of recalled scripts shows vitamin D counted for some of the unidentified specials including licensed preparations, products available from specialist importers, special manufactured products and products available as nutritional supplements. Product availability and cost also varied considerably.

Spend on specials and individually formulated products



How we did it

Our vitamin D prescribing guidance acknowledged the weak areas in the evidence, but made broad recommendations about supplementation. So many GPs had started prescribing vitamin D, but behaviour varied widely.

We began to wonder whether we should be prescribing vitamin D at all. We have a strong commitment to grassroots GP involvement – and the GPs are the ones who have to explain what we were doing to patients.

In September, we wrote to all our GPs about our findings on vitamin D and costs. Prescribing advisers went to our locality commissioning meetings to get discussion going across practices, and in November we had a Protected Learning Time event.

At the event, we had a debate about vitamin D. The emerging view was that our role as GPs is to advise and support people to make choices to optimise their health and wellbeing, rather than prescribe a medical solution to what is often a lifestyle problem.

Obviously there are non-contentious areas around true deficiency, where medicalisation is appropriate. The main example of this is that the NHS prescribes for clinical deficiency, and pregnant women and children are already covered for means-tested provision of supplements by the Healthy Start programme so that cost does not stop them sustaining a healthy level of vitamin D. Given that there's a huge grey area around the health consequences of insufficiency, Tower Hamlets's current position is that vitamin D is a dietary supplement and so patients are asked to get their own over the counter. This solution was similar to that adopted in our neighbouring borough of Hackney.

With the support of public health, we developed a leaflet for patients on lifestyle choices that advocated healthy eating and exercise, flagging up the fact that changing your diet and going outdoors during the day increases your vitamin D levels. The prescribing team also warned local pharmacists they might see an increase in patients buying or asking about vitamin D.

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Having decided our stance on vitamin D, we realised the preparations we did prescribe varied enormously in cost. One preparation was £85 per capsule of a 50,000 IU formulation. So we decided to rewrite the guidelines for GPs. Our prescribing team identified key products to ensure consistency and set up clear advice on how to prescribe vitamin D in a cost-effective way:

- **Adults** For deficiency, prescribe Pro D (20,000 IU) at five capsules daily for two days. If maintenance is needed, prescribe one tablet of Solgar (1,000 IU) daily.
- **Children** For deficiency, prescribe Vigantoletten (1,000 IU) at three tablets daily for two months for babies aged one to six months, or six tablets per day for two months for children aged six months to 12 years.

We rolled the scheme out to primary care via prescribing advisers and locality commissioning groups. We provided additional metrics for collecting data on specials in QIPP prescribing dashboards: specials cost as a percentage of total practice cost, specials spend per 1,000 patients and specials cost per item.

We used some of the money left from our underspend to employ extra prescribing advisers to go round practices, implement the guidance and update the systems' formularies. Later in the year we decided to implement ScriptSwitch, which we hadn't done before because prescribing quality has been high in our CCG. It cost £102,000 a year, but seems cost-effective as it will deliver on a number of prescribing developments beyond specials.

Community pharmacists worked with prescribing advisers to find cost-effective suppliers and procure specials where necessary, and this work has now been built into the community pharmacy incentives scheme. We also collaborated with local acute trusts to implement preferred product choices there.

The only area we didn't intervene was in blood testing for vitamin D and to ask colleagues to be aware that significant deficiency may be accompanied by other features, such as proximal myopathy.

Challenges

For some GPs, this represented a major change in their attitudes – but having discussed the dilemma across the primary care community, we found a majority were concerned about medicalisation and were committed to supporting people to make healthier choices.

Having a prescribing adviser to review practice and patient prescribing enabled rapid change – but we realised the changes were often not being sustained. ScriptSwitch enables ongoing feedback to GPs from the prescribing team, while acknowledging that it does not always incorporate all specials because of the variation of products available.

Outcomes

We reduced our spending on specials including vitamin D from a forecast year-end spend of £2.8m to an actual year-end spend of £2.1m. The cost of specials including vitamin D has reduced from a peak of £276,023 a month down to an average of £90,000 a month by year-end, with the biggest drop coming in the three months of implementation (September to November). We expect this drop to be sustained.

The future

We will continue to report about specials to practices via the QIPP prescribing dashboards and document the cost of specials in our finance reports to the CCG board. Outlier practices will get support from the prescribing team. We'll look out for new research and products and review the guidelines when appropriate. We will continue to use ScriptSwitch to make our procurement of medicines more cost-effective.

We learned the hard way that when developing new guidelines, we need to work through the cost implications and to make sure guidelines and commissioning work together.

This initiative also opens the wider question of medicalisation. What can become a health problem is driven by social determinants. Trying to deliver a solution via a health perspective only is costly and ineffective. Further work is needed to address these social determinants more widely. For vitamin D, this includes how we get people outdoors – for example, by promoting outside play in schools.

Dr Isabel Hodkinson is a GP in Bow, east London, and co-vice chair of Tower Hamlets CCG

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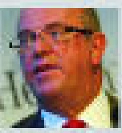

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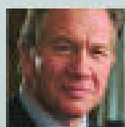

