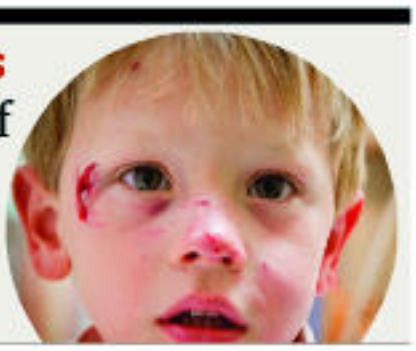

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BriefingMedia

At the heart of general practice since 1960

Just 125 GPs to be retrained under revalidation, says GMC

- Fewer GPs could face remediation than currently
- DH delays release of revalidation cost estimates

By Sofia Lind

Revalidation could identify fewer than 125 GPs who require remediation in its first five-year cycle – fewer than are currently singled out under existing processes – the chair of the GMC has suggested.

The disclosure from Sir Peter Rubin – the first concrete indication of how many GPs could face remediation – comes amid mounting confusion over the cost of revalidation.

The Department of Health this week said it will not be publishing its impact assessment before a formal decision is made on rollout.

Last week the GMC backed revalidation to begin on 3 December, with health secretary Jeremy Hunt likely to rubber-stamp the process shortly.

Sir Peter told Pulse he had been told 'fewer than 10' GPs were likely to require remediation across an area with a population of five million. Extrapolated across the UK, this would mean that only about 125 GPs would need remediation in a five-year revalidation cycle.

Figures from the National Clinical Assessment Service show GPs required remediation in 42 cases in 2011/12 alone, after referral from PCTs based on appraisals or complaints – suggesting revalidation could identify even fewer doctors requiring remediation than the current system.

Sir Peter: 'tiny number' of GPs to face remediation

Sir Peter said: 'We are talking about tiny numbers of doctors [who will require remediation]. In an area with a population of five million, we were told, by somebody who would know, the number of GPs needing remediation in that area was under 10.'

But GPs said the figure called into question the huge effort being committed to roll out revalidation, and also criticised the lack of transparency over the cost of the process.

The DH revealed this week its impact assessment setting out all the likely costs of revalidation will only be published after a final decision is made on rollout. The NHS Commissioning Board and the GMC, which has publicly insisted 'revalidation is affordable and benefits outweigh costs', have also remained tight lipped on the likely cost (see box).

Costs likely to be factored into the DH impact assessment include expanding appraisal, the revalidation support team and responsible officers, estimated to cost £22m per year.

GPC negotiator Dr Peter Holden said he was unsurprised few GPs were expected to require remediation: 'We have been surveyed to death over the years and consequently things ought to be in good shape.'

Dr Peter Tyerman, a GP in Barnsley, South Yorkshire, said: 'The costs taken out of patient care are out of all proportion to the benefits. Nobody has shown any evidence it will make any difference.'

And Dr Krishna Korlipara, a retired GP in Bolton who served on GMC Council from 1984 to 2008, said: 'The effort and cost are greater than the value.'

Professor Mike Pringle, RCGP president-elect, said he expected the number of GPs facing remediation to increase by 'a handful' at most. He said: 'You might say if there is no increase, why are we doing it? Well, since it became obvious revalidation was serious, it has had a catalytic effect on standards.'

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Revalidation cost kept under wraps

- **Department of Health: has drawn up impact assessment of all associated costs, but will not publish until after decision on rollout**
- **NHS Commissioning Board: has agreed to fund remediation, but refuses to disclose likely costs**
- **GMC: plans to publish organisational costs relating to revalidation at the end of the financial year. Last year the regulator's continued practice and revalidation directorate cost £2.7m.**

BIG Question Are PCTs taking longer to resolve payment disputes? ▶ pulsetoday.co.uk

Practices forced to fight for overdue LES payments

NHS reforms leave PCTs in administrative 'chaos' with some GPs considering legal action to recoup cash

EXCLUSIVE

By Sofia Lind

A vacuum in PCT management caused by an exodus of staff is forcing practices to chase thousands of pounds in overdue enhanced services payments, with some being forced to consider legal action to recoup money owed.

A Pulse survey of 252 GPs has found as many as one in eight practices is owed LES funding, with many submitting formal appeals to reclaim the money, and some even taking legal action.

It comes as LMCs claimed the transition to CCGs had led to administrative 'chaos' in PCTs, with one even claiming a key manager had 'disappeared'.

Some 13% of GPs surveyed said they were owed LES payments from their PCT, with 7% having made a formal appeal to reclaim the money, and a similar proportion considering, planning or taking legal action.

Legal experts estimated there had been a 50% rise in GP appeals for LES monies owed by PCTs in the first six months of 2012/13 compared with the same period last year, while medical accountants said up to one in four practices was appealing over unpaid LES or QOF funding.

Andrew Lockhart-Mirams, senior partner at Lockharts Solicitors, said sums of up to £30,000 were being disputed, but most were between £3,000 and £8,000. 'For practices this is the difference between bread and butter, and bread, butter and jam,' he said.

Bob Senior, head of medical services at RSM Tenon, said: 'We see more of this now than in previous years; I would say it now affects about 20-25% of practices. In these tough economic times even £5,000-£10,000 is a lot.'

Dr Tony Grewal, medical director of Londonwide LMCs, said London PCT clusters were in administrative 'chaos,' citing one case where an administrator responsible for making LES payments was not replaced, forcing practices to wait three months for their money, and cover costs out of their own pockets.

He said: 'In some cases, they were owed thousands. As a GP, you are left with the options to either sack staff or reduce your drawings.'

He said the LMC was also dealing with a case where a cluster official who had signed off a LES had apparently disappeared, with not even the head of the

Chasing payments

50%
increase in GP appeals for LES payments in first six months of 2012/13 compared with last year

25%
proportion of practices chasing LES or QOF payments

7%
proportion of GPs considering or taking legal action

£3k-8k
average amount of money owed to GPs

Sources: Lockharts Solicitors, RSM Tenon accountants, Pulse survey of 252 GPs

GP trainees 'used to plug staffing gaps'

GP trainees are being widely used to ease NHS staffing shortages and have even been asked to complete two placements in the same specialty, the new head of the BMA's junior doctors' committee has claimed.

Dr Ben Molyneux, a GP trainee in London who was elected to chair the committee last week, warned medical training was suffering as a result of financial pressures, and said some trainee GPs had reported they were struggling to fulfil recommended training requirements.

He said trainees in a number of places in the south of England were being used to plug staffing gaps, and claimed students training with the Surrey, Sussex and Kent Deanery had been made to complete two placements in psychiatry to help a trust's staffing shortage.

The deanery said trainees had been asked to complete two placements on educational grounds rather than to fill gaps.

But Dr Molyneux said: 'Some trainees have been forced to complete two placements in psychiatry because the trust is short-staffed. Junior doctors should not be denied a rounded training programme that exposes them to a range of specialties.

'It puts a strain on their learning. If they are doing paediatrics and psychiatry it is much more easy to demonstrate their learning than if they are doing two psychiatry placements.'

He said the BMA was trying to find out how widespread the problem was, but added it was affecting 'a significant minority'.

Dr Molyneux added: 'The economic climate in the NHS, coupled with changes introduced by the Health and Social Care Act, has created a perfect storm.'

'Juniors should not be denied a rounded education programme'
Dr Ben Molyneux

But a spokesperson for Surrey, Sussex and Kent Deanery said: 'The purpose of the additional placements - two four-month [placements] compared with other deaneries who offer six-month placements - in psychiatry and other specialties is because the deanery places importance on that area of GP training. There is no evidence to suggest it is due to staff shortages.'

Dr Tony Grewal: GPs awaiting payment are forced to 'either sack staff or reduce drawings'

cluster able to track them down: 'We are trying desperately to keep a handle on responsible staff but are finding that someone is there one week, then has disappeared the next week.'

A spokesperson for NHS London said: 'We are working with GPs to make sure all systems are in place to smoothly manage the transition. We are concerned to hear about this and would urge the practice to speak to their local PCT in the first instance.'

GPC negotiator Dr Chaand Nagpaul said his own practice in Harrow, Middlesex, was having problems recovering costs for extended hours. 'Just getting hold of an individual is proving difficult,' he said.

Dr Krishna Chaturvedi, a GP in Westcliff-on-Sea, Essex, said his area had seen disputes over a host of LES payments for services such as childhood immunisations and maternity services.

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EDITORIAL ▶

Hard truth about the fall in GP funding 22

Scots GPs won't join strike ballot

Scottish GP leaders have said the poor support for industrial action in June was the main reason for not joining hospital colleagues in balloting over fresh action in protest at the Government's pension reforms.

The UK BMA Council last week ratified BMA Scotland's decision to ballot hospital doctors on the possibility of three further days of action in December and January. The proposed action will go further than June's action, with a bank holiday service proposed, meaning only doctors providing emergency care would attend work.

But the Scottish GPC ruled out the possibility of joining secondary care colleagues, after gathering a 'representative sample' of views from LMCs.

BMA Council decided against further days of UK-wide industrial action following the BMA's Annual Representative Meeting in June.

In a letter to Scottish GPs, Scottish GPC chair Dr Alan McDevitt said: 'The committee concluded that while GPs remain extremely angry about the changes to their NHS pensions, there is limited support for strike action at this time.'

Dr Sandy Sutherland, a GP in Midlothian, said: 'The lack of success in June meant that the eagerness has diminished.'

Dr Georgina Brown, vice-chair of Glasgow LMC, said: 'Single-day absence from work is not really effective because patients will wait until the next day. There is far more scope for hospital doctors to take effective action than GPs.'

DAY OF ACTION

PCTs drop threat of contractual sanctions

PCTs have dropped threats to impose contractual sanctions on GPs who took part in the BMA's day of pensions industrial action on 21 June.

All PCTs in London had written to the capital's 6,000 GPs prior to the day of action to warn them they could face a breach-of-contract notice or have pay withheld if they opted to take part.

NHS North Central London and NHS South West London have now confirmed they have no plans to take any retrospective action against GPs, having previously failed to rule it out.

The week in general practice

INSIDE

Dr Peter Swinyard

MORE ONLINE

▶ pulsetoday.co.uk/news

Labour leader Ed Miliband has confirmed he will repeal the health act – but hinted he might keep some of the coalition NHS reforms
▶ pulsetoday.co.uk/politicalnews

Download of the week
Read the CQC's consultation on GP registration fees
▶ pulsetoday.co.uk/downloads

Video of the week
Watch the Big Interview with GPC deputy chair Dr Richard Vautrey
▶ pulsetoday.co.uk/the-big-interview

Leave me out of the bedroom, says Peverley
▶ page 23

CQC fees to rise year on year

GPs must stump up £6m in first year and pay more subsequently, under proposed model agreed with BMA

By Sofia Lind

GP practices will be expected to foot a £6m bill towards the cost of CQC regulation in the first year of the process, then pay more in subsequent years, the regulator has revealed.

Subject to consultation, the CQC's proposals mean most GP practices will pay an annual registration fee of between £550 and £850 in the first year, with the maximum fee set at £15,000. However this is likely to rise in the second year when the CQC is intending to recover more of its costs through fees.

The regulator has estimated the total cost of registering primary care will be £12m in the first year, and has guaranteed the Treasury it will recover 50% of this in fees.

But the CQC said it hoped in future to recover most of its costs through fees, with the percentage covered to rise to about 75% in the second year, and after that incrementally year on year.

The CQC's fees consultation presents three separate models, including a recommended option worked out in collaboration with the BMA.

Under the first model, fees are based entirely on list size, ranging from £300 to £1,600.

Under the second model, fees are based only on number of locations, and range from £600 to £50,000.

Under the third, recommended, model, a practice with just one location would pay between £550 and £850 depending on list size. If a practice had more than one location, the fees would be determined by the number of locations according to a climbing ratio (see box).

Dr John Canning: proposed fees structure 'fairer than others'

The consultation will run until 21 December, with a final decision next March. The system is due to go live on 1 April.

Glyn Barker, CQC investment appraisal manager, said: 'It is fair to say we will go to 75% [recovery through fees] next year. We don't think it is viable to go to 100% recovery through fees.'

The CQC estimates around 7,500 primary care providers will register as a one-location practices, and fewer than 1,000 as two- or three-location practices. It expects only eight to register with more than 40 locations.