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Abu Dhabi	S	R			S		S	S					No			Le
Afghanistan	R	R	S	R	R	S	S	S	C				Yes, below 2,000m, May–Nov	MF or DO or MON	PC	Le
Albania	S	R					S	S	C			S	No			Le
Algeria	R	R				S	S	S	C				Yes, low risk Illizi in South	W		Sh Le
Angola	R	R	S	R	R	S	S	S	M				Yes, high risk	MF or DO or MON	PC	Sh Ta
Antigua & Barbuda		S					S		C				No			
Argentina	S	R					S	S	S				Yes, rural areas near NE border with Bolivia and NW border with Brazil and Paraguay Other areas very low	C W	P	
Armenia	S	R			S	S	S	S				S	No	W		
Australia									C		S		No			
Austria												S	No			
Azerbaijan	S	R				S	S	S				S	Variable risk at SW border Jun-Oct	C	P	Le
Bahamas		R					S		C				No			
Bahrain	S	R				S	S	S	C				No			Le
Bali	R	R			R	S	S	S	C		S		Yes, low risk	W		
Bangladesh	R	R	S		R	S	S	S	C		S		Yes, SE and Chittagong Hill Tracts. Elsewhere, low risk	MF or DO or MON W	PC	Le
Barbados		S			S		S		C				No			
Belarus		R			S	S	S	S				S	No			
Belize	S	R				S	S	S	C				Variable risk in south, low risk Belize City	C	P	
Benin Republic	R	R	S	R	S	S	S	S	M	S			Yes, high risk	MF or DO or MON	PC	Sh Le
Bermuda		S					S						No			
Bhutan	R	R	S			S	S	S	C		S		Yes, southern districts	MF or DO or MON	DRF	Le
Bolivia	R	R			R	S	S	S	R				Yes, high risk in Amazon basin. Variable risk on Paraguayan and Argentine borders	MF or DO or MON PC	PC DRF	
Borneo	R	R	S		S	S	S	S	C		S		Low risk, coastal areas of Malaysian Sarawak and Sabah. Indonesian Kalimantan, high risk all areas	W MF or DO or MON PC	PC PC	
Bosnia		R			S	S	S	S				S	No			Le
Botswana	R	R	S		S	S	S	S	C				Yes, northern half only Nov-June	MF or DO or MON	PC	Sh Ta
Brazil	S	R			S	S	S	S	R				High risk in NW half in Amazonia states. Elsewhere, very low	MF or DO or MON W	PC	Sh Le Tc
Brunei		R				S	S	S	C		S		No			
Bulgaria		R				S	S	S				S	No			
Burkina Faso	R	R	S	R	R	S	S	S	M	S			Yes, high risk	MF or DO or MON	PC	Sh Le Ta
Burundi	R	R	S			S	S	S	M				Yes, high risk	MF or DO or MON	PC	Sh Ta
Cambodia	R	R	S		R	S	S	S	C		S		Yes Yes, significant risk elsewhere. Minimal risk Phnom Penh, Angkor Wat, Siem Reap	DO or MON MF or DO or MON W	PC PC	
Cameroon	R	R	S		R	S	S	S	M	S			Yes, high risk	MF or DO or MON	PC	Sh Ta
Canada													No			
Cape Verde Islands	R	R			S	S	S	S	C				Yes, very low risk Aug-Nov	W		Le
Cayman Islands		S					S						No			
Central African Rep.	R	R	S	R	R	S	S	S	M	S			Yes, high risk	MF or DO or MON	PC	Sh Ta
Chad	R	R	S	R	R	S	S	S	R	S			Yes, high risk	MF or DO or MON	PC	Sh Ta
Chile	S	R					S	S					No			Tc
China (Mainland)	S	R	S	R		S	S	S	C		S	S	Yes, in Yunnan and inland Hainan. Elsewhere, very low/no risk	MF or DO or MON W	PC	Sh
China (Hong Kong)		R				S	S						No			
China (Macao)		R				S	S	S			S		No			
Colombia	S	R					S	S	R				Yes, high Eastern half Variable risk elsewhere <1,600m Very low around Medellin, Bogota & Cartagena	MF or DO or MON PC W	PC DRF	Le Ta
Comoros	R	R	S		S	S	S	S					Yes, high risk	MF or DO or MON	PC	Le
Congo	R	R	S	R	R	S	S	S	M				Yes, high risk	MF or DO or MON	PC	Sh Ta
Congo-Dem. Rep.	R	R	S	R	R	S	S	S	M	S			Yes, high risk	MF or DO or MON	PC	Sh Ta
Cook Islands		R					S						No			
Costa Rica		R			S		S	S	C				Small variable risk area on East coast. Rest of country, low risk	C W	P	Le Tc
Croatia		S					S	S				S	No			Le
Cuba		R					S	S					No			
Cyprus		S											No			Le
Czech Republic		S					S					S	No			
Djibouti	R	R	S		S	S	S	S	C				Yes, high risk	MF or DO or MON	PC	Sh Le
Dominican Republic	R	R	S		R	S	S	S					Yes, high risk along Haitian border, variable risk elsewhere	C	P	Sh Le
Dubai	S	R			R		S	S					No			Le
East Timor (Timor Leste)	R	R			S	S	S	S	C		S		Yes, high risk	MF or DO or MON	PC	Le
Ecuador	R	R				S	S	S	R				Yes, moderate risk coastal provinces, substantial on Peru and Columbian border. Elsewhere low risk	MF or DO or MON W	PC	Tc
Egypt	R	R					S	S	C				No			
El Salvador	R	R					S	S	C				Yes, low risk	W		
Equatorial Guinea	R	R	S		R	S	S	S	R				Yes, high risk	MF or DO or MON	PC	Sh Ta
Eritrea	R	R	S		R	S	S	S	C	S			Yes, high risk (no risk in Asmara)	MF or DO or MON	PC	Sh Le
Estonia		S					S	S				S	No			
Ethiopia	R	R	S		R	S	S	S	R	S			Yes, high risk below 2,000m (No risk in Addis Ababa)	MF or DO or MON	PC	Sh
Falklands (Tristan da C.)													No			
Fiji	S	R			R		S		C				No			
Finland												S	No			
France												S	No			Le
French Guiana	S	R			S	S	S	S	M				High risk inland and border areas, coast and islands, low no risk	MF or DO or MON	PC	Sh Tc
French Polynesia		R					S						No			
Gabon	R	R	S	R	R	S	S	S	M				Yes, high risk	MF or DO or MON	PC	Sh
Gambia	R	R				S	S	S	R	S			Yes, high risk	MF or DO or MON	PC	Sh Ta
Georgia	S	R				S	S	S				S	Yes, v. low risk SE villages July-Oct	W		
Germany												S	No			
Ghana	R	R	S		R	S	S	S	M	S			Yes, high risk	MF or DO or MON	PC	Sh Ta
Goa	R	R		R	R	S	S	S	C		S		Yes, variable risk	PC	DRF	Le
Greece and Islands		S					S					S	No			Le
Greenland		R			S		S	S					No			
Grenada		S					S	S	C				No			
Guadeloupe		S				S	S		C				No			
Guam		R				S	S						No			
Guatemala	S	R				S	S	S	C				Yes, some risk below 1,500m	C	P	
Guinea	R	R	S	R	R	S	S	S	R	S			Yes, high risk	MF or DO or MON	PC	Sh Ta
Guinea Bissau	R	R	S		S	S	S	S	M	S			Yes, high risk	MF or DO or MON	PC	Sh Ta
Guyana	S	R				S	S	S	R				Yes, high risk all areas except coastal strip	MF or DO or MON	PC	Sh
Haiti	R	R	S		R	S	S	S	C				Yes, high risk throughout country	MF or DO or MON	PC	
Hawaii							S						No			
Honduras	R	R				S	S	S	C				Yes, risk variable	C	P	Le
Hungary								S				S	No			
India	R	R	S	R	R	S	S	S	C		S		Yes, high risk Assam Yes, low risk in southern states, Delhi, Jaipur, Agra, Mumbai Yes, elsewhere	MF or DO or MON W PC	PC DRF	Le
Indonesia	R	R	S		R	S	S	S	C		S		Yes, high in Lombok Very low in Bali and cities Yes, variable elsewhere	MF or DO or MON W PC	PC DRF	Sh
Iran	S	R	S		S		S	S	C				Yes, rural SE provinces Mar-Nov	MF or DO or MON	PC	Sh Le
Iraq	R	R	S		R	S	S	S	C				Yes, v. low risk rural north May-Nov	W	P	Sh Le
Israel		R					S	S					No			Le
Italy		S					S					S	No			Le
Ivory Coast	R	R	S	R	R	S	S	S	M	S			Yes, high risk	MF or DO or MON	PC	Ta
Jamaica		R			S		S		C				No			
Japan							S				S	S	No			Sh
Jordan	S	R					S	S	C				No			Le
Kazakhstan		R			R	S	S	S	C			S	No			Le
Kenya	R	R	S	R	R	S	S	S	R	S			Yes, high risk (Nairobi and highlands low risk)	MF or DO or MON	PC	Sh Le Ta
Kiribati	S	R			S	S	S		C				No			
Korea (North)	R	R			S	S	S	S	C		S		Yes, limited risk extreme south	W		
Korea (South)	S	R				S	S				S		Yes, limited risk extreme north	W		
Kosovo		R				S	S	S				S	No			Le
Kuwait	S	R			R		S						No			
Kyrgyzstan	S	R		R		S	S	S				S	Yes, low risk some S & W areas	W		Le
Laos	R	R	S		R	S	S	S	C		S		Yes, high risk (minimal risk Vientiane)	MF or DO or MON	PC	
Latvia	S	S			S	S	S	S				S	No			

Key

M = immunisation mandatory
R = immunisation recommended as risk of infection is substantial
S = immunisation sometimes recommended:
- for more than three visits in a one-year period
- a stay of more than three months in a rural area
- for high-risk occupational groups
- for backpackers staying more than one month
- when entering the limited geographical risk area for the target disease

C = See Yellow fever, next column

Where **S** appears for cholera, it indicates that only high-risk travellers, usually healthcare workers in areas of known epidemics, should be immunised.

Vaccinations information

Tetanus
Five tetanus doses are considered protective for life by the DH, although there is no evidence base for this. Travellers at risk of tetanus-prone wounds should be given 10-yearly boosters if they are going to poorer countries in Africa, Asia and South America where specific immunoglobulin may be unavailable.

Polio
All travellers should have completed the British vaccination schedule for polio immunisation in childhood or as adults.

Yellow fever
● An international certificate of vaccination may be required for those entering from, or transiting through airports in YF endemic countries where **C**, **S**, **R** or **M** appears indicated in the yellow fever column. For details consult: http://wwwnc.cdc.gov/travel/yellowbook/2012/chapter-3-infectious-diseases-related-to-travel/yellow-fever-and-malaria-information-by-country.htm#seldyfm298

● **M** = Mandatory generally indicates that all travellers aged >12 months should carry an international certificate of vaccination. Country specific ages are indicated in the web site above.

Information source and updates
This chart is based on information from the UK TRAVAX website and other databases. TRAVAX is an information service provided by Health Protection Scotland (www.travax.scot.nhs.uk; telephone 0141 300 1130).

The chart is updated regularly. Readers are advised to use the latest chart only, to ensure that their practice reflects the most recent advice.

Travel vaccinations and malaria information author
Dr Michael Jones, consultant physician, Regional Infectious Disease Unit, Western General Hospital, Edinburgh

Parasitic infections

Short-term travellers staying in good conditions are usually at low risk of acquiring parasitic infections. Schistosomiasis is common and potentially serious. Leishmaniasis and trypanosomiasis are less common but potentially lethal. Expatriates in remote areas at risk of other rare diseases are not shown in this chart.

Sh = schistosomiasis. Travellers should avoid swimming in freshwater lakes and rivers in endemic areas.

Ta = African trypanosomiasis (sleeping sickness). Transmitted by tse-tse flies, and a risk in some African game parks and rural areas. Travellers should use insect repellents, close windows if fly swarms approach and seek medical attention for any signs of infection around bites one to three weeks later.

Tc = South American trypanosomiasis (Chagas' disease). Transmitted by reduvid bugs that feed at night and reside in the thatch and crevices of rural dwellings. Travellers should avoid sleeping in huts.

Le = leishmaniasis. Transmitted by sandflies in arid areas (including Mediterranean coastal areas), mostly at night. Travellers should use insecticide-impregnated mosquito nets and insect repellent.

Travel medicine update

Polio
Polio is resurgent in Nigeria, which has already reported more cases than the 62 in 2011. By late August, new wild-type virus cases, including both serotype 1 and 3, totalled 77 in 2012. Immunisation mop-up days will be held in late September and the possibility of conducting immunisation campaigns in Niger across the border from Katsina State is being explored. Transmission continues in Afghanistan, with a total of 17 cases in 2012. The World Health Organization goal of global polio eradication remains frustratingly elusive, although no cases have been reported from India this year and early indications are that the global number of cases in 2012 will be less than the 650 in 2011.

West Nile virus (WNV)
WNV has been causing problems in Europe and North America. Forty-three states in the US have reported infections, with a total of 693 human cases in 2012 including 26 deaths and 59% classified as neuro-invasive. This is the highest number of infections reported to the Centers for Disease Control and Prevention since WNV was first detected in the US in 1999. Southern states have been hit hardest and almost half the cases are from Texas.

Canada has also seen an increase in WNV, with 49 cases in Ontario, of which 60% occurred in Toronto. Smaller numbers have been reported from neighbouring provinces.

A total of 57 cases have been reported in Greece, four from Romania, and 127 with four deaths in the Russian Federation.

WNV is transmitted by daytime biting Culex mosquitoes. Most infections are asymptomatic and severe infection is rare, so reported cases represent the tip of the iceberg. WNV is rarely reported in travellers and the risk is greatest in those undertaking outdoor activities, who should take particular precautions to prevent mosquito bites during summer months. A vaccine is needed to halt human cases because the bird reservoir will remain.

Source
travax.nhs.uk
polioeradication.org/Dataandmonitoring/Poliothisweek.aspx

Specialist advice

For advice on complex itineraries and other queries, use the following helplines:
Birmingham 0121 424 0357/ 3354/2357
Edinburgh, Western General Hospital 0131 537 2822
National Travel Health Network and Centre (Monday to Friday, 9am-12pm, 2pm-4.30pm) 0845 602 6712 (local call rate)

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Destination	Typhoid	Hepatitis A	Cholera	Polio	Diphtheria	Tuberculosis	Hepatitis B	Rabies	Yellow fever	Meningitis ACWY	Japanese encephalitis	Tick-borne encephalitis	Malaria: Risk areas and seasons	Malaria: Recommended regimen	Malaria: Alternative regimen	Main parasitic hazards
Lebanon	S	R			S		S	S	C				No			Le
Lesotho	R	R	S		S	S	S	S	C				No			Sh
Liberia	R	R	S	R	S	S	S	S	M				Yes, high risk	ME or DO or MON	PC	Sh Ta
Libya	S	R			S	S	S	S	C				No risk			Le
Liechtenstein		S					S					S	No			
Lithuania		S				S	S	S				S	No			
Macedonia		R					S	S				S	No			Le
Madagascar	R	R			S	S	S	S	C				Yes, high risk	ME or DO or MON	PC	Sh
Madeira		S					S						No			
Malawi	R	R	S			S	S	S	C				Yes, high risk	ME or DO or MON	PC	Sh Ta
Malaysia	R	R	S		S	S	S	S	C		S		Yes, high risk Sabah and deep forests of peninsular Malaysia	ME or DO or MON	PC	
Maldives	R	R				S	S	S	C				No			
Mali	R	R	S	R	R	S	S	S	M	S			Yes, high risk	ME or DO or MON	PC	Ta
Malta and Gozo		S					S		C				No			Le
Martinique		S				S	S		C				No			Sh
Mauritania	R	R	S	R	R	S	S	S	R	S			Yes, high risk all year in south Low risk in far north	ME or DO or MON	PC	Sh Le
Mauritius		R					S		C				No	W		
Mayotte	R	R				S	S	S	C				Yes, high risk	ME or DO or MON	PC	Le
Mexico	R	R					S	S					Yes, southern rural areas only Elsewhere and tourist areas	C W	P	Tc
Moldova	S	R			S	S	S	S				S	No			
Mongolia	S	R				S	S	S				S	No			
Montenegro		R				S	S	S				S	No			Le
Montserrat		S					S		C				No			
Morocco	R	R				S	S	S					No	W		Le
Mozambique	R	R	S		R	S	S	S	C				Yes, high risk	ME or DO or MON	PC	Sh Ta
Myanmar (Burma)	R	R	S		R	S	S	S	C		S		Yes, Kayin and East Shan state Yes, elsewhere Low/no risk Mandalay & Rangoon	DO or MON ME or DO or MON W	PC PC	
Namibia	R	R	S		S	S	S	S	C				Yes, NE third only Elsewhere low risk	ME or DO or MON W	PC	Sh
Nepal	R	R	S	R	R	S	S	S	C		S		Yes, below 1,500m (no risk in Kathmandu)	PC	DRF	Le
Neth Antilles		S					S		C				No			
Netherlands													No			
New Caledonia	S	R					S		C				No			
New Zealand													No			
Nicaragua	R	R				S	S	S	C				Yes, variable risk in north, low risk in south	C	P	Le Tc
Niger	R	R	S	R	R	S	S	S	M	S			Yes, high risk	ME or DO or MON	PC	Sh Ta
Nigeria	R	R	S	R	R	S	S	S	R	S			Yes, high risk	ME or DO or MON	PC	Sh Ta
Norway		S										S	No			
Oman	S	R					S	S	C				Sporadic imported risk	W		Sh Le
Pakistan	R	R	S	R	R	S	S	S	C		S		Yes, significant below 2,000m	ME or Do or MON	PC	PC
Panama	R	R			S	S	S	S	R				Yes, high risk NE coast & Colombia border Variable risk east & west of Canal	ME or DO or MON C	PC P	
Papua New Guinea	R	R	S		R	S	S	S	C		S		Yes, high risk below 1,800m	ME or DO or MON	PC	
Paraguay	R	R			S	S	S	S	R				Yes, extreme eastern areas, Oct-May	C	P	Le Tc
Peru	R	R				S	S	S	R				Yes, high risk in Amazonian Loreto Dept. Variable risk SE area bordering Brazil & Bolivia, and around Tumbes & Piura	ME or DO or MON C	PC P	Le Tc
Philippines	R	R	S		S	S	S	S	C		S		Yes, many rural areas below 600m No risk – Cebu, Bohol, Catanduanes	PC W	DRF	Sh
Poland		S					S	S				S	No			
Portugal		S					S						No			
Puerto Rico		R			S		S	S					No			Sh Le
Qatar	S	R				S	S	S					No			Le
Reunion		R				S	S		C				No			Sh
Romania	S	R				S	S	S				S	No			
Russian Federation	S	R			S	S	S	S	C		S	S	No			
Rwanda	R	R	S			S	S	S	M				Yes, high risk	ME or DO or MON	PC	Sh Ta
Sabah	R	R	S		S	S	S	S	C		S		Yes, high risk inland Low risk coastal area and Kota Kinabalu	ME or DO or MON W	PC	
Samoa	S	R			S		S	S	C				No			