Dr John Canning, GPC contracts and regulation subcommittee chair, who led BMA discussions with the CQC over fees, said: 'We don't back any structure, but some are fairer than others. Pure location or pure list size are potentially worse.'

But he added that the GPC objected to year-on-year increases: 'This is unfair as we have no route to increase income or fees so have to pay out of our pockets.'

One GP, who asked not to be named, said the plan was 'bonkers' and warned: 'As fees are ramped up this will trigger the closure of many small rural branch surgeries.'

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CQC's preferred fees structure

For GP practices with one location:	
Small practice (fewer than 5,000 patients)	£550
Medium practice (5,000-10,000 patients)	£650
Large practice (10,000-15,000 patients)	£750
Very large practice (15,000+ patients)	£850
2 locations	**£1,200**
3 locations	**£1,600**
4 locations	**£2,000**
5 locations	**£2,400**
6-10 locations	**£3,000**
11-40 locations	**£6,000**
40+ locations	**£15,000**

Source: CQC consultation on fees

Q&A

GP registration with the CQC

When do GPs have to register by?
The deadline for GPs to register with the regulator is December.

What happens from April 2013?
After being registered, GPs will have to demonstrate compliance against the regulator's essential standards, pay annual fees and undergo inspections every two years.

How will inspections work?
The CQC is considering whether to give GPs between 48 hours' and 10 days' notice of visits following feedback from pilots. But it may still make unannounced inspections if it has been alerted to a potential problem.

Surgery inspections will last up to a full day, and will include interviews with practice staff and patients.

What will practices be assessed on?
Practices will be assessed against 16 'essential standards' including cleanliness, treating patients with respect and whether practices have the right number of qualified staff. Resulting reports will be published in the public domain.

IN BRIEF

GP wins Labour award

Dr Kailash Chand has received a national merit award at the Labour Party conference.
Full story ▶ pulsetoday.co.uk/politicalnews

NICE looks at social care

The DH has asked NICE to develop further standards for integrated health and social care.
Full story ▶ pulsetoday.co.uk/clinicalnews

NHS Direct transfer row

A row over the transfer of staff from NHS Direct to a new 111 service has been taken to the DH.
Full story ▶ pulsetoday.co.uk/politicalnews

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NovoMix® 30 FlexPen®
All presentations contain soluble insulin aspart/protamine-crystallised insulin aspart 100 U/ml in the ratio 30/70.
Indication: Treatment of diabetes mellitus in adults, adolescents and children aged 10 to 17 years. **Posology and administration:** Potency of insulin analogues is expressed in units (U). In patients with type 2 diabetes, NovoMix® 30 can be given in monotherapy or in combination with oral antidiabetic drugs (OADs) when blood glucose is inadequately controlled with OADs alone. The recommended starting dose is 6 U at breakfast and 6 U at the evening meal. Titration is according to pre-meal blood glucose levels (pre-breakfast glucose for adjustment of evening dose and pre-evening meal glucose for adjustment of breakfast dose). NovoMix® 30 can also be initiated once daily with 12 U at the evening meal and it is generally recommended to move to twice daily when the daily dose reaches 30 U; this can be done by splitting the dose into equal breakfast and dinner doses. If twice daily dosing results in recurrent daytime hypoglycaemic reactions the morning dose can be split into morning and lunchtime doses and thrice daily dosing instituted. Only consider combination of NovoMix® 30 with pioglitazone following clinical evaluation of the patient's risk of developing signs and symptoms of fluid related adverse reactions. Initiate NovoMix® 30 cautiously, titrating to the lowest dose required to obtain glycaemic control. In patients with type 1 diabetes the individual insulin requirement is usually between 0.5 and 1.0 U/kg/day and may be fully or partially supplied with NovoMix® 30. Dose adjustment may be necessary with increased physical activity, changes in diet or during concomitant illness. NovoMix® 30 can be used in the elderly; limited experience of NovoMix® 30 in combination with OADs in patients older than 75 yrs. Renal or hepatic impairment may reduce insulin requirements. In this population or the elderly glucose monitoring should be intensified and dose adjusted accordingly. NovoMix® 30 can be used in children and adolescents aged 10 yrs and above; limited clinical data for children aged 6-9 yrs. No studies in children under the age of 6 yrs; only use in this age group under careful medical supervision. When transferring a patient from biphasic human insulin to NovoMix® 30, start with the same dose and regimen, then titrate according to individual needs. For subcutaneous administration only; not to be used in infusion pumps. NovoMix® 30 has a faster onset of action than biphasic human insulin and should generally be given immediately before a meal. When necessary it can be given soon after a meal. Penfill® designed to be used with Novo Nordisk insulin delivery systems. Penfill® and FlexPen® are designed to be used with NovoFine® and NovoTwist® needles. **Contraindications:** Hypersensitivity to active substance/ excipients. **Special warnings and precautions for use:** Use of inadequate doses or discontinuation of treatment may lead to hyperglycaemia and ketoacidosis which are potentially lethal. Travelling between time zones may require change in the insulin regimen. Too much insulin, omission of a meal or strenuous exercise may lead to hypoglycaemia. Compared with biphasic human insulin NovoMix® 30 may have a more pronounced glucose-lowering effect up to 6 hours after injection. This may need to be compensated for through adjustment of dose and/or food intake. Reduction of early warning symptoms of hypoglycaemia may be seen upon tightening control and symptoms may disappear with longstanding diabetes. Tighter control of glucose levels can increase the potential for hypoglycaemic episodes and therefore require special attention during dose intensification. The fast onset of action should be considered in patients where a delayed absorption of food might be expected. Concomitant disease in kidney, liver, adrenal, pituitary or thyroid gland may require change in dose. Transferring to a new type or brand of insulin should be done under strict medical supervision; may require changes in dose/number of injections. Injection site reactions, usually transitory, may occur; rotation of injection sites may help reduce or prevent these reactions, rarely they may require discontinuation of NovoMix® 30. Cases of cardiac failure were reported when pioglitazone was used in combination with insulin, especially in patients with risk factors for development of cardiac heart failure; if the combination is used, patients should be observed for signs and symptoms of heart failure, weight gain and oedema. Pioglitazone should be discontinued if any deterioration in cardiac symptoms occurs. Hypoglycaemia may constitute a risk when driving or operating machinery. **Fertility, pregnancy and lactation:** Limited clinical experience in pregnancy. No restrictions on use during breast-feeding. No differences in animal studies between insulin aspart and human insulin regarding fertility. **Undesirable effects:** Very common (≥1/10); common (≥1/100 to <1/10); uncommon (≥1/1,000 to <1/100); rare (≥1/10,000 to <1/1,000); very rare (<1/10,000); not known (cannot be estimated from the available data). Very common: hypoglycaemia; Uncommon: urticaria, rash, eruptions; refraction anomalies, oedema and local hypersensitivity reactions on instituting therapy and are usually of transitory nature; diabetic retinopathy with intensification may result in temporary worsening; lipodystrophy; Rare: peripheral neuropathy – acute painful neuropathy, usually reversible, may occur with rapid improvement in glycaemic control; Very rare: anaphylactic reactions - generalised hypersensitivity reactions are potentially life-threatening. The Summary of Product Characteristics should be consulted for a full list of side effects. **MA numbers:** NovoMix® 30 Penfill® EU/1/00/142/004 NovoMix® 30 FlexPen® EU/1/00/142/009 **Legal Category:** POM **Basic NHS Price:** 5 x 3 ml Penfill® £28.84 5 x 3 ml FlexPen® £29.99 **Further prescribing information can be obtained from:** Novo Nordisk Limited, Broadfield Park, Brighton Road, Crawley, West Sussex, RH11 9RT.
Date created/last revised: March 2012
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References: 1. Gumprecht J *et al.* Intensification to biphasic insulin aspart 30/70 (BIAsp 30, NovoMix® 30) can improve glycaemic control in patients treated with basal insulins: A subgroup analysis of the IMPROVE™ observational study. *Int J Clin Pract* 2009; **63**(6): 966–972. **2.** Qayyum R *et al.* Systematic Review: Comparative Effectiveness and Safety of Premixed Insulin Analogues in Type 2 Diabetes. *Ann Intern Med* 2008; **149**: 1–12. **3.** Unnikrishnan A *et al.* Practical guidance on intensification on insulin therapy with BIAsp 30: a consensus statement. *Int J Clin Pract* 2009; **63**(11): 1571–1577.

UK/NM30/0312/0009e Date of preparation: April 2012

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GPs to immunise pregnant women against pertussis

DH launches UK-wide vaccination campaign after sharp rise in whooping cough cases

By Gemma Collins

GPs have been charged with leading the immunisation of 730,000 pregnant women a year against whooping cough, as part of Department of Health moves to stem a sharp rise in cases of the disease among newborns.

As of this week, all pregnant women are being offered the pertussis vaccine as part of a £10m temporary programme being rolled out across the UK.

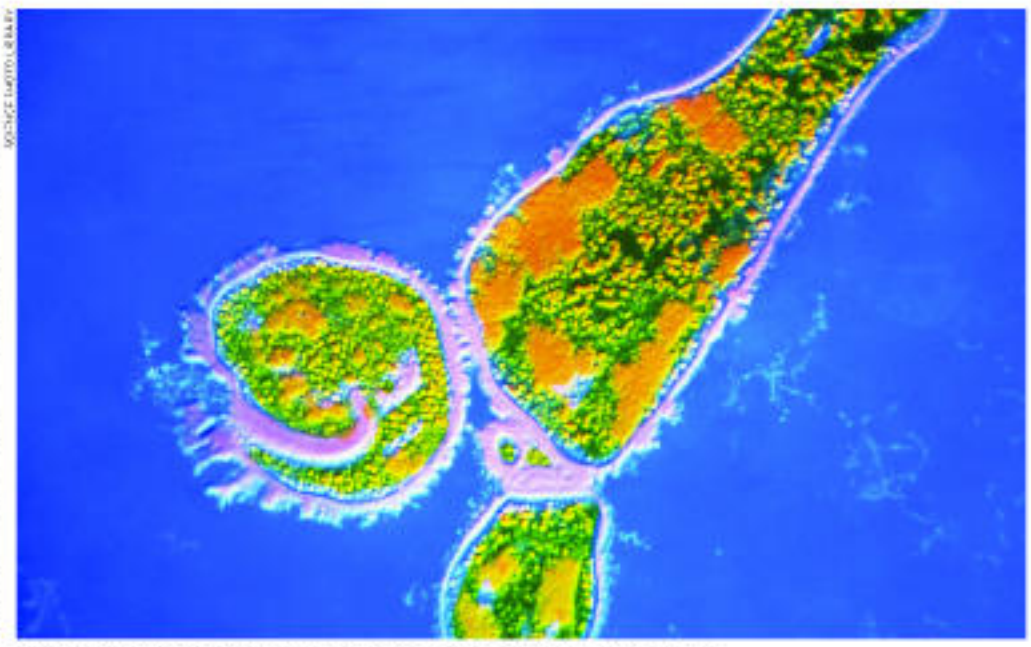
Women who are between 28 and 38 weeks pregnant are expected to receive the Repevax vaccine as part of their routine antenatal appointment with a nurse, midwife or GP.

GPs have also been handed responsibility for chasing up patients to ensure all those that should receive the vaccine do.

The move follows a major surge in whooping cough cases with 4,791 so far this year – more than four times the number reported for the whole of 2011.

The impact on newborns is causing the most concern, with nine deaths in England and 302 cases of infection in babies under 12 weeks old in just eight months.

PCTs will commission practices and midwives to administer the vaccine, and where GPs administer the vaccine, they will receive the standard item-of-service fee of £7.67 for doing so.



SCIENCE PHOTO LIBRARY

Pregnant women across the UK will be vaccinated against pertussis

Professor David Salisbury, DH director of immunisation, said: 'GPs will have to discuss this with their pregnant patients. There will be work in this. The actual administration is a matter of seconds so I don't see that as being burdensome, but certainly the discussion may well be a piece of time that needs to be set aside.

'We have got deaths and cases that we need to prevent.'

Professor Salisbury said the DH had looked at a range of options for tackling the sudden increase in whooping cough cases, including a school-leavers' booster or bringing the first immunisation age down to six weeks.

But it was decided the UK would follow in the footsteps of the US, which introduced a similar programme 18 months ago.

Professor Salisbury said the booster for school-leavers was an 'option for the future' but immunising pregnant women was the solution to preventing whooping cough in infants 'right now'.

Dr Richard Vautrey, GPC deputy chair, said the programme was a 'sensible response' to the recent surge, while the payments were an 'appropriate amount'. But he added: 'We shouldn't underestimate the difficulties practices will have in both contacting patients and reassuring pregnant women and it will take some time. We hope the information that has been put out publicly will convince pregnant women this is the right thing to do.'

The DH said the programme was temporary but would continue for the 'time being' while being evaluated by the Joint Committee on Vaccination and Immunisation.

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MORE ONLINE
Read the DH's Q&A on the programme
pulsetoday.co.uk/download

The new programme in numbers

£10m
cost of the temporary programme

730,000
number of pregnant women in UK targeted annually

£7.67
how much GPs will be paid per vaccine administered

Source: Department of Health

ANALYSIS
Practices should be able to cope

With the new announcement, we are targeting the most vulnerable in our communities.

It is the infants who fare worst and it is in this age group that pertussis more often kills. We have lost very young unimmunised infants to pertussis and many more are being admitted to hospitals and spending time on respirators. By immunising their mothers before the infants are born, we are passing on immunity and creating a safer home environment for them.

This is the best first step we can take for now. I believe GP practices will be able to cope with the workload, which involves one dose of the vaccine after the 28th week of pregnancy, ideally at around 30 weeks' gestation.

There is financial help for GP practices and I know GPs want to protect their most vulnerable patients. I am sure every practice will make this campaign a priority.

I do think we can and should do more. I see no reason why for the fourth booster, at around 15 years, we omit the pertussis component. We should be giving a pertussis booster to our school children.

Dr George Kassianos is the RCGP's immunisation lead

GMC responds to GPC's incentive concerns

The GMC has advised doctors to think carefully about joining controversial incentive schemes for cutting referrals – but has refused to intervene to directly block the schemes that GP leaders fear are 'unethical'.

GPC chair Dr Laurence Buckman wrote to the GMC last month to call for an end to controversial schemes that offer GPs financial incentives for altering their referrals and prescribing behaviour.

In a written response to Dr Buckman, GMC chair Sir Peter Rubin said doctors 'must act in the best interests of patients when making referrals and providing or arranging care' but stopped short of explicitly calling for existing schemes to cease.

Sir Peter wrote: 'Any scheme which results in care to patients being compromised will be in breach of our guidance both in relation to accepting incentives, and on the duty to provide a good standard of practice and care.'

But he added: 'We accept, as you do, that financial incentives can provide a legitimate way of influencing or changing doctors' behaviour.'

CCGs are under intense pressure to cut referrals

The kind of schemes flagged up by the GPC as being potentially 'unethical' involve GPs being set arbitrary targets to reduce prescribing, A&E attendance and referrals.

In some areas, CCGs are paying GPs a set sum per patient for reductions in urgent care, elective care and prescribing, while the GPC has also raised concerns over the quality premium.

Dr Simon Poole, deputy chair of the GPC's commissioning and service development subcommittee, called for stronger guidance: 'I will welcome greater clarity from the GMC because I think some of the schemes that are around may cross that threshold where GPs and practices are put in an absolutely impossible position.'

MORE ONLINE
Read the GMC's response in full
pulsetoday.co.uk/news-analysis

Amisulpride 'most common' in dementia

Amisulpride is the most commonly GP-prescribed antipsychotic in dementia patients, according to a study that suggests a huge difference in practice compared with psychiatrists.

A review of data from 1,051 patients with dementia in the south-east of England found more than 15% were being prescribed antipsychotics, with the majority taking amisulpride, according to the study published in *BMC Psychiatry* last week.

The Government's flagship National Dementia Strategy, published in 2009, called for a two-thirds reduction in the usage of antipsychotics for the behavioural symptoms of patients with dementia, although it did not specify amisulpride as a drug to target.

Amisulpride was used by a third of the 161 patients prescribed low-dose antipsychotics. Risperidone, the only antipsychotic licensed for this indication, was used by 23% of patients, while quetiapine was prescribed to 22% and haloperidol was used by 4%.

A study of old-age psychiatrists found most used quetiapine when necessary, with amisulpride in fourth place.

'The efficacy of amisulpride for this indication is unproven and although there may be less harm associated with quetiapine, there is no evidence that quetiapine is effective in people with dementia,' the authors said.

Furthermore neither amisulpride nor quetiapine are licensed to treat the behavioural and psychological symptoms of dementia'.

The efficacy of amisulpride for this indication is unproven
Study authors

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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
Reference: 1. Sanofi Pasteur MSD. Data on file 2012 UK15877

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

Ministers signal national rollout of personal health budgets – before pilots have concluded

PERSONAL BUDGETS

DH to extend personal budgets

By Alisdair Stirling

The Government has announced it will bankroll personal health budgets for patients to the tune of £1.5m during the first stage of a national roll-out, even though pilots of the scheme have yet to conclude.

The funding will see the project through from this autumn until April 2013, when the NHS Commissioning Board will take responsibility for further rollout of the scheme via CCGs.

Norman Lamb, care and support minister, said the funding would be made available subject to results from the pilot programme involving 60 PCTs, due to conclude this autumn.

But the GPC said that the timing of the announcement showed the Government had already made up its mind, and could undermine CCGs' autonomy to decide whether rolling them out locally would be appropriate.

The pilots involve care plans that set out patients' needs or desired health outcomes, the amount of money in their budget, and how this will be spent.

Budgets are signed off by PCTs, with CCGs due to take on this responsibility from April 2013.

But the proposals have proved controversial, with a DH interim report on the pilots showing patients had been allowed to use NHS funds to buy theatre tickets, frozen meals and complementary therapies.

Dr Peter Swinyard: 'potty' to extend scheme while pilots ongoing

The draft mandate to the NHS Commissioning Board, published in July this year, said 'the Government wants commissioners across the country to offer personal health budgets wherever appropriate'.

Mr Lamb said: 'We want to be on the front foot as the results become known.'

But Dr Chaand Nagpaul, GPC negotiator, warned that the Government was forsaking 'proper assessment' of the pilots and pursuing an 'ideological initiative'. He said: 'The jury is still out. We don't yet know what will work and what won't. In addition, it would be sensible not to pre-empt the wishes of CCGs, who may have their own ideas of how they want personal budgets to work.'

Dr Peter Swinyard, chair of the Family Doctor Association and a GP in Swindon, said: 'It's absolutely potty to run a pilot scheme and not see what it says.'

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Personal budget pilots: what patients bought

Employing carers in the home

Homeopathy

Theatre tickets

AUTONOMY

Board 'won't act as superior'

The NHS Commissioning Board has attempted to allay fears from GP commissioners that it will act as their 'superior' by promising to work in partnership with CCGs.

In its response to the Department of Health's consultation on the NHS Commissioning Board's draft mandate, which closed last week, the board said it would act as a 'national support centre' and 'local commissioning partner' to CCGs.

It said: 'We will recognise the principle of "assumed liberty" for CCGs because we firmly believe that local need and local inequalities should be the spur to action, and that local people should be fully involved in the design of services.'

Senior GP commissioners, who have voiced concerns that the board would impose too much bureaucracy on CCGs, welcomed the response, but urged the board to commit to receiving 360-degree feedback from CCGs.

Dr Michael Dixon, interim president of NHS Clinical Commissioners said: 'We have heard these words before. There needs to be a clear plan about how this mutual respect will be delivered in practice.'

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

CONSTITUTIONS

CCGs urged to consider 'ethics'

Campaign group 38 Degrees is petitioning CCGs across England to amend their constitutions in order to guard against private sector involvement in the NHS.

It hopes CCG boards and GP member practices will use carefully suggested wording drawn up by the organisation's legal team to 'improve their constitutions, giving them a better framework within which to act locally to safeguard the NHS', while at the same time operating within the legal requirements of the Health and Social Care Act.

The group suggests amendments to various areas, including allowing CCGs to consider 'ethical and social factors when making commissioning decisions, in addition to purely economic criteria'.

It also suggests placing 'a stronger emphasis on disclosure and public engagement' strengthening CCGs' commitment to public involvement, and strengthening requirements for transparency 'in terms of what information is placed in the public domain, and how people are informed about how to access it.' It also urges 'a thorough review of conflict of interest instructions to ensure that all possible conflicts are covered by the constitution'.

ENHANCED SERVICES

Enhanced services funding slumps

Spending on enhanced services in England hit its lowest level for four years in 2011/12, new figures show

By Alisdair Stirling

Spending on GP enhanced services in England has fallen to its lowest level for four years, official figures reveal.

Funding for extended hours access also halved last year, according to the latest statistics from the NHS Information Centre.

The figures – published last week in the *Investment in General Practice 2007/08 to 2011/12* report – show that overall, annual investment in general practice rose 0.6%, from £9,789m in 2010/11 to £9,848m last year. The rise was slightly steeper in Scotland – up 0.9% from £741.6m to £747.9m.

But although spending on enhanced services increased in Northern Ireland, Wales and Scotland, in England it fell from a high of £835.3m in 2009/10 to £764.4m in 2011/12 – just £7m above 2007/8 levels of £756.7m.

Local enhanced services (LES) funding in England was hardest hit, with funding falling from a peak of £336m in 2009/10 to £269.6m in 2011/12.

The figures confirm findings from a Pulse investigation earlier this month that showed cuts in LES funding of nearly 50% in some areas as managers continue to tighten the screws on GP funding.

On extended hours, last week's report showed funding crashed from £75.6m in 2010/11 to £37.5m during 2011/12.

Funding for extended hours halved last year

Directed enhanced services (DES) payments for extended hours were cut from £3.01 to £1.90 per patient in 2011, and as Pulse reported in May this year, PCTs have been inserting clauses in LESs to allow them to reclaim funding for unfilled appointments.

The report also showed funding for PCTMS and APMS has continued to rise, reaching £462.5m – its highest level for five years.

Premises funding also continued to rise and reached a five-year peak of £661.7m last year, according to the report.

GPC negotiator Dr Chaand Nagpaul said the situation was 'very regrettable'.

He said: 'PCTs winding down, the QIPP agenda and the financial challenges the NHS faces are all having an impact. This matches feedback we're getting from GPs on the ground.

'It's also likely to be counter-productive. We know that investment via enhanced services is key to delivering the cost efficiencies the Government wants to see. If anything, we need to be seeing far greater investment in these.

'It illustrates the short-termism that's plagued PCT thinking recently. I just hope CCGs [will take] a more mature approach to investment in GP enhanced services.'

Dr Thomas Reichelm, a GP in West Malling in Kent, said: 'In my area, we have next to no enhanced services now. It really gets my goat. We're an easy touch to coerce and threaten.

'It's all to make up for the constant failure to claw money back from secondary care.'

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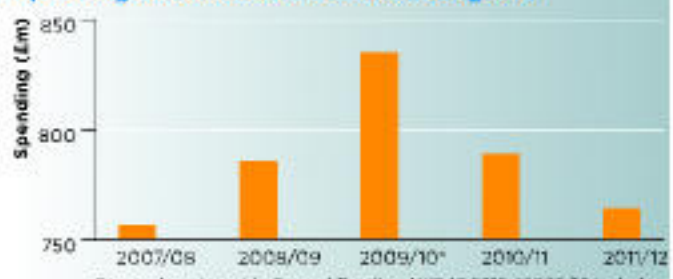
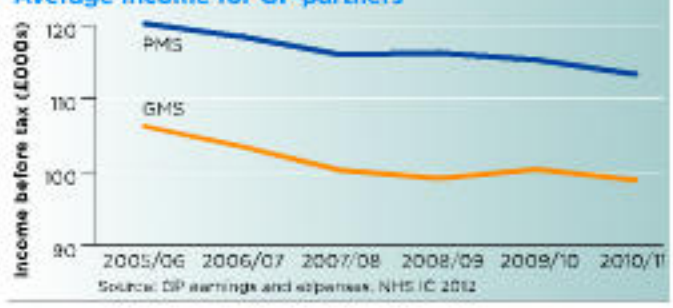
How funding has fallen

Spending on enhanced services in England



Source: Investment in General Practice, NHS IC 2012. *2009/10 includes £600,000 for long term conditions care plans.