Destination	Typhoid	Hepatitis A	Cholera	Polio	Diphtheria	Tuberculosis	Hepatitis B	Rabies	Yellow fever	Meningitis ACWY	Japanese encephalitis	Tick-borne encephalitis	Malaria: Risk areas and seasons	Malaria: Recommended regimen	Malaria: Alternative regimen	Main parasitic hazards
Sao Tome	R	R	S			S	S	S	M				Yes, high risk	ME or DO or MON	PC	Sh Le
Saudi Arabia	S	R			R		S	S	C	S M			Yes, SW region, rural areas of Asir region Elsewhere (no risk Mecca, Medina)	ME or DO or MON W	PC	Sh Le
Senegal	R	R	S	R	R	S	S	S	R	S			Yes, high risk	ME or DO or MON	PC	Sh Ta
Serbia		R				S	S	S				S	No			Le
Seychelles	S	R				S	S		C				No			
Sierra Leone	R	R	S	R	R	S	S	S	M				Yes, high risk	ME or DO or MON	PC	Sh Ta
Singapore		S					S		C		S		No			
Slovakia		S					S	S				S	No			
Slovenia		S					S	S				S	No			
Solomon Islands	R	R				S	S		C				Yes, high risk	ME or DO or MON	PC	
Somalia	R	R	S		R	S	S	S	R				Yes, high risk	ME or DO or MON	PC	Sh Le
South Africa	S	R	S		S	S	S	S	C				Yes, ME risk bordering Zimbabwe, Mozambique & Eastern Swaziland, including Kruger, Kosi Bay & Jozini	ME or DO or MON	PC	Sh Ta
Spain		S					S						No			Le
Sri Lanka	R	R				S	S	S	C		S		Yes, for north and NE, north of Anuradhapura & Polonnaruwa Elsewhere	PC W	ME, DO DRF	
St Helena & Ascension		S							C				No			
St Kitts & Nevis		S					S		C				No			
St Lucia		S					S		C				No			
St Vincent & Grenadines		S					S		C				No			
Sudan	R	R	S	R	R	S	S	S	R	S			Yes, high risk	ME or DO or MON	PC	Sh Le
South Sudan	R	R	S	R	R	S	S	S	R	S			Yes, high risk	ME or DO or MON	PC	Sh Le
Surinam	S	R			S	S	S	S	R				Yes (except Paramaribo and coast)	ME or DO or MON	PC	Sh Le
Swaziland	R	R	S		S	S	S	S	C				Yes, high risk, eastern areas	ME or DO or MON	PC	Sh
Sweden		S										S	No			
Switzerland		S										S	No			
Syria	S	R			S		S	S	C				No			Sh Le
Taiwan		R				S	S				S		No			
Tajikistan	R	R	S			S	S	S				S	Yes, Jun-Oct variable on NW & SW borders Elsewhere	PC	ME, DO or MON	
Tanzania	R	R	S		R	S	S	S	R				Yes, high risk	ME or DO or MON	PC	Sh Ta
Thailand	S	R	S		S	S	S	S	C		S		Yes, on extreme fringe of international borders Elsewhere	DO or MON W		
Tibet	S	R	S	R	R	S	S	S	C		S		No			
Tobago		S			S		S	S	C				No			Tc
Togo	R	R	S		S	S	S	S	M	S			Yes, high risk	ME or DO or MON	PC	Sh Ta
Trinidad		S			S		S	S	R				No			Tc
Tunisia	R	R					S	S	C				No			Le
Turkey	S	R					S	S					Yes, Syria border May-Oct Elsewhere	C W	P	Le
Turkmenistan		R			S	S	S	S				S	No			
Uganda	R	R	S	R	R	S	S	S	R	S			Yes, high risk	ME or DO or MON	PC	Sh Ta
Ukraine	S	R			R	S	S	S				S	No			
United Arab Emirates	S	R			S		S	S					No			Le
Uruguay		R					S	S	C				No			Tc
USA													No			
Uzbekistan	S	R				S	S	S				S	Yes, very low risk extreme SE	W		Le
Vanuatu	S	R			S	S	S						Yes, high risk	ME or DO or MON	PC	
Venezuela	S	R			S		S	S	R				Yes, high risk to south of Orinoco River Variably low risk north of Orinoco No risk Caracas or Margarita	ME or DO or MON C W	PC P	Le Tc
Vietnam	R	R	S		S	S	S	S	C		S		Low risk in cities, coast between Ho Chi Minh & Hanoi, Mekong Delta Elsewhere	W ME or DO or MON	PC	
Virgin Islands		S					S						No			
West Papua (formerly Irian Jaya)	R	R			R	S	S	S	C		S		Yes, high risk below 1800m	ME or DO or MON	PC	Sh Ta
Yemen	R	R	S		R	S	S	S	C				Yes, but no risk in Sana'a city	PC	DRF	Sh Le
Zambia	R	R	S		R	S	S	S	S				Yes, high risk	ME or DO or MON	PC	Sh Ta
Zimbabwe	R	R	S		R	S	S	S	C				Yes, high risk Zambezi valley Yes, elsewhere below 1,200m Nov-Jun Negligible risk Harare and Bulawayo	ME or DO or MON ME or DO or MON W	PC PC	Sh Ta

Key to malaria prophylaxis regimens

Regimen MON
Malarone (atovaquone/proguanil), one tablet daily. Begin 1-2 days before departure, continue while in malarious area and for 7 days after return. ACMP suggest Malarone is safe for periods in continuous use of at least 1 year and possibly longer. Safety in pregnancy has not been established, and use in pregnancy should only be considered if benefit to the mother outweighs risk to foetus. Children use paediatric tablets.

Regimen PC
Proguanil (Paludrine) 200mg daily plus chloroquine 300mg or 310mg base weekly (=Avloclor 2x250mg). Begin 1 week before travel and continue for 4 weeks after return.

Regimen ME
Mefloquine, 1x250mg tablet weekly. ACMP suggest it is safe in continuous use for periods of at least 3 years. Begin at least 2½ weeks before travel (at least 3 doses before arriving in malarious area). Avoid in first trimester of pregnancy and do not start pregnancy until 3 months after stopping mefloquine. Inadvertent use in first trimester is not an indication for termination. If pregnant women must travel to chloroquine-resistant falciparum area, seek expert advice and conduct careful risk-benefit analysis. Use in any trimester may be justified.

Regimen C
Chloroquine 300mg or 310mg base weekly (=Avloclor 2x250mg). Begin 1 week before travel and continue for 4 weeks after return.

Regimen P
Proguanil (Paludrine) 200mg daily. Begin 1-2 days before travel and continue for 4 weeks after return.

Regimen W
No chemoprophylaxis but be aware of risk. Avoid mosquito bites and carry standby treatment if going to be far from medical facilities.

Regimen DO
Doxycycline, 1 tablet of 100mg daily. Begin 1-2 days before travel and continue for 4 weeks after return. Not for children or pregnant women. Be aware of oesophageal ulceration, photosensitivity and very rare intracranial hypertension risk. Take with food or milk and avoid ingestion in late evening.

Regimen DRF
In the alternative regimen column, **DRF** is Drug-Resistant-Falciparum regimen. **DRF = ME** or **DO** or **MON**

Primaquine
A causal prophylactic that may be used when G6PD deficiency has been excluded in travellers with contra-indications to other anti-malarials. Active against all species. Adult dose 30mg daily. Start 1-2 days before departure and continue for 7 days after return.

Children's doses of antimalarial prophylactics

Weight in kg	Chloroquine Proguanil	Mefloquine	Age
Under 6.0	0.125 adult dose ¼ tablet	not recommended	term to 12 weeks
6.0 to 9.9	0.25 adult dose ½ tablet	0.25 adult dose ¼ tablet	3 months to 11 months
10.0 to 15.9	0.375 adult dose ¾ tablet	0.25 adult dose ¼ tablet	1 year to 3 years 11 months
16.0 to 24.9	0.5 adult dose 1 tablet	0.5 adult dose ½ tablet	4 years to 7 years 11 months
25.0 to 44.9	0.75 adult dose 1½ tablets	0.75 adult dose ¾ tablet	8 years to 12 years 11 months
45kg and over	Adult dose 2 tablets	Adult dose 1 tablet	13 years and over

Doxycycline only above 12 years and the adult dose is given

Children's doses

Paediatric malarone for prophylaxis

Weight in kg	Number of tablets daily
11-20	1 paediatric tablet
21-30	2 paediatric tablets
31-40	3 paediatric tablets
Above 40	1 adult tablet

Specialist advice

For malaria advice
Malaria Reference Laboratory **020 7636 3924** (health professionals only)
Birmingham **0121 424 0357/ 3354/2357**
Edinburgh **0131 537 2822**
Glasgow **0141 300 1130**
Liverpool **0151 708 9393**
Oxford **01865 225 214**

Although every effort is made to ensure that information in these pages is correct, the compilers and Pulse cannot accept responsibility for the consequences of errors © PULSE 2012

Hajj 2012

This year, the Hajj is expected to fall between 24 and 29 October. The World Health Organization has published the Ministry of Health of Saudi Arabia requirements for entry visas for the Hajj in 2012. A full report can be accessed in the WHO weekly epidemiological record (see URL below).

Meningococcal meningitis
Adults and children under two years must have a vaccine certificate for the meningococcal ACWY vaccine issued not more than three years and not less than 10 days prior to arrival in Saudi Arabia. For UK travellers, proof of vaccination is a visa requirement.

Yellow fever
All travellers arriving from countries known to be infected with yellow fever must carry a valid certificate. Otherwise the traveller will be vaccinated and placed under surveillance for six days or from the last date of exposure.