Average income for GP partners



Source: GP earnings and expenses, NHS IC 2012

GP INCOME

Expenses take toll on earnings

Soaring practice expenses have taken a further toll on GP earnings, with GP partners' income falling by an average of 1.5% in 2010/11, figures show.

Data from the NHS Information Centre's *GP Earnings and Expenses* report for 2010/11 show that partners' income fell to an average of £104,100 – bringing GP pay to £6,000 less than its peak level six years ago, a year after the new contract was introduced – while income for GMS GPs dipped into five figures.

GMS partners earned an average of £99,000, down 1.3% from £100,400 in 2009/10, while PMS GPs earned an average of £113,400, down 1.6%.

Overall, average gross earnings rose 1.5%, from £262,700 in 2009/10 to £266,500 last year, but total expenses rose by 3.5% from £156,900 to £162,400. This drove the expenses-to-earnings ratio – the proportion of gross earnings taken up by expenses up 1.2 percentage points to 60.9%, a record since the new contract in 2004.

Average income before tax for salaried GPs decreased by 0.7% between 2009/10 and 2010/11, from £58,000 to £57,600.

GPs in England had the highest average income of £107,700, compared with £89,300 in Scotland, £92,300 in Wales and £88,000 in Northern Ireland.

Regional breakdowns in England showed GPs in the south-west of the country had the lowest income before tax – an average of £93,200 – and the highest earnings to expenses ratio at 64.2%.

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first licenced ✓ *guaranteed quality* ✓ *cost effective* ✓ *no chalky taste* ✓ *variable dosage* ✓ *gelatin halal certified* ✓

Fultium®-D_3

Colecalciferol 800IU (equivalent to 20 micrograms vitamin D3)

Fultium-D_3 800 IU Capsules
Abbreviated Prescribing Information
Please refer to the Summary of Product Characteristics (SmPC) before prescribing Fultium-D_3

Fultium-D_3 capsules: Each capsule contains colecalciferol 800 IU equivalent to 20 micrograms vitamin D_3. Also contains 124.5 mg arachis oil (peanut oil).

Indication: The prevention and treatment of vitamin D deficiency. As an adjunct to specific therapy for osteoporosis in patients with vitamin D deficiency or at risk of vitamin D insufficiency.

Dosage and administration: Vitamin D deficiency in adults and the elderly (serum levels <25nmol/l (<10ng/ml)) 1-4 capsules (800-3200IU) daily for up to 12 weeks dependent upon the severity of the disease and the patients response to treatment.

Vitamin D insufficiency in adults and the elderly (serum levels 25-50nmol/l (10-20 ng/ml) AND Long term maintenance therapy following treatment of deficiency AND Prevention of deficiency 1-2 capsules (800-1600IU) daily.

As an adjunct to specific therapy for osteoporosis 1 capsule daily.

Vitamin D deficiency or insufficiency in children over 12 years 1 capsule daily depending on the severity of the disease and the patient's response to treatment. Should only be given under medical supervision.

Fultium-D_3 should not be used by children under 12 years.

The capsules should be swallowed whole (not chewed) with water.

Contraindications: Hypersensitivity to vitamin D or any of the excipients in the product; peanut or soya allergy; hypervitaminosis D; nephrolithiasis; diseases or conditions resulting in hypercalcaemia and / or hypercalciuria; severe renal impairment.

Warnings and Precautions: Vitamin D should be used with caution in patients with impairment of renal function or sarcoidosis and the effect on calcium and phosphate levels should be monitored. In patients with severe renal insufficiency, vitamin D in the form of colecalciferol is not metabolised normally and other forms of vitamin D should be used. Close monitoring of calcium levels should be carried out under medical supervision. Caution is required in patients receiving treatment for cardiovascular disease. Consider vitamin D supplementation from other sources. Contains arachis oil (peanut oil).

Interactions: Concomitant treatment with phenytoin, barbiturates and glucocorticoids can decrease the effect of vitamin D.

Interactions have also been seen with digitalis and other glycosides, ion exchange resins, laxatives such as paraffin and cytotoxic agents.

Pregnancy and lactation: There are no or limited amounts of data for the use of Fultium-D_3 in pregnancy and lactation. Vitamin D is excreted in breast milk. It should therefore only be used under medical supervision.

Effects on ability to drive and use machines: Fultium-D_3 has no influence on the ability to drive and use machines.

Undesirable effects: Allergic reactions are possible. Uncommon disorders include metabolic and nutrition disorders; hypercalcaemia and hypercalciuria; skin and subcutaneous disorders.

Overdose: Refer to SmPC.
Legal Category: POM
Pack size: 30 capsules
NHS Price: £3.60
MA Number: 17871 / 0151

MA Holder: Jenson Pharmaceutical Services Ltd, Carradine House, 237 Regents Park Road, London N3 3LF, UK.
Full Prescribing Information available from Internis Pharmaceuticals Ltd, Carradine House, 237 Regents Park Road, London N3 3LF, UK.

Adverse events should be reported. Reporting forms and information can be found at http://yellowcard.mhra.gov.uk/ Adverse events should also be reported to Jenson on 01271 334 609.

Date of preparation: August 2012
Unique ID No: FUL-ADV-0050

internis.

With a long-term record of success in reducing symptoms, exacerbations and hospitalisations vs placebo, SPIRIVA® is a LAMA you can count on to help lead your COPD patients to everyday victories.[1,2]

LAMA = long-acting muscarinic antagonist.

References: 1. SPIRIVA® 18 µg Summary of Product Characteristics. http://medicines.org.uk/emc. Accessed August 2012. 2. Tashkin DP *et al.* for the UPLIFT Study Investigators. A 4-year trial of tiotropium in chronic obstructive pulmonary disease. *N Engl J Med* 2008;359:1543–1554.

Prescribing Information (UK) SPIRIVA® (tiotropium) Inhalation powder, hard capsules containing 18 microgram tiotropium (as bromide monohydrate). **Indication:** Tiotropium is indicated as a maintenance bronchodilator treatment to relieve symptoms of patients with chronic obstructive pulmonary disease (COPD). **Dose and Administration:** Adults only age 18 years or over: Inhalation of the contents of one capsule once daily from the HandiHaler® device. **Contraindications:** Hypersensitivity to tiotropium bromide, atropine or its derivatives, or to the excipient lactose monohydrate which contains milk protein. **Warnings and Precautions:** Not for the initial treatment of acute episodes of bronchospasm, i.e. rescue therapy. Immediate hypersensitivity reactions may occur after administration of tiotropium bromide inhalation powder. Caution in patients with narrow-angle glaucoma, prostatic hyperplasia or bladder-neck obstruction. Inhaled medicines may cause inhalation-induced bronchospasm. In patients with moderate to severe renal impairment (creatinine clearance ≤ 50 ml/min) tiotropium bromide should be used only if the expected benefit outweighs the potential risk. Patients should be cautioned to avoid getting the drug powder into their eyes. They should be advised that this may result in precipitation or worsening of narrow-angle glaucoma, eye pain or discomfort, temporary blurring of vision, visual halos or coloured images in association with red eyes from conjunctival congestion and corneal oedema. Should any combination of these eye symptoms develop, patients should stop using tiotropium bromide and consult a specialist immediately. Tiotropium bromide should not be used more frequently than once a day. Spiriva capsules contain 5.5 mg lactose monohydrate. **Interactions:** Although no formal drug interaction studies have been performed, tiotropium bromide inhalation powder has been used concomitantly with other drugs without clinical evidence of drug interactions. These include sympathomimetic bronchodilators, methylxanthines, oral and inhaled steroids, commonly used in the treatment of COPD. The co-administration of tiotropium bromide with other anticholinergic-containing drugs has not been studied and is therefore not recommended. **Fertility, Pregnancy and Lactation:** No documented clinical data on exposed pregnancies are available. The potential risk for humans is unknown. Tiotropium bromide should therefore only be used during pregnancy when clearly indicated. It is unknown whether tiotropium bromide is excreted in human breast milk. Use of tiotropium bromide during breast feeding is not recommended. A decision on whether to continue or discontinue breast feeding or therapy with tiotropium bromide should be made taking into account the benefit of breast feeding to the child and the benefit of tiotropium bromide therapy to the woman. Clinical data on fertility are not available for tiotropium. **Effects on ability to drive and use machines:** No studies have been performed. The occurrence of dizziness, blurred vision, or headache may influence the ability to drive and use machinery. **Undesirable effects:** Common (≥ 1/100 to <1/10) Dry mouth. Uncommon (≥ 1/1000 to <1/100) Dizziness, headache, taste disorders, vision blurred, atrial fibrillation, pharyngitis, dysphonia, cough, gastrooesophageal reflux disease, constipation, oropharyngeal candidiasis, rash, dysuria, urinary retention. Serious undesirable effects consistent with anticholinergic effects include glaucoma, constipation and intestinal obstruction including ileus paralytic as well as urinary retention. An increase in anticholinergic effects may occur with increasing age. Prescribers should consult the Summary of Product Characteristics for further information on side effects. **Pack sizes and NHS price:** Combopack HandiHaler device and 30 capsules (3 blister strips) £34.87 Refill Pack 30 capsules (3 blister strips) £33.50. **Legal category:** POM. **MA Number:** PL 14598/0062. **Marketing Authorisation Holder:** Boehringer Ingelheim International GmbH, D-55216 Ingelheim am Rhein, Germany. Prescribers should consult the Summary of Product Characteristics for full prescribing information. **Prepared in** August 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 Boehringer Ingelheim Drug Safety on 0800 328 1627 (freephone).

Date of preparation: August 2012 UK/SPI-121330

SPIRIVA®
(tiotropium)
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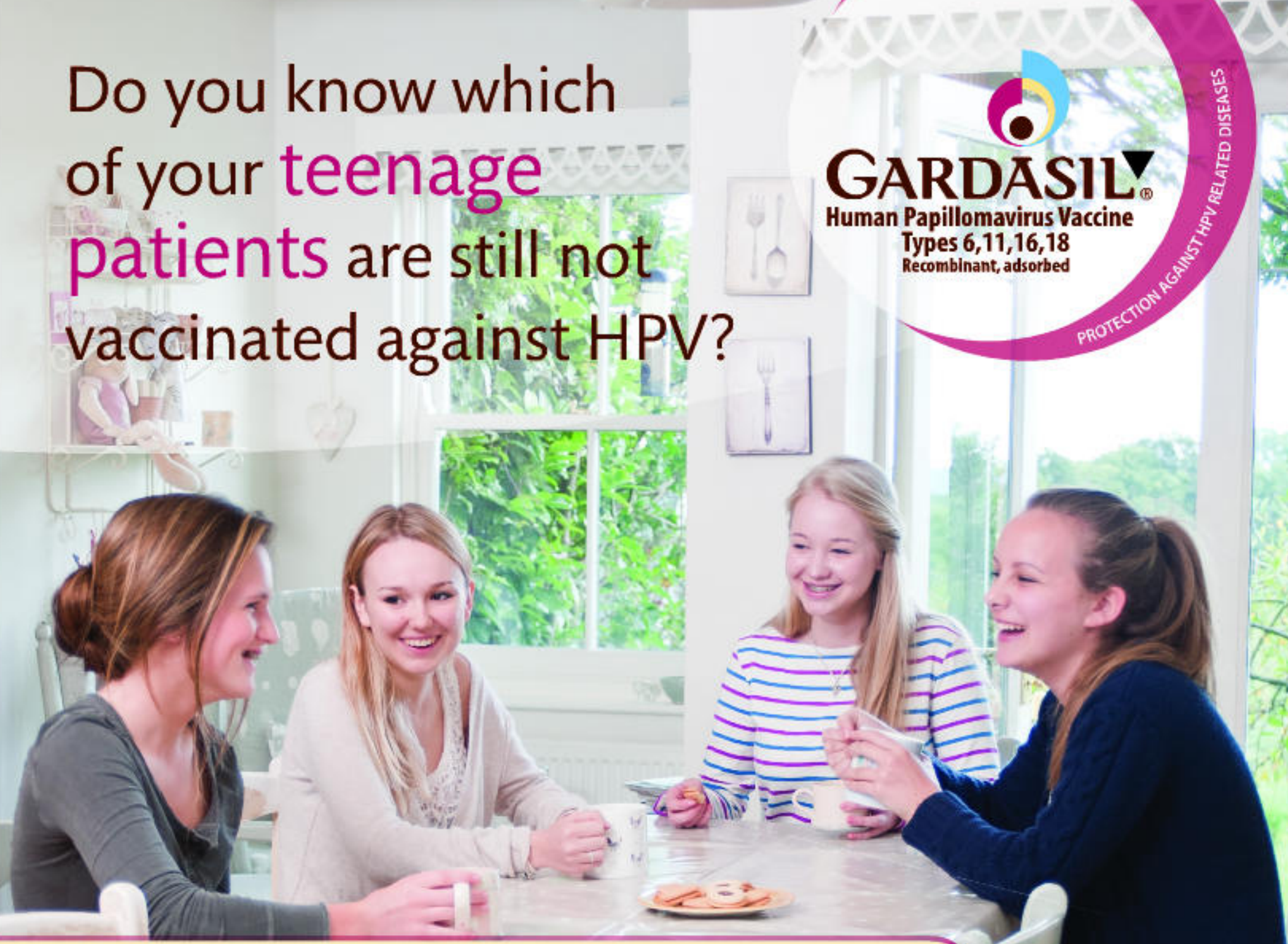
Do you know which of your teenage patients are still not vaccinated against HPV?