Polio
The recommendations are complex, but the implications are that all travellers from the UK should ensure they are up to date with the recommended combined polio/tetanus/diphtheria vaccine. A booster should be given if it is more than 10 years since the last dose.

Seasonal influenza
Recommended for Hajj attendees, especially those at increased risk.

Measles and rubella
These viral infections are resurgent. Travellers should be immune, either by previous vaccination (two doses of MMR) or natural measles infection.

Sources
travax.nhs.uk
who.int/wer/2012/wer8730/en/index.html

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DOCTORS/GPS REQUIRED

Mid Cheshire Hospitals NHS
NHS Foundation Trust

Shropdoc

Central Cheshire Urgent & Primary Care Centre

The Urgent Care Centre at Leighton Hospital, Crewe, is recruiting sessional GPs to provide enhanced Primary Care to walk-in and GP referral patients. We are operational from 08.00 – 18.30 weekdays but extended hours are planned to include evenings.

The GP and primary care Nurse Practitioner team deliver immediate care to walk-in and ambulance patients along with clinical pathways in partnership with Acute Trust staff. Current pathways include the Community DVT and IV@Home (antibiotics for cellulitis) services. There is a very active project list and we are seeking GPs with an interest in urgent Primary Care who wish to have both a clinical and developmental role in the service. These pathways are needed to support the CCG urgent care strategy – providing care closer to home and avoiding admission.

The GP workforce is provided and managed by Shropdoc and terms & conditions are competitive.

If you are interested in this post and would like to learn more about what is involved in the first instance, please contact Dr Russell Muirhead or Dr Simon Chapple for further information.

russellmuirhead@doctors.org.uk Phone – 01743 454900

simon_chapple@doctors.org.uk Phone - 01270 273807

Salaried GP
Blessing Medical Centre
London W9

We are looking for a forward thinker who can rise to challenges to join a small practice situated in Kilburn. 20 Minutes from central London and 40 minutes from junction 1 - M1

We are a single handed practice
One part time nurse
2500 patients
EMIS PCS – paperlight
Small efficient reception/admin team
Up to 7 sessions per week Monday – Friday

As a key member of the team you will need to innovative, efficient and flexible. Preferably qualified for contraceptive services, minor surgery, antenatal & postnatal, child development and immunisations. If you have any special interests in diabetes, COPD or hypertensive management this would also be an advantage.

To apply, please contact Debbie Nimblette Practice Manager, to arrange an informal visit or email you CV with covering letter to debbie.nimblette@nhs.net.

Closing Date: 5th October Interviews 15th October

RCGP Core Skills in Musculoskeletal Care Trainer

Approx. 6 sessions (TBC)
Oct 2012 - Mar 2013, with potential for role to continue

The Royal College of General Practitioners are seeking nine trainers to deliver workshops for a pilot being developed with Arthritis Research UK. Experience of managing MSK problems in primary care is essential. Three workshops will be delivered in Feb/Mar 2013, with a training day in Nov 2012.

Contact msk@rcgp.org.uk
Application deadline 25 Sep 2012

Downlands Medical Centre, Polegate, East Sussex
Full-time Partner wanted from 1st May 2013.

Due to the retirement of one of the Partners, this long established very friendly Practice situated in Polegate just outside Eastbourne, East Sussex is looking for an enthusiastic motivated GP to join 5 other Partners.

We are a GMS Practice. Practice population 10,300. We are paper light using Vision.

We have a full Practice health team centred in Polegate with a branch Surgery in Willingdon. We have very high QOF achievements.

Above average earnings and offer 8 sessions per week. No Capital Requirements

We are on the edge of the South Downs National Park and are 4 miles away from Eastbourne beach and yachting marina.

Applications in writing with CV to Mrs Andie Piper, Practice Manager, Downlands Medical Centre, 77 The High Street, Polegate, East Sussex BN26 6AE or andie.piper@nhs.net. If you would like to arrange an informal visit or require further information please email us or ring 01323-482323.

An established friendly PMS Practice is seeking 2 Salaried GPs with a view to partnership. Full or Part Time considered.

Newark Road Surgery, Lincoln, Lincolnshire, LN6 8RT

University and Cathedral city with excellent local schools

- 6000 List Size
- Quality Focus
- Providing comprehensive enhanced services
- Nurse Practitioner and friendly, experienced clinical and admin support team
- Committed to clinical excellence
- Specialist Interest encouraged
- Multi-Professional Learning Organisation
- Mentorship Support
- SystemOne Clinical System
- High QOF achievement
- Member of Optimus, a Federation of 6 practices.

For further information about us visit: newarkroadsurgery.co.uk or contact Dr Jane Marshall or Chris Symonds, Practice Manager on 01522 537944 or e-mail: christopher.symonds@lpct.nhs.uk

Apply by CV and covering letter to Practice Manager by 12 Oct 2012.

GP PARTNERSHIP VACANCY
Claygate, Surrey

An established suburban village practice. The local area has excellent schools and amenities and good access to main airports and London

- List size 8000
- Three GP partners, two salaried GPs
- Over 20 years experience of training GPRs
- Fully computerised (Synergy)
- PMS
- Modern purpose built premises
- 2 practice nurses, 1 HCA and phlebotomist
- Active in local CCG
- Longstanding patient participation group

We are seeking a highly motivated doctor to fill a practice vacancy of 6-8 sessions. There is opportunity for the individual to develop clinical and managerial skills and to play a full part in the further development of the practice.

Applications with C.V. and covering letter to:
Ms. Leana Ait-Younes, Practice Manager, Capelfield Surgery, Elm Road, Claygate KT10 0EH.
Email: aleana@nhs.net.
www.capelfieldsurgery.co.uk
Closing Date: 5:00pm Friday 5th October 2012

SALARIED GP with a view to PARTNERSHIP
5 - 6 SESSIONS PER WEEK
SOUTHWATER/HORSHAM, WEST SUSSEX

An opportunity has arisen in this modern, forward thinking GMS practice.
We currently have 3 Partners, 7500 patients, superb modern premises and high QOF achievement. Our location is in a pleasant, semi-rural area, adjacent to the market town of Horsham.

We are looking for a dynamic, enthusiastic and highly motivated team player who can demonstrate high standards of clinical excellence.

Initially, this will be a negotiable salaried position. For the right applicant, who demonstrates a commitment to working within our team and is keen to help drive the practice forward, we will offer the opportunity of a profit share partnership.

Applications by CV and covering letter to Felicity Belkin, Practice Business Manager, The Village Surgery, Station Road, Southwater, West Sussex RH13 9HQ or email felicity.belkin@nhs.net
Informal visits to the practice will be welcomed

Closing date: 28 September 2012
Interview date: Week commencing 8 October 2012

Check out our website: www.southwatersurgery.co.uk

THE MARISCO MEDICAL PRACTICE

FULL TIME PARTNER REQUIRED
EAST COAST LINCOLNSHIRE

We are seeking to recruit an enthusiastic and highly motivated GP to replace a retiring partner. Start date to be agreed but before end 2012 if possible.

About us:
9 Partners based in new flagship premises
Training Practice
GMS Contract
Well organised and supportive primary care team
SystmOne clinical system, paperless practice
Maximum QoF Achievement
List Size – 14,000 patients
No Out of Hours requirement
Excellent housing in rural villages at competitive prices
Excellent Grammar Schools and environment

Please see our Practice Website: www.marisco.gpsurgery.net

Apply in writing with CV to Janet Goult, Practice Manager Marisco Medical Practice, Stanley Avenue, Mablethorpe LN12 1DP
For an informal chat or to arrange a visit, telephone 01507 474190
Email: Janet.Goult@lpct.nhs.uk

Closing date: 21st September, 2012

The Castle Hedingham Surgery

We are a small rural **dispensing** practice looking for a salaried GP to join the team with a view to partnership

- **4-6 sessions per week**
- **Approximately 2000 patients**
- **SystmOne**
- **Very high QoF achievement**
- **No out of hours commitments**

Please apply in writing with a CV to

Rachel Howard, Practice Manager,
The Castle Hedingham Surgery, 10A Falcon Square,
Castle Hedingham, Halstead, Essex, CO9 3BY
Tel 01787 461784 Fax 01787 469402

DOCTORS/GPS REQUIRED

Hywel Dda Health Board

Out of Hours Salaried General Practitioner

Up to £95,000 depending on experience
37.5 hours per week, Permanent
GP Principals/Salaried GPs and newly qualified trainees

Want to escape to the country and live in the beautiful county of Pembrokeshire? Are you a hill walker or keen on all water sports? If yes, then come and enjoy the UK's only coastal National Park, and combine these loves with a new career in Out of Hours General Practice in Pembrokeshire.