GARDASIL®
Human Papillomavirus Vaccine
Types 6,11,16,18
Recombinant, adsorbed

PROTECTION AGAINST HPV RELATED DISEASES



In 2010/11, over 10% of eligible girls did not start their course of HPV vaccination.[1]

You have an opportunity to change this. Gardasil® is available at no cost for GP practices through Movianto UK Ltd, for all previously unvaccinated girls aged 12-17.

Identify them, then help protect them.

For further information, contact your local Sanofi Pasteur MSD representative or visit www.gardasil.co.uk

ABRIDGED PRESCRIBING INFORMATION

GARDASIL® (Human Papillomavirus Vaccine [Types 6, 11, 16, 18] (Recombinant, adsorbed)).

Refer to Summary of Product Characteristics for full product information.

Presentation: Gardasil is supplied as a single dose pre-filled syringe containing 0.5 millilitre of suspension. Each dose of the quadrivalent vaccine contains highly purified virus-like particles (VLPs) of the major capsid L1 protein of Human Papillomavirus (HPV). These are type 6 (20 µg), type 11 (40 µg), type 16 (40 µg) and type 18 (20 µg). **Indications:** Gardasil is a vaccine for use from the age of 9 years for the prevention of premalignant genital lesions (cervical, vulvar and vaginal) and cervical cancer causally related to certain oncogenic Human Papillomavirus (HPV) types and genital warts (condyloma acuminata) causally related to specific HPV types. The indication is based on the demonstration of efficacy of Gardasil in females 16 to 45 years of age and in males 16 to 26 years of age and on the demonstration of immunogenicity of Gardasil in 9- to 15-year old children and adolescents. **Dosage and administration:** The primary vaccination series consists of 3 separate 0.5 millilitre doses administered according to the following schedule: 0, 2, 6 months. If an alternate schedule is necessary the second dose should be administered at least one month after the first and the third dose at least three months after the second. All three doses should be given within a 1 year period. The need for a booster dose has not been established. The vaccine should be administered by intramuscular injection. **Contraindications:** Hypersensitivity to any component of the vaccine. Hypersensitivity after previous administration of Gardasil. Acute severe febrile illness. **Warnings and precautions:** The decision to vaccinate an individual should take into account the risk for previous HPV exposure and potential benefit from vaccination. As with all vaccines, appropriate medical treatment should always be available in case of rare anaphylactic reactions. The vaccine should be given with caution to individuals with thrombocytopenia or any coagulation disorder because bleeding may occur following an intramuscular administration in these individuals. Syncope, sometimes associated with falling, has occurred after vaccination with Gardasil; vaccinees should be carefully observed for approximately 15 minutes after vaccination. There is insufficient data to recommend use of Gardasil during pregnancy therefore the vaccination should be postponed until after completion of the pregnancy. The vaccine can be given to breastfeeding women. Gardasil will only protect against diseases that are caused by HPV types 6, 11, 16 and 18 and to some limited extent against diseases caused by certain related HPV types. Vaccination is not a substitute for routine cervical screening. Individuals with impaired immune responsiveness, due to either the use of potent immunosuppressive therapy, a genetic defect, or other causes, may not respond to the vaccine. As with any vaccine, vaccination with Gardasil may not result in protection in all vaccine recipients. There are no safety, immunogenicity or efficacy data to support interchangeability of Gardasil with other HPV vaccines. **Undesirable effects:** Very common side effects include: headache and at the injection site, erythema, pain and swelling. Common side effects include bruising and pruritus at the injection site, pyrexia, nausea, and pain in the extremity. Rarely urticaria and very rarely bronchospasm has been reported. Idiopathic thrombocytopenic purpura, Guillain-Barré Syndrome and hypersensitivity reactions including, anaphylactic/anaphylactoid reactions have also been reported. For a complete list of undesirable effects please refer to the Summary of Product Characteristics. **Package quantities and basic NHS cost:** Single pack containing one 0.5 millilitre dose pre-filled syringe with two separate needles. **NHS cost:** £86.50 per dose. **Marketing authorisation holder:** Sanofi Pasteur MSD SNC, 8 rue Jonas Salk, F-69007, Lyon, France **Marketing authorisation number:** EU/1/06/357/007 (pre-filled syringe with two separate needles) **Legal category:** POM ® Registered trademark **Date of last review:** May 2012

References: 1. Department of Health, Third Annual Report on HPV coverage. http://immunisation.dh.gov.uk/annual-hpv-vaccine-coverage-in-england-in-201011-report/ Date accessed August 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.

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UK15592 a 08/12

GPs forced to switch software

Hundreds of practices across the UK must look for new IT systems provider after CSC drops iSoft products

By Alisdair Stirling

Hundreds of practices across the UK must search for a new IT supplier after CSC confirmed it is dropping its iSoft products Synergy, Premiere and Ganymede from the UK primary care market.

CSC said it would support GP practices in England and Northern Ireland until the end of October next year and practices in Wales until March 2014.

Some 582 GP practices in the UK use the software – 467 in England and 115 in Northern Ireland and Wales.

GP leaders described the announcement as 'a disaster' and warned practices would have to plan switching to a new system around QOF returns.

A company statement said: 'CSC remains fully committed to the primary care marketplace.

'Following an in-depth review of our strategy for this area of our healthcare business we have concluded that we will not support a small number of former iSOFT products we provide. We believe this decision is in the best long-term interests of our customers. We will of course be continuing to support these GP practices through the transition for at least another 12 months.'

Dr Paul Cundy, chair of the GPC's IT subcommittee and a GP in Wimbledon, south London, said: 'I'm a Synergy user and it's a disaster as I'd be surprised if any other system can match the functionality. It's the most complex of the systems and when we looked at changing four years ago we thought it was the best.

'Because of the QOF, practices should consider migrating either before December or after April next year, remembering it takes 18 months to fully bed into a new system assuming everything's straightforward.

'In terms of GP IT in general, it's disappointing because it means the market is contracting, which results in less incentive to innovate.

'The GPC's advice would be: don't panic, make sure you have a look at all the available systems and consider the impact on third-party applications. I don't want to hear of a single GP being coerced into one system or another by their PCT or CCG.'

Dr Grant Ingrams, a GP in Coventry and former GPC IT subcommittee chair, said the migration would be 'a headache'.

'Migrating causes huge upheaval,' he said. 'There's normally a delay of a day or two in switching over from one system to another. No two systems are completely intra-operable. So you can lose some data quality.'

@pulsetoday

Dr Paul Cundy: decision 'a disaster' for Synergy users

What to watch out for when migrating system

- **Reactivation of archived prescriptions**
- **Mapping errors resulting in different unrelated medications being linked, such as quinine/Quinidine**
- **Issues with preservation of units of measure caused by different systems' interpretation of decimal points**

Source: The Good Practice Guidelines for GP Electronic Patient Records Version 4 2011, Department of Health

RCGP targets safe prescribing

The RCGP is set to add modules to the GP curriculum to improve safe prescribing in the wake of the recent PRACTICE study that found errors or omissions in one prescription in 20.

As a result of the report, published in May, the college hopes to add five 30-minute modules on safe prescribing. These will focus on tackling why some patients end up with the wrong dosage of drugs or miss timely prescription reviews.

The modules that are expected to go live next August have been developed by the college in collaboration with Professor Tony Avery, one of the lead researchers in the PRACTICE study and professor of primary healthcare at the University of Nottingham. The plans are subject to RCGP Council and GMC approval, and will require the securing of £50,000 to develop new course material.

The proposals could also include dedicating more time to prescribing during training at practices – with a GP's trainer potentially monitoring their first 100 prescriptions, to look for risk patterns.

Professor Avery said: 'Prescribing drugs offers a fantastic opportunity to help manage disease but we are also aware that sometimes things go wrong, or we make mistakes, so we want to do what we can to understand the underlying causes.'

LMC draws up 'pricing basket' for dumped work

GPs 'irritated' by the increasing amount of secondary care work being dumped on primary care are developing a 'pricing basket' to present to PCTs to ensure the work is funded.

Dr Paul Roblin, chief executive of Buckinghamshire, Oxfordshire and Berkshire LMCs, said GPs in the Thames Valley area were 'universally irritated' by increasing requests 'bounced' to GPs from secondary care, and as a result had initiated plans to draw up a LES, with a menu of options to fund this work.

He said GPs were receiving requests concerning patients with eating disorders or ADHD referred through child and adolescent mental health services. They were being asked to take weekly pulses, lying and standing blood pressures and blood tests, and to send the results back to secondary care.

Dr Roblin said: 'It was like they wanted a hospital at home to prevent acute admissions. Some GPs comply but others say "No, we're not doing it, it's your job." When we bring it up with the PCT they tend to go quiet and act like solving this is in the "too difficult to do" pile.'

Minutes from Buckinghamshire LMC's September meeting said: 'Many representatives felt that those prescribing drugs should be able to perform and assess the results of physical checks required.'

Test your knowledge of skin tumours with our picture quiz
▶ page 33

The report backed routine screening for alcohol misuse

Alcohol screening for all 'cost-effective'

Screening at next visit would capture more patients over 10 years

By Julia Gregory

Screening every patient for alcohol misuse the next time they visited their GP would be cost-effective compared with current arrangements but would require substantial 'front-loaded' investment, according to research.

Researchers said that although current arrangements under the alcohol screening DES were cost-effective and would screen about 40% of the population in England over 10 years, 96% could be captured in the same period if they were screened next time they visited their GP.

At present, the £8m clinical DES, of which £4.1m was taken up last year, requires practices to screen newly registered patients aged 16 and over. But the Commons public accounts committee has been critical because it only applies to new patients instead of applying to all.

Researchers at the University of Sheffield examined the cost-effectiveness of the current system and an alternative model that would screen patients next time they visited their GP.

The study, published in the journal *Alcohol and Alcoholism*, concluded the current system was on track to deliver 'modest cost savings' of £120m over 30 years.

The study considered a range of alternative models for a next-consultation strategy. It found that the model offering the greatest health gains – using the split-threshold AUDIT screening tool – had the largest programme costs of the options considered (£702m over current practice) but remained cost effective under the NICE framework (at £7,625 per quality-adjusted life year gained).

But because people see their GPs much more often than they register with a new one, the system would need substantial frontloading to fund the 3.5 million screens due in the first year.

The research is the first appraisal of screening and brief interventions (SBI) in the UK and follows similar research in the US and the Netherlands.

The strategies compared

Next-registration strategy
- Currently used in DES
- Predictable volumes: 2.5 million a year
- £95m cost over 10 years outweighed by long-term saving on NHS costs of £215m
- Some 26 million people not screened at 10 years

Next-consultation strategy
- Large-scale implementation
- 35 million screens would be done in first year but fewer after
- £475m cost at 10 years but NHS savings of £682m
- Only 1.5 million not screened after 10 years

The authors said: 'Our model suggests that opportunistically screening patients on next GP consultation would be cost-effective compared with current DES guidance, but this must be balanced against the challenge of implementing on such a scale.'