We offer:

- Manageable caseloads and the benefit of significant investment in technology and infrastructure
- Nurse triaged calls resulting in telephone advice, treatment centre appointments and home visits
- 4 hours per week protected time for personal and group Continuous Professional Development
- 1 hour per week pro rata to review best clinical practice evidence and writing of guidelines and protocols for the service.

Full GMC registration, possession of JCPTGP certification and ongoing participation in Appraisal/Revalidation are mandatory.

Enjoy a new career in our Out of Hours Service.

For further information and details of how to apply please visit www.jobs.nhs.uk

Reference: 100-MED-P019

Closing date: 30th September 2012.

Hywel Dda Health Board web page can be accessed via the below web address.
www.hyweldda.wales.nhs.uk

FULL – TIME SALARIED G.P.

with a view to partnership

Croston, Lancashire

Starting Date: 1st January 2013

Two doctor GMS semi-rural Practice run from a purpose built premises and supported by full Practice staff, including Practice Nurse and a Practice Manager

EMIS LV system - High QOF achiever

The existing partners are contemplating retirement.

Please reply, with full CV, to
Practice Manager
Croston Medical Centre, 30 Brookfield, Croston, Leyland, Lancashire PR26 9HY. Telephone: 01772 600081

Closing date for applications: 30.09.2012
Informal enquiries/visits are welcome

South Tees Hospitals NHS
NHS Foundation Trust

together we do the amazing

Maximise your skills and realise your ambitions through exciting experiences, training and development opportunities. Our patients consistently acknowledge the high quality of care we provide. Listening to your ideas, involving you and working flexibly we believe in making your working life successful.

Division of Community Services
Marske-by-the-Sea

SALARIED GP (8 sessions per week)

Salary range £61,252 - £81,781 per annum pro rata

Marske Medical Centre is a forward-thinking APMS practice based in the pleasant seaside town of Marske on the edge of the North Yorkshire moors. Managed by South Tees NHS Foundation Trust Division of Community Services we have a strong link with James Cook University Hospital with plenty of opportunities for specialist involvement.

We are seeking flexible enthusiastic GPs with excellent clinical and communication skills to work with our fully motivated multi-disciplinary team to further develop innovative services for our patients.

About the surgery

- We provide excellent care to approximately 6,000 patients in Marske and the surrounding areas.
- High achievements in prescribing, patient involvement & QoF score.
- Additional services such as weekly minor surgery clinics, a heart failure clinic and acupuncture.
- Highly motivated & qualified nursing staff dealing very efficiently with most of the chronic care.
- Fully computerised using SystmOne.
- South Tees Hospital NHS Foundation Trust offers an attractive salary package with enhancements, comprehensive personal training and potential further development opportunities in other areas.

If you would like to discuss this opportunity further please contact Marilyn MacLean (Business Manager) on 01642 759910 or Jane Watson (Office Manager) on 01642 759914 or Dr. Richard Rigby on 01287 640385 (Associate Medical Director) for an informal discussion.

All applications must be submitted online at www.jobs.nhs.uk quoting the reference number: GP020812 unless you have a disability which prevents you from doing so. However if you are having difficulties completing the application online, you can contact the Human Resources Recruitment Team on (01642) 854610 or alternatively visit your local Job Centre or library.

Closing date: 27 September 2012.

To apply visit the website address below.

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Our fellows spend a fully-funded year at the Institute for Healthcare Improvement in the US, where they combine academic and practical learning in quality improvement.

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Or email **qif@health.org.uk**

Now open for applications

Applications close on Tuesday 9 October 2012

*capes not included

THURSO, HIGHLANDS, SCOTLAND (www.thursohalkirkmp.co.uk)

ADDITIONAL PARTNER REQUIRED

We are looking for an additional partner to join our innovative GMS practice in an area of outstanding local beauty in the North of Scotland. We require an enthusiastic, hardworking and committed GP who will play an active role within the practice to maintain our values and help develop patient services for the future. We are committed to providing high quality health care with a wide range of services tailored to meet the needs of our patients.

- 6 – 9 sessions (but could be flexible)
- Non Equity or Equity Partner position
- List size approximately 6,000 (currently four partner practice)
- Dispensing branch surgery (six miles from town)
- Established Training Practice – Specialist Registrars and Undergraduate teaching, Practice Based Small Learning Group (PBSLG)
- High patient satisfaction survey scores
- Clinical support team includes Practice Nurses and Health Care Assistant
- In the final stages of recruiting a Nurse Practitioner/Prescriber
- Happy and enthusiastic administrative team
- GP led community hospital next door
- IT – INPS (Vision), FrontDesk and Docman clinical systems with on site VC facility for training / meeting purposes and telemedicine
- Well equipped premises
- Enhanced services and extended hours offered
- No out of hours commitment (although opportunities exist locally)
- Clinics provided by visiting Midwife and Physiotherapist
- Generous annual leave plus 5 public holidays (includes 5 days study leave)
- Maternity/paternity pay written into contract
- Excellent local facilities, housing and schools, low crime rate
- Twenty miles from nearest airport
- Vacancy available now but willing to wait for the right person
- Applications welcome from current ST3s, newly qualified and experienced GPs

Further information, including Practice Profile, GP/Locum testimonials and the results of our patient satisfaction survey are available on our newly updated practice website at www.thursohalkirkmp.co.uk. Information together with a promotional video on the town of Thurso and the surrounding area can be found at www.thursotown.co.uk.

If you would be interested in joining our friendly, forward thinking and high quality practice team in this beautiful part of Scotland, please write (enclosing CV) to: Christine Tait, Management Partner, Thurso & Halkirk Medical Practice, 69 Princes Street, Thurso, Caithness KW14 7DH. For more information or for informal enquiries please contact Christine on 01847 895495 or c.tait@nhs.net.

DOCTORS/GPS REQUIRED

Partners4Health

Frustrated by the QOF treadmill?
Enjoy working with the acutely ill?
Passionate about delivering excellent, patient centred care?

Based in the historic city of Chester, Partners4Health is recruiting additional GPs to support our existing team of doctors, Advanced Nurse Practitioners and healthcare assistants to deliver urgent care in

- Hospital at Home, an innovative service that treats patients in their own home who would normally need to be admitted to hospital
- General Practice where you will be part of the practice team and have the opportunity to maintain your GP skills

Partners4Health is an NHS body and successful applicants will benefit from excellent terms and conditions including the NHS pension scheme. Salary range £76,000-£82,500 per annum for a 37.5 hour week including protected development time.

Candidates must have completed their GP training and have a minimum of 12 months further experience in Primary Care.

Closing date for applications 28 September 2012

For further information contact Dr John Hodgson, Medical Director 01244 385387 or johnhodgson1@nhs.net
For a job pack contact Anne Briffa, office manager on 01244 385388 or a.briffa@nhs.net

THE AVENUES MEDICAL CENTRE

Part Time Salaried GP Vacancy with a view to partnership – 5 sessions per week.

An enthusiastic salaried GP is required to join two existing partners in a City Practice.

We are a friendly, supportive SystmOne practice achieving high QOF targets, with a list size of 6100.

We are close to good schools, varied housing, good culture and leisure and have easy national and international access.

For further information, or to make an informal visit, please contact:

Caroline Whitaker, Business Manager,
147-153 Chanterlands Avenue, Hull, HU5 3TJ,
on 01482 303876 or carolinewhitaker@nhs.net

Applications in the form of a full CV including the details of two referees should be sent to Caroline Whitaker at the above address or email address.

NEWPORT, SOUTH WALES

We are looking for a Partner from Jan 2012
initially salaried for 6 months
Friendly, City Practice, High QOF achievement
Well organized practice with excellent management, nursing & administrative support
Informal visits can be arranged
More details on request from:
Practice Manager, Bryngwyn Surgery
4 & 6 Bryngwyn Road
Newport NP20 4JS T: 01633 263463
Sandra.bogue@gp-w93046.wales.nhs.uk
Closing date 30.10.2012

South East London - Lewisham
Lee Health Centre

Salaried GP

Required for 6 sessions, plus extended hours

Friendly well established PMS three doctor practice

- Six sessions
- 6500 patients
- EMIS PCS migrating to EMIS Web shortly
- High QOF achievement
- Excellent nursing and admin support team

Applications with CV by email to:
Dr Leo Antony, Partner, leo.antony111@yahoo.co.uk
Closing date 28th September 2012

SELF-EMPLOYED ASSISTANT/SALARIED GP

(WITH A POTENTIAL PARTNERSHIP OPPORTUNITY)

Dr Laws & Partners, Shadbolt Park Surgery, Worcester Park, Surrey

We are looking for an enthusiastic GP to join our busy, friendly, PMS plus practice, 30 minutes from London and close to the rolling downs of Epsom Race Course, to work 4 to 5 sessions a week starting late September.