But they admitted: 'A policy of [screening] at next GP consultation is a very-large scale implementation, with front-loaded resourcing needs, delivering interventions to almost 80% of hazardous and harmful drinkers over 10 years.'

Dr Phil Brooks, a locum GP in Newcastle, was sceptical about extending the screening. He said: 'The population knows how much it should drink. If you screen someone it implies you can do something about it.'

He added: 'People know that they are drinking too much.'

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

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* The need for a second dose is currently unknown

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Anxiety in elderly could be first sign of dementia

DEMENTIA

Threefold risk of dementia with anxiety

By David Swan

Patients diagnosed with anxiety have an almost three times greater risk of developing dementia and it is a stronger risk factor than both depression and cerebrovascular disease, according to a UK primary care study.

The study's authors suggest older patients could be presenting with anxiety which is caused by their first experiences of cognitive impairment.

Primary care researchers at Keele University in Staffordshire used the Consultations in Primary Care Archive to identify 400 cases of dementia and matched them to 1,353 controls without dementia.

After adjusting for various risk factors, a previous diagnosis of anxiety was independently associated with an almost threefold increase in risk of later dementia (odds ratio 2.7), compared with patients with no diagnosis of dementia.

This was higher than the increases in risk associated with cerebrovascular disease (OR 2.2) and a prior depression diagnosis (OR 1.54), although a diagnosis of depression and anxiety was associated with the highest risk of all (OR 2.9). Cerebrovascular disease is a well known risk factor for the development of dementia and previous research has suggested a diagnosis of depression is also a risk factor.

But this is the first study to look in detail at an association between anxiety and dementia, while adjusting for a diagnosis of depression. It is also the first to suggest anxiety is such a strong risk factor.

NICE guidelines on dementia mention vascular risk factors, but not mental health disorders as being risk factors.

The SIGN guideline on dementia states that 'the presence of comorbid depression' should be considered as part of an assessment for suspected dementia, but does not include anxiety in its recommendations.

Study lead Dr Claire Burton, a GP and research fellow at the department of primary care and health sciences at Keele University, says: 'It seems reasonable to postulate that – as with depression – patients may present with anxiety symptoms as a direct cause of the insight they have into their early experiences of cognitive impairment.

'One possible course of action would be to include a screen for cognitive impairment in the routine follow-up of older patients with anxiety and depression and incorporate this in the QOF.'

Dr Kate Thomas, a GPSI in mental health in Glasgow who runs a community memory clinic, said: 'This suggestion of a stronger association with anxiety is important to know and it's certainly reasonable to use the MMSE in older patients presenting with anxiety.'

***Family Practice* 2012, online 17 September**

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Risk factors

Increased risk of future dementia diagnosis

Anxiety	x2.7
Cerebrovascular disease	x2.2
Depression	x1.5

Could anxiety be an early sign of cognitive impairment?

DIABETES

Dipsticks 'could miss microalbuminuria'

Dipstick testing is not a reliable method of identifying microalbuminuria in patients with type 2 diabetes, according to UK research.

The sensitivity of the Micral-Test, one of the two urine dipstick tests used in the study, was high, at 91.7% compared with a single laboratory albumin-creatinine ratio (ACR) measurement derived from the same urine sample. However specificity was low at 44%.

Microalbustix had a sensitivity of 33.3% when compared with an ACR measurement, but had a higher specificity of 92%.

Although testing costs would be reduced by using these dipstick tests rather than ACR, neither could reliably detect microalbuminuria, the authors said.

The data was collected from four practices in Oxford over six weeks. Each of the 98 participants made four visits to their local surgery at two-weekly intervals, giving a urine sample on each occasion.

The single laboratory ACR measurements taken for comparison to dipstick testing were based on NICE thresholds for microalbuminuria.

***Family Practice* 2012, available online 17 September**

CANCER

Bisphosphonates 'not a cancer risk'

Bisphosphonates are not associated with an increased risk of cancer, according to research conducted on a UK primary care population.

Researchers used the UK General Practice Research Database to identify 41,826 bisphosphonate users aged 40 and 46,036 matched controls.

Although previous studies have observed an increased risk of breast, colorectal and oesophageal cancers in long-term bisphosphonate users, in this study they were significantly less likely to develop cancer compared with non-users – a 13% overall decrease in risk.

There was also a significant 24% decrease in risk for developing colorectal cancer compared with non-users.

Women were 29% less likely to develop breast cancer when compared with non-users, a significant decrease. Ovarian and endometrial cancers were also associated with significant reductions, but this data only featured small numbers of bisphosphonate cases.

Study lead Dr Chris Caldwell, lecturer at Queen's University in Belfast, said: 'Our findings indicate that bisphosphonates do not appear to increase cancer risk, although it is unclear to what extent confounding by low bone density may explain the association between bisphosphonates and reductions in breast and colorectal cancer incidence.'

***International Journal of Cancer* 2012, online 1 September**

BACK PAIN

Spinal manipulation benefits limited

Spinal manipulation is no more effective than other interventions, such as physiotherapy or exercise, in treating acute low back pain, according to a new Cochrane review.

Pain at one month was 0.2 points lower on the visual analogue scale for spinal manipulation compared with other interventions, but this was not a clinically relevant effect.

Functional status at one week, as measured by a questionnaire, was a clinically irrelevant 0.07 points higher in the spinal manipulation participants than those who underwent other interventions.

At one month, spinal manipulation was associated with a 0.1 point improvement in functional status, but again the effect was not clinically relevant.

The review looked at 16 randomised controlled trials with a total of 2,674 patients aged 18 or over. All had acute low back pain of less than six weeks' duration.

The technique was also compared to a sham technique of non-targeted manipulation – and no significant difference in outcomes was seen.

Study lead Dr Sidney Rubinstein, a senior researcher at the Institute for Health and Care Research at the University of Amsterdam, said: 'No strong recommendations can be made for the use of spinal manipulation for acute low back pain.'

Cochrane 2012, online 12 September

DEMENTIA

Medication has no role in mild memory loss

Cholinesterase inhibitors do not have a role in reducing the risk of dementia developing in patients with mild cognitive impairment, a Cochrane review has concluded.

The review included eight randomised controlled trials involving 5,149 patients with mild cognitive impairment.

Donepezil, galantamine or rivastigmine reduced the risk of a patient developing dementia by 31% at one year compared with patients on placebo, but this was not a significant effect. This dropped to a 16% decrease at three years. There was a 33% decrease in risk at two years, a significant effect, but based on just two studies in the same report.

There was evidence of a significant 9% increase in risk for adverse events in those on cholinesterase inhibitors compared with placebo.

Study lead Dr Tom Russ, clinical research fellow for the Scottish Dementia Clinical Research Network, said there was no basis for prescribing the drugs for patients with memory complaints 'who do not meet the diagnostic criteria for dementia'.

The Cochrane Library 2012, online 12 September

GUIDANCE ROUND-UP

Daily aspirin to cut pre-eclampsia risk

Pregnant women at high-risk of pre-eclampsia should be offered 75mg of aspirin daily to be taken from 12 weeks until at least 36 weeks.
The NICE quality standard for antenatal care also states commissioners should put such systems in place.
The standard also recommends pregnant women at risk of venous thromboembolism receive specialist advice.

NICE quality standard for antenatal care, 2012

Two-week rule for epilepsy seizures

Adults with epilepsy that present with a first unprovoked seizure should be seen by a specialist within two weeks, according to a NICE quality standard on epilepsy, currently in consultation.
It also advises that any adult requiring neuro-imaging should have an MRI and that the patient should know the results within four weeks of the test being requested.

NICE quality standard for epilepsies

Antibiotics use in throat infections

Throat infections should not be treated with antibiotics, according to US guidelines.
Bacteria have been found to be responsible for only 20-30% of sore throats in children, and 5-10% in adults.

Infectious Disease Society of America 2012

CPD TIP OF THE WEEK

Checking testosterone in erectile dysfunction

Checking testosterone levels in every man with erectile dysfunction may not yet be standard practice in primary care – but it's worth doing in men who don't respond to an initial trial of a PDE-5 inhibitor, say the authors of a recent case-based learning module.
Low testosterone is a common cause of failure of PDE-5 inhibitors so it's worth checking in these patients. The module states this is particularly true for diabetic patients, where levels are often low – 50% may have a poor response to PDE-5 inhibitor.
The module – Hot topics in men's health – also covers other aspects of ED management as well as late-onset hypogonadism and premature ejaculation.

ONLINE CPD
Hot topics in men's health
www.pulse-learning.co.uk

New series: Primary care urology
Managing haematuria
▶ page 37

BNP could improve CVD risk tools

UK research suggests adding BNP testing to risk calculations could predict many more CV events

By Emma Wilkinson

Adding a BNP test to currently available risk calculators could significantly boost the accuracy of cardiovascular disease risk calculators, suggests a large Scottish study.

The researchers measured NT-proBNP levels in the serum samples from the pivotal West of Scotland Coronary Prevention Study (WOSCOPS), which tracked cardiovascular events in 4,800 middle-aged men for 15 years and first reported in 1995.

Patients taking part in the study had high cholesterol and had been classified as having a moderate risk using a standard risk calculator, and 1,690 had a cardiovascular event during follow-up.

After adjusting for classical and clinical cardiovascular risk factors and the risk of non-CVD death, elevated NT-proBNP levels were associated with a 17% increased risk of a CV event. It was more likely to predict fatal than non-fatal events.

The researchers compared this marker to C-reactive protein – also suggested as a possible addition to CVD risk calculators – and found that adding BNP was twice as good at accurately predicting cardiovascular risk than CRP.

The analysis showed that adding BNP to traditional risk calculators produced incremental gains in prediction of 19.8% compared with 9.8% with the addition of CRP.

Research suggests BNP is a more accurate predictor of CVD than cholesterol

How new markers impact on the accuracy of Framingham*

	Men with no CVD(%)	Men with CVD(%)
NT-proBNP	+8.8	+8.2
CRP	+3.8	+0.6

*Net percentage reclassification improvement when added to Framingham data
Source: Saver P. Strategies to get useful biomarkers in CV disease. European Society of Hypertension 2012. Plenary session. 29 April 2012.

Study leader Dr Paul Welsh, research associate at the University of Glasgow Institute of Cardiovascular and Medical Sciences, said: 'NT-proBNP predicts CV events in middle-aged men without clinical evidence of CHD, angina or history of stroke.

'In fact there is evidence – again from predominantly male cohorts – that NT-proBNP predicts risk better than cholesterol. But large population studies are now needed in men and women to calculate if the improved accuracy has enough of a clinical impact to justify the extra cost of testing.'

Dr Matt Hughes, a GP in Cardiff and a hospital practitioner in cardiology, said: 'Although it's not surprising that NT-proBNP predicts CV risk, these results warrant larger-scale studies, especially after data earlier this year which showed adding it to Framingham improved the accuracy of the calculator by almost 9% in hypertensive men without CVD' (see box, left).

But Dr John Robson, GP and cardiovascular lead for NHS Tower Hamlets, said: 'It's an interesting study but we know CRP doesn't add anything to existing models so we'll have to see how this performs when validated in an independent cohort.'

***European Heart Journal* online 20 September**

@pulsetoday

Make failing hospitals private, says think tank

Private companies should be allowed to bid to run up to 30 NHS hospitals, 21 of which of the Department of Health has already classified as 'clinically and financially unsustainable', according to influential health policy think tank Reform.

Takeover: tackling failing NHS hospitals argues the Government's current policy of merging between failing NHS hospitals will not work.

The report, by Professor Paul Corrigan, former health adviser to Tony Blair and now a management consultant, calls for private companies and the best NHS hospitals to take over troubled hospitals because, he argued, it is the surest way to turn them around. 'Supporting mergers between unsuccessful NHS hospitals because you cannot find anything else to do with them is not going to suddenly make mergers a successful method of improving failing hospitals,' he said.

The report added that forcing underperforming hospitals to merge with other underperforming hospitals would fail because it creates larger underperforming hospitals.

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- ✔ As add-on to metformin and SU
- ✔ As add-on to thiazolidinedione (TZD)
- ✔ As add-on to metformin and TZD
- ✔ Added on to insulin +/- metformin

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

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The hard truth about the fall in GP funding

Steve Nowottny
Editor

Put down the *Daily Mail*. Ignore your complaining colleagues. If you really want an accurate picture of practice funding and GP pay, you need to read *Investment in General Practice 2007/8 to 2011/12* and *GP Earnings and Expenses 2010/11*.

These two sober, considered reports from the NHS Information Centre, numbering 104 pages between them, offer an analysis of GP funding which is about as authoritative as they come, albeit one with a slight time lag.

Subject to rigorous scrutiny by the Technical Steering Committee, with representation from the four UK departments of health, NHS Employers and the BMA, the reports cover everything from the global sum to enhanced services, partner income to salaried GP pay, and compare trends with previous years. Pretty much without exception, the arrows point in one direction.

It's important not to overstate the case. GPs are much better rewarded for a difficult job than they were in generations past. Some 200 lucky partners reported a before-tax income of more than £250,000 in 2010/11. But since a 2005/6 peak, the generous provision of the new GMS contract has been systematically eroded year on year.

Our story this week revealing how practices are having to chase around *Mary Celeste* PCTs to recoup enhanced services cash will resonate with many. But it is the inexorable rise in expenses that in the long term is likely to prove more significant – and will, despite GPs' best intentions, have the greatest impact on patients. In our feature on small practice funding (page 44), Essex GP Dr John Cormack, who has claimed he runs the NHS's worst-funded practice, puts it bluntly: 'In 30 years in general practice I've never found it more difficult to provide even a basic service to my patients.'

One crucial figure buried in the reams of Information Centre data is the arcane 'earnings-to-expenses ratio' – the proportion of gross earnings taken up by expenses. In 2010/11 this rose to 60.9%, a record since the new contract. It has no doubt climbed again since. The blithe assumption behind successive pay freezes has been that GPs' loyalty to patients will trump small business imperatives – and so far, GPs have consistently proved willing to take the hit in their own pay packets.

But with a new round of contract talks under way, the Department of Health would do well to consider how long that will continue, and how much more general practice can take. In the current environment, a significant uplift in practice funding may be too much to hope for. But at the very least, ministers must properly cover GPs' rising expenses. Whatever fat there was has long since disappeared. It's hard to see how further cuts can be made without hurting patients.

Revalidation costings kept under wraps

Revalidation is top of most GPs' list of current concerns – and after 13 years of planning, starts in just two months. So how much will it cost?

The good news is, the DH probably has a pretty good idea. Work began in 2009 on a revalidation impact assessment, predicting the likely costs of improved appraisals, responsible officers, multi-source feedback, remediation and so on. The bad news is, you're not allowed to see it – or at least, not until after the health secretary has formally given revalidation the green light.

Of course, Pulse has every confidence the impact assessment will show revalidation is entirely affordable and the benefits outweigh any costs, exactly as the GMC insists. But for the time being, you'll just have to take their word for it.

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

PhilPeverley

COLUMNIST OF THE YEAR 2012

Leave me out of the bedroom

Phil is used to helping patients with intimate problems – but there are some things a middle-aged bloke from Hartlepool just doesn't want to know

I've recently had a falling-out with my internal karma sutra coach. Obviously, this has left me in a very difficult position.

As a family GP, I think it a good thing on the whole that my patients can come to me with a wide variety of problems. Several of them trust me to advise on some of their most intimate dilemmas. But let's face facts; I just don't want to bloody well know about their bedroom antics.

One recent patient, a young, confident, professional woman, typifies my concerns. 'I'm alright in most positions, doctor,' she tells me. 'But doing it doggy-style gives me a pain deep inside, about here. What do you think? Do I need a scan?'

'I think you need a fricking modesty transplant,' is what I think, but don't say. Internally, I'm curling up into a foetal position. This is horrible. Why does she think I'm in any position to have an opinion on this? I'm just not equipped to deal with this sort of thing.

I remember quite vividly the course of lectures back in medical school on blood dyscrasias. I can recall embryology and seminars on the limbic system. I feel sure that if we'd had a series of lectures on the ins and outs of rumpy-pumpy, it would have stuck in my mind.

For Christ's sake, I'm a middle-aged working-class bloke from Hartlepool. What do I know about bum sex or threesomes? I only know two positions: socks on or socks off. I am not, by any criteria you care to mention, Dr Ruth.

Another low point was when a pointy-faced, boney-arsed, haggard nightmare of a woman literally dragged her skinny alcoholic beau into my consulting room. 'There's something wrong with him, doctor. He can only last about eight minutes. Can you make him last a bit longer?'

Eight minutes, I thought. What's his secret?

However, instead of congratulating him, I asked his partner to step out of the room for a minute. With a face like a wasp with a grievance, she complied.

I only know two positions: socks on or socks off

The boyfriend and I eyed each other nervously. If this was an episode of *Mad Men*, I'd have offered him a cigarette. 'What's this all about then?' I asked.

'Oh I dunno, doc. She's been reading one of those women's magazine that says we're all supposed to bang away for hours like Sting and his missus. She thinks that everybody does it like that.' We each raise a cynical eyebrow.

'Go out and buy a Ouija board, you and your missus,' I advised him. 'Raise the ghost of Nye Bevan, and ask him whether this is what he meant when he thought up the National Health Service. Then get back to me.'

Dr Phil Peverley is a GP in Sunderland

More online

Already crowned Columnist of the Year at the PPA awards in June, Phil has now been shortlisted as Business Columnist of the Year in the prestigious British Society of Magazine Editors (BSME) awards.

Go to pulsetoday.co.uk/peverley to read Phil's full back catalogue of columns, including the three that won him his latest nomination: 'My shopping tips for patients', 'Whiplash: a shameful fiction' and 'A pussy-footed sort of protest'.

MargaretMcCartney

Please stop vilifying 'part-timers'

Margaret is sick and tired of all the negative press being given to part-time GPs

'Part-time women doctors are a 'risk' to the NHS.'[1] Thus shouted the headline above *The Daily Telegraph*'s coverage of the launch of the GMC's report *The State of Medical Education and Practice in the UK*. At present, we were told, 57% of registered UK doctors are men, but in five years women will outnumber them. The realisation was, finally, that more doctors will be needed to provide the same care.

It's sad to see that working part time is somehow seen to be equivalent to a 'risk' and that it is women who are singled out for not being good enough. My 'half-time' five sessions a week as a GP works out at just over 26 hours, and this doesn't include professional development, local meetings or time to read the *BMJ* or *New England Journal of Medicine*.

This is not an insignificant number of hours – in fact, it's really quite a respectable contribution to general practice. But being a 'part-timer' is often an accusation levelled in a derogatory way.

In February, Anna Soubry, the Conservative MP who has since been appointed as a health minister, appeared on a TV programme and responded to a point RCGP chair Dr Clare Gerada made about what her collagues thought of what was then the health bill, by saying: 'But you work part time.' Those of us who work less than 'full time' hours were not allowed, in Soubry's eyes, to have valid views.

Inevitable chauvinism

Can you see the problem with this? Part timers are the 'risk' – yet what about the huge benefits we have to offer as a workforce? I would happily bet that we work more hours than our written contract demands.

And then there's the inevitable chauvinism inherent in it being women who are often the part-timers, and that somehow, caring for family members is a lesser way for a woman to spend her time. This is rot. Especially when you consider that many men work part time in the surgery and balance this with management roles or new commissioning work.

In fact, there is nothing new about female doctors working fewer hours in practice than men. In 2009, it was found that women worked on average 60% full-time equivalent compared with men's 80%.[2] Neurologists reported the same thing in 2007.[3] In 2006, it was found that in Scotland, male GPs spent 18% more time on GMS but 50% more time on non-GMS services.[4] And back in 2000 the Royal College of Psychiatrists reported 'the exponential' growth of part-time trainees and those planning to be part-time consultants.[5] As far back as 1997, the Department of Health noted that flexible working was now a 'general trend'.[6]

I would happily bet we work more hours than our contract demands

And in fact, the UK Medical Careers Research Group had been following graduates from 1974 to the mid-1980s and telling whoever wanted to listen what was happening.[7] This is not new, the data is out there. Yet it is women who are being blamed for daring to want to bring up their families, or care for relatives themselves. Meantime, all those men who wish to contribute to society in another way – through non-GMS services, for example – escape the pejorative term 'part-timer'.

There is another challenge – of helping people who want to work part time take on leadership or other roles. I'm not sure what's the best approach to this, but it is definitely not to suggest that we part-timers aren't contributing enough. We are.

Dr Margaret McCartney is a GP in Glasgow

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NICE guidelines are crucial – but they are not compulsory

The institute's recommendations are advisory for GPs and sometimes almost aspirational in nature, writes NICE chair **Sir Michael Rawlins**

There appears to be confusion about the circumstances in which it is obligatory for GPs to follow NICE guidance. The quick answer is 'never'. But the longer answer is worth understanding, particularly as GPs take on commissioning.

In some instances, NICE public health guidance applies to GPs, such as identifying people at high risk of type 2 diabetes. Occasionally our medical technologies programme assesses innovative devices that may help primary care. But two forms of NICE guidance are of special relevance to GPs: technology appraisals and clinical guidelines.

Technology appraisals are assessments of the clinical and cost effectiveness of either individual or groups of similar health technologies.

Many technology appraisals involve new pharmaceuticals used primarily in secondary care including new – and sometimes very expensive – drugs for late-stage malignant disease.

When NICE gives a 'positive opinion' about the use of a particular product there is a legal obligation on the NHS to make it available if the patient's doctor feels it is clinically appropriate. There is no obligation on a doctor to prescribe it, but if they consider it to be in the patient's best interest the NHS must provide it.

These arrangements were originally put in place in 2002 and were reinforced in 2009 by the NHS Constitution. The current Government has confirmed that the arrangements will remain in place when CCGs begin their work. My contacts with members of CCGs indicate their support for these arrangements.

If CCGs have to make their own decisions three problems immediately arise.

First, differences in availability of new medicines would occur, as would the resurgence of 'postcode' prescribing.

Second, there is every likelihood that patients would shop around trying to find a CCG to provide the product recommended.

And third, many GPs believe their

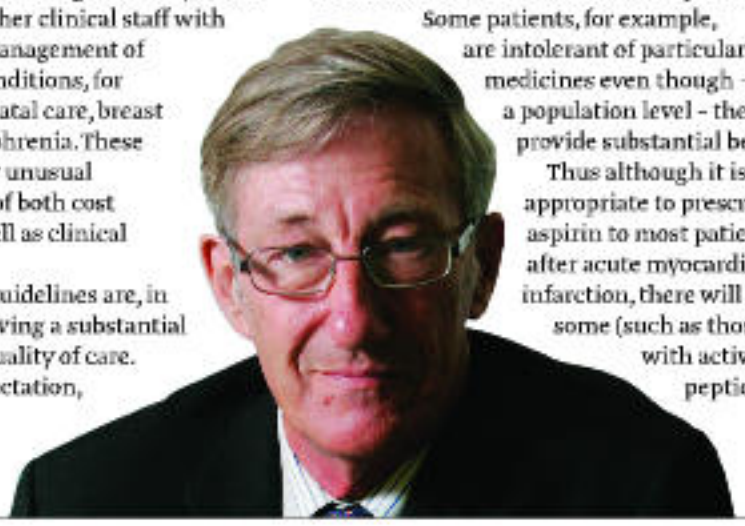
relationship with patients would suffer. Patients and their families would suspect (albeit erroneously) that a CCG's refusal to agree to the provision of a product would put money into the pockets of GPs.

Then there are clinical guidelines, which provide GPs and other clinical staff with guidance on the management of specific clinical conditions, for instance, for antenatal care, breast cancer and schizophrenia. These guidelines are very unusual in taking account of both cost effectiveness as well as clinical effectiveness.

NICE's clinical guidelines are, in most instances, having a substantial influence on the quality of care.

There is no expectation, however, that all patients with a particular condition will be treated according to the provisions of NICE guidelines, for two reasons.

First, it is impossible to define an appropriate pathway of care for every encounter between a doctor and a patient. Some patients, for example, are intolerant of particular medicines even though – at a population level – they provide substantial benefit. Thus although it is appropriate to prescribe aspirin to most patients after acute myocardial infarction, there will be some (such as those with active peptic ulceration or aspirin-induced asthma) for whom it is dangerous.



Second, the provision of care according to NICE guidelines may require infrastructure changes that take time to accomplish. NICE's guideline on depression, for example, proposed much wider use of cognitive behavioural therapy (CBT) than was currently available. Substantial investment in clinical psychology has now put CBT within the reach of most patients who need it.