We are an urban practice, but set in a park with beautiful views

- 3 GP Partners, 2 Salaried GPs and 2 Associate GPs
- List size 7750, young demographics
- EMISWeb - we use the latest web based computer system
- High QOF points achiever
- 4 practice nurses, an HCA, & phlebotomy services
- Extensive enhanced services and PMS clinics such as in house Cardiology including 24hr BPs & 24hr ECGs. Minor Surgery. Warfarin clinics and a Paediatric clinic, also Antenatal and Family Planning clinics.
- On site Ultrasound Service
- FY2 training and we are looking to become a Registrar training practice in the future.
- Members of Locality CG and Surrey Downs CCG
- Active PPG

There are plans to expand and we hope to offer a partnership of possibly 6-8 sessions in the near future.

Informal visits and enquiries welcome. Letters of application and CV to:

Mrs Nicky Goulter (Practice Manager)
Dr Kate Laws & Partners
Shadbolt Park House Surgery
Salisbury Road, Worcester Park, Surrey, KT4 7BX.

Tel 020 8335 0678 –
Email nicky.goulter@nhs.net or katelaws46@gmail.com

Stratford Village Surgery, London E15

Salaried GP (Maternity Cover) and .5 part time salaried GP required

We are looking for a salaried GP for eight/nine sessions a week to join an established practice, which is supported by a well motivated and friendly team. Start date ASAP.

List size 8,900+
High QOF Achiever and EMIS Web user
Please send your C.V. and covering letter to
Karen Stubbs- Business manager
Stratford Village Surgery
50c Romford Road, Stratford, London. E15 4BZ
Or e-mail to karenstubbs@nhs.net

Ballards Walk Surgery Basildon, Essex.

Salaried GP required.

We are looking for a salaried G.P. for eight / nine sessions a week to join or established practice, which is supported by a well motivated and friendly team. Start date ASAP.

List size 7100
High QOF Achiever
System One User - Paper light
Purpose built premises
Salary negotiable depending on experience.
6 weeks holiday and one week study leave.

Please send your C.V. and covering letter to
Practice Manager
Ballards Walk Surgery
49 Ballards Walk, Basildon, Essex. SS15 5HL.
Or e mail C.V. to jackiemellia@nhs.net

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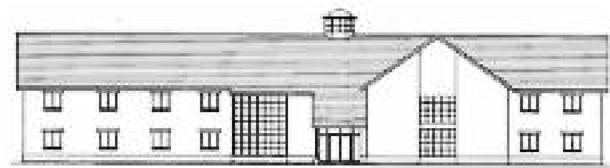

Bungay Medical Practice

Partner or Salaried GP
Norfolk/Suffolk Border

This well organised, thriving and friendly practice situated in a market town has a vacancy for one and a half GPs. They would be joining a team of nine – a mixture of salaried GPs and partners (many of whom were previously salaried in the practice).

- Modern purpose-built premises with dispensary
- Personalised patient lists (total list size 10,500)
- Community Hospital
- Teaching medical students, F2s and GP Trainees
- Research Practice
- High QOF achiever

Practice details can be viewed on our website: www.bungaymedical.co.uk

For more information, or to arrange an informal visit, contact Sarah Harris, Practice Manager, Bungay Medical Practice, 28 St John's Road, Bungay, Suffolk NR35 1LP.

Telephone 01986 891727 or email sarah.harris2@nhs.net

Full time salaried GP
(would consider two part time / job share)

Are you a highly motivated, caring GP?
Would you like to join our friendly, committed, dynamic, established South Tyneside Training Practice?

Please submit CV and covering letter to
Sharon Thompson, Business Manager
Mayfield Medical Centre
Park Road, Jarrow, Tyne and Wear, NE32 5SE
or email sharon.thompson@stpct.nhs.uk

For further information contact
Sharon Thompson on 0191 4897183

Salary negotiable depending on experience.

Closing date: 28th September 2012

GP PARTNER SALARIED PART FULL TIME GRAVESEND

Seeking an enthusiastic GP for six-eight sessions initially to join our friendly team in a well established practice. The incoming doctor must be fully committed to develop the practice and take over full control from the retiring senior partner.

- Emis PCs
- List size 2500
- No OOH commitment
- High QOF achiever

Wendy Hopkins
186 Parrock Street, Gravesend, Kent DA12 1EN
Tel: 01474-567888 parrock.surgery@nhs.net

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

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Please email your CV to: peter@harleystreetgroup.co.uk
or call on 020 7224 0030

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URGENTLY REQUIRED

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Recruitment & Employment Confederation

SALARIED GP

(WITH A POTENTIAL PARTNERSHIP OPPORTUNITY)
Up to 6 Sessions per week

Dr. Bevan and Partners, Spinney Brook Medical Centre
Northamptonshire

We are looking for an enthusiastic GP to join our busy, friendly, semi rural Practice from November 2012.

- 6 GP Partners (5 wte)
- List size 10,800
- Modern purpose built premises (Main and Branch Surgery)
- Dispensing Branch Surgery
- High QOF points achieved
- PMS Practice
- Secure OOH arrangement
- Training Practice (Registrar and Undergraduate)
- EMIS LV / Paper light (moving to EMIS web)
- GP Triage/Nurse Practitioners
- Excellent road and rail links

Informal visits and enquiries welcome. Letters of application and CV to:

Mrs. Alison Fenn Coles (Practice Manager)
Dr J. M. Bevan & Partners
Spinney Brook Medical Centre
59 High Street, Irthlingborough, Northants. NN9 5GA

Tel: 01933 650593 – Email: alison.fenncoles@gp-k83028.nhs.uk

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OVERSEAS

Are you considering a lifestyle change? Practise as a GP in rural Western Australia.

Rural Health West is the leading rural workforce agency in Western Australia.

Come meet the experts who can answer your questions about working as a rural general practitioner in Western Australia. We will be visiting **London** and **Manchester** in **October 2012**.

Email for information or to book a personal appointment and quote 'PULSE' in the subject line.

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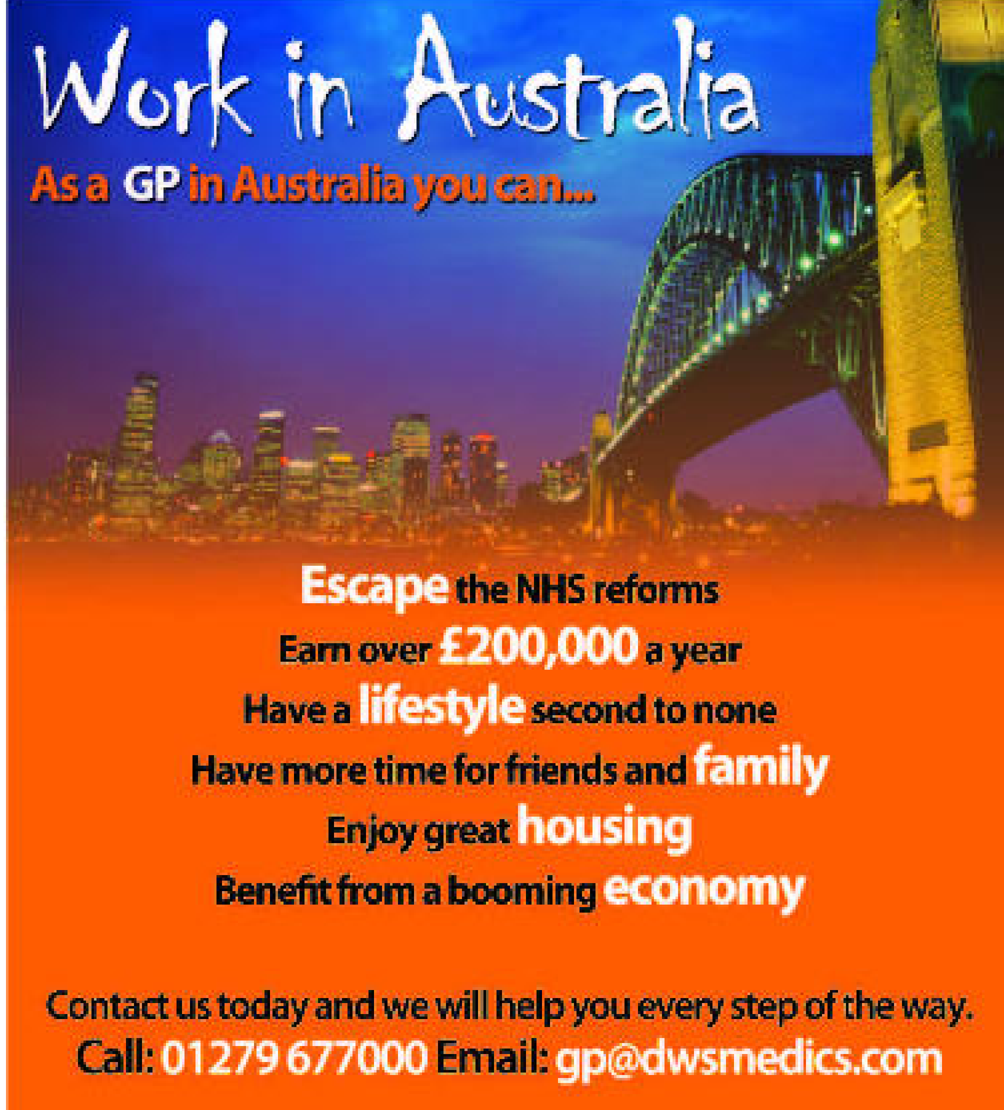
W www.ruralhealthselect.com.au



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EDITOR'S CHOICE

A snapshot of yesteryear's GP

Looking for clues to a serious disease, keeping a small business going and showing compassion – was the Edwardian GP so different from today's? Dr Stephen Connellan asks

Some 30 years ago, I received a book from my uncle. Other than the title 'Tactics' there was no other indication as to author, publisher or year of writing. The theme was one of doctor-patient relationships, and the book also advised on how to retain and increase the size of one's practice – rather like the Practice Business section in Pulse.

Advice from the Wellcome Library suggested this was a series of articles, bound together with a view to publication. I decided to re-publish it, this time with my comments and contextualisation for the modern reader.

Based on a number of comments within the text, my guess is that the book was produced in the early 20th century. I tried to find out who had written it using the internet, but have so far failed to identify the author – although I'm sure he was male and probably worked in London.

His approach to the practice of medicine provides an insight into the challenges that faced the Edwardian equivalent of today's GP.

He refers to the treatments on offer, equipment used, historical figures and the prevalent diseases of the day. There are many areas in which we see his compassion for patients – although some of his advice arguably seems biased towards making a good impression on them, and thus a good living for himself.

In some ways, the way the doctor used to work varies significantly from modern practice. He emphasises the importance of creating a good impression on women, as it is their word of mouth that will enhance his reputation...

Dr Stephen Connellan: reflecting on doctor-patient relationships

Dr Stephen Connellan is a retired consultant respiratory physician

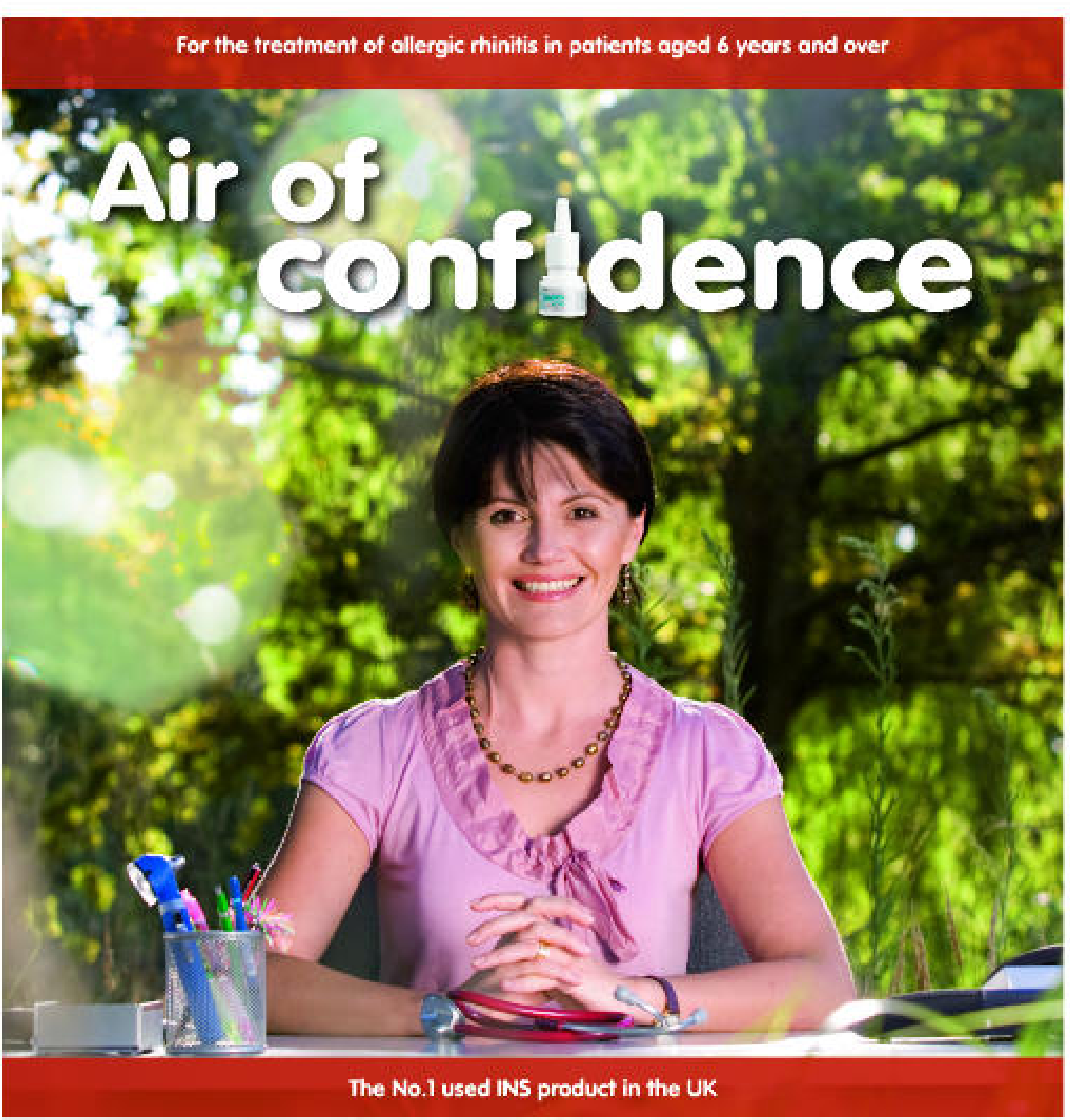
MORE ONLINE
You can read the full article at
pulsetoday.co.uk/off-duty

VIDEO

THEBIGINTERVIEW

Want to know how the GPC is going to cope with no female negotiator? We spoke to Dr Beth McCarron-Nash about the GPC election, women in general practice and the future of GP training.

▶ pulsetoday.co.uk/the-big-interview



Further information is available on request to MSD.

Consult the Summary of Product Characteristics for further information before prescribing, particularly in relation to side effects, precautions and contra-indications

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

POM

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05-14 RESP-1024263-0000

Alcohol-Free

Nasonex®

mometasone furoate 50mcg per spray

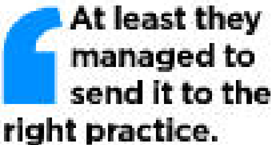
Date of preparation: May 2012

WHAT YOU'VE BEEN SAYING

▶ pulsetoday.co.uk/forum

Why is the answer to everything to make businesses larger?

... on the King's Fund's calls for practices to federate



At least they managed to send it to the right practice.

... on admin errors that delayed discharge letters by a year

Out of the frying pan, into the fire.

... on the recent Cabinet reshuffle

SURVEY

Have your say on rationing

Pulse is carrying out a survey on the rationing of local services to try to gauge the extent to which clinical procedures and treatments are being restricted across the UK. If you have a few minutes to spare, please take part.

SURVEY
Have your say here
pulsetoday.co.uk/rationing

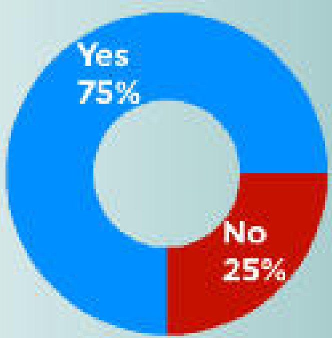
THIS WEEK'S POLL

Are you happy with Jeremy Hunt as the new health secretary?

Vote at ▶ pulsetoday.co.uk/polls

Last week's poll

Should patients be allowed to top up their personal budgets?



Turn inside for this week's shot of the world according to Copperfield
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