Clinical guidelines, though, play a major role defining the contents of the QOF, quality standards and the commissioning outcomes framework.

The construction of all three performance measures are critically underpinned by a NICE guideline.

The necessity for this is in part because of the need to ensure these metrics are supported by the best available evidence; and without an underpinning clinical guideline this would be impossible. But it is also because without an underpinning clinical guideline it would be unreasonable to expect NHS clinicians to achieve the required standards.

So NICE's guidance is never clinically mandatory, but is accompanied by the following statement: 'This guidance represents the views of NICE and was arrived at after careful consideration of the evidence available. Healthcare professionals are expected to take it fully into account when exercising their clinical judgment. However, the guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient in consultation with the patient and/or guardian or carer.' (And we mean it!)

Sir Michael Rawlins is chair of NICE

Why I quit the BMA over its failure on pensions

The industrial action was unimaginative and badly co-ordinated, writes **Dr Ian King**

I have been a GP for almost 30 years and joined the BMA in 1979 in order to receive the *BMJ* when I was a medical student. I have never been that interested in medical politics and believed that the BMA would do its best to ensure that doctors are treated fairly. But now I suspect I have been rather naive in that regard.

To be honest, I found the advice for GPs that the BMA produced for the 'day of action' on 21 June embarrassing. It was a gift to the papers, who seem to enjoy doctor-bashing at every opportunity, and I think it lost us as a profession considerable credibility in the eyes of the public. The then-health secretary Andrew Lansley must have been laughing his head off.

For starters, it seemed as if the BMA did not understand primary care and how it works. Many GPs are self-employed, contracting to provide services to the NHS, and in doing so employ a large number of clinical and administrative staff to make their services run as smoothly as possible for their patients.

How would it ever have been possible to cease working for a day in that situation without harming any patients, given the many consultations that occur?

Furthermore the message the BMA was giving to the public seemed unclear. I got their point about the pension renegotiation in 2008, and the fact there should be no further change. But where the message was not clear was the fact that doctors were now being expected to pay more than other senior civil servants for the same pension.

This is an unfair extra 'tax' on doctors who are, after all, a soft target because they put patients' interest ahead of their own in most cases. From talking to friends, it was clear this message had not got through.

It is a pity that nothing more imaginative was discussed with the profession. We were balloted to ask if we would take action and I said 'yes' to that. But we were not asked for our opinions on what type of action we wanted. And when it became clear the BMA had opted for something that would harm patients, like many others I went to work squirming slightly. As I drove I listened to the BMA's chair at the time, Dr Hamish Meldrum, on Radio 4's *Today* programme. Even to me, his defence sounded unconvincing.

As predicted, nothing changed as a result - except that, to add to our embarrassment, the BMA is now trying to negotiate with other unions that their members pay more and doctors pay less into the pension. Good luck with that.

Better targets for action

I cannot understand why more obvious targets for industrial action - options that would not have harmed patients, yet would have potentially embarrassed the Government - were not considered. For example, why are we co-operating with paying hundreds of pounds each year for the joy of CQC accreditation, which will serve little purpose other than to tick a box and could significantly disrupt the safe running of practices by diverting scarce resources into completing policies and protocols?

Why as a profession are we co-operating with commissioning and the abolition of PCTs? Let's face it, it is unlikely we will be able to make the savings QIPP demands because no one is being honest with the public about what the NHS can afford to do. Expectations are inexorably rising and GP commissioners will not be allowed to start on a level playing field with the old PCTs as we are expected to do their work for significantly less money. If or when we fail, it will be our fault. There's another potential headline for the doctor-bashing newspapers.

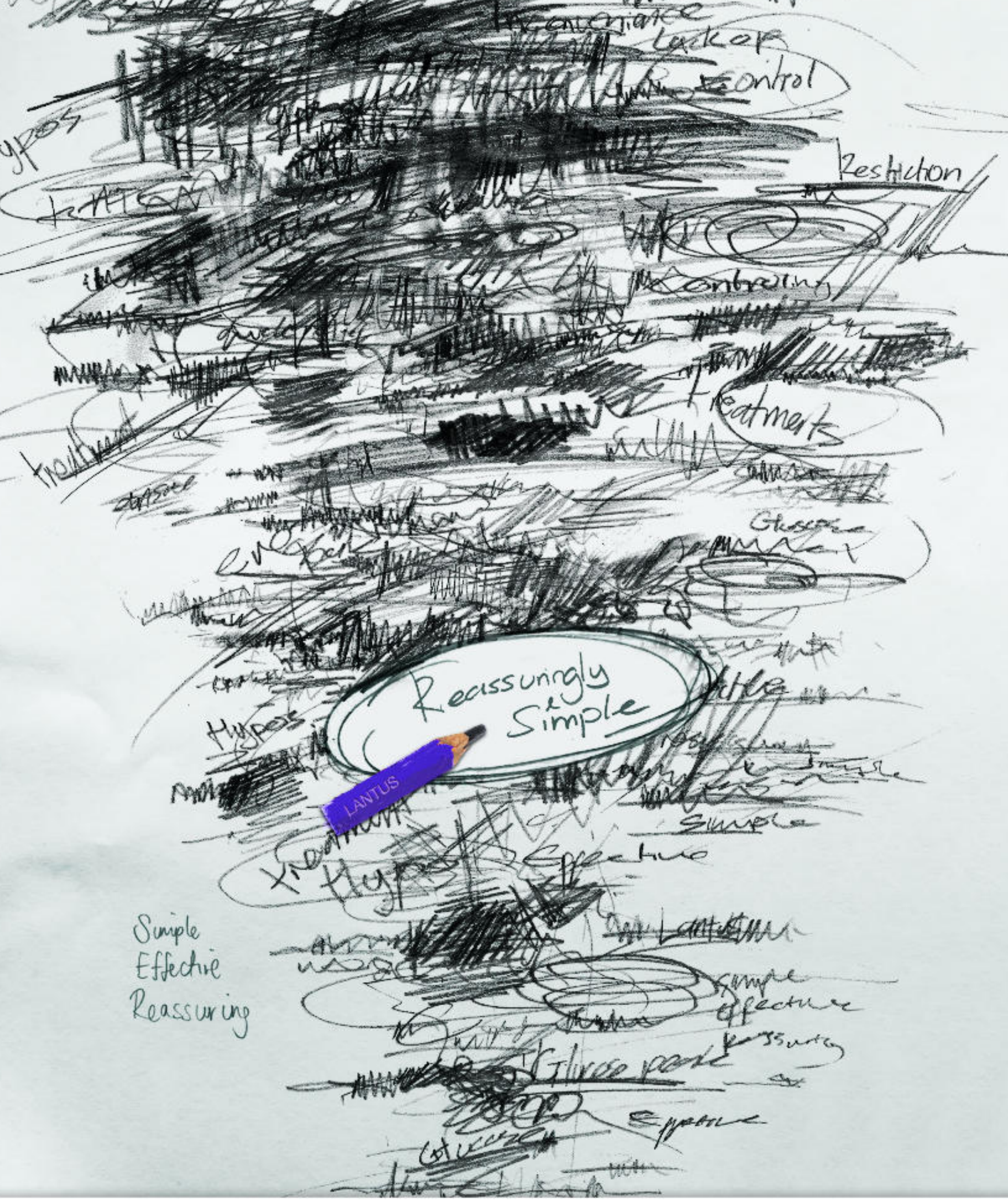
As a last resort, the profession could refuse to co-operate with revalidation. There are plenty of other monitors on our performance without this. If no one is revalidated, is it really likely the GMC or the Government will say no patient can go to primary care because their GPs are unlicensed?

After 21 June, I resigned my BMA membership, pending it reconsidering a more sensible approach to the new pension tax against doctors, and more effective communications with members about what we think of the campaign. Hopefully the £400 or so I will save from my membership fees will go a little way to towards offsetting this extra pensions 'tax' I must now pay.

Dr Ian King **is a GP in Redhill, Surrey**

We need 10% more funding

The Government must recognise the burden on GPs in the next round of contract talks and award the profession an equivalent increase in funding, writes Dr Robert Morley. Go online to pulsetoday.co.uk/opinion to read his article and leave your comments on what he, Dr King and Professor Sir Rawlins have said this week.



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We need an honest debate on 'rationing'

From Dr Jeremy Platt
Bracknell, Berkshire

LETTER OF THE WEEK

The use of the pejorative and disquieting term 'rationing' in your recent story on treatment restrictions is unhelpful ('GPs face the flak as NHS rationing drive accelerates', pulsetoday.co.uk/news).

It represents a misleading use of language, similar to the use of the word 'privatisation' in another debate.

To my mind, and I suspect to many others', the term 'rationing' in healthcare commissioning implies a ceiling of secondary care activity that will not be breached – for example, there will be no more than a certain number of hip replacements in one year, and if this number is reached before the end of the year no more will be carried out.

If this were to happen in our part of the newly configured NHS, I would consider it a failure on the part of the commissioners.

Commissioning policy should be designed to ensure that those patients who need elective procedures get them, and to prevent those who will not benefit from them taking the resources and thereby denying the needful.

No one would argue that people without visual impairment should get their cataracts operated upon.

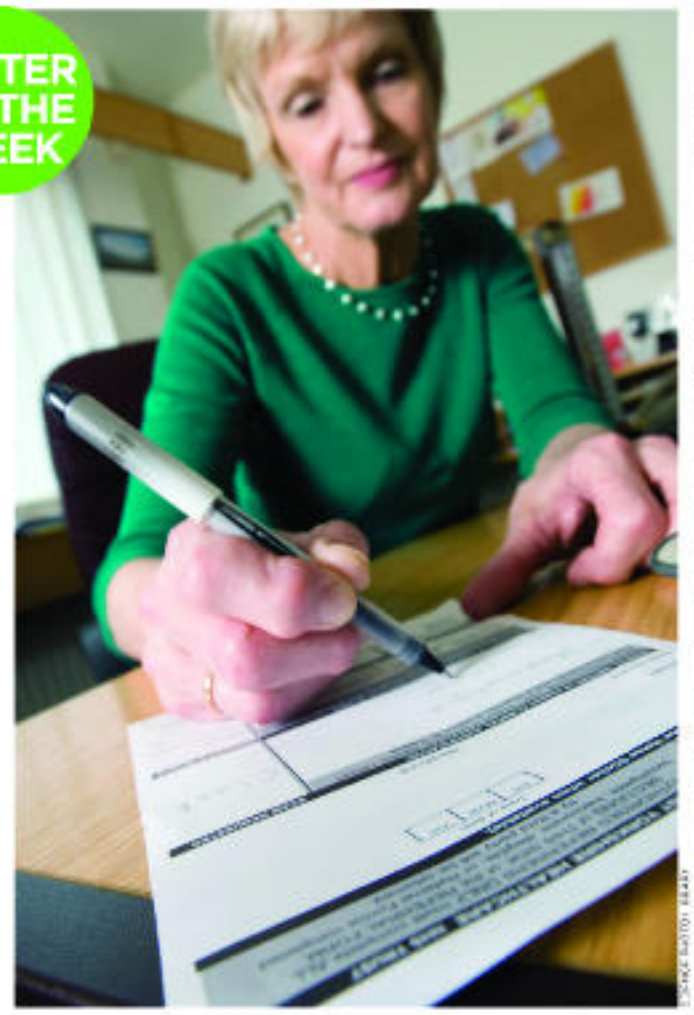
It is less clear who should get total hip or knee replacements, but obviously not everybody who has radiological evidence of osteoarthritis should have one. The body mass index threshold for bariatric surgery is debatable, but there must be a threshold.

Procedures without evidence of benefit must not be commissioned.

I was surprised to read that some GPs felt that secondary care trusts were colluding, as they saw it, in rationing, by referring back patients who missed appointments, and by overemphasising risks of surgery.

I wish our local secondary care providers would voluntarily decrease their activity in this, or indeed, in any, way.

Our observation is that they are all too ready to call patients back for unnecessary follow-up appointments, and to create internal referrals which have the (surely unintended) result of increasing their revenue.



How can GPs ensure patients only get necessary procedures?

GPs are in a downward spiral

From Dr Thomas Bloch
Broadway, Worcestershire

Dr Paul Harris's letter, 'No wonder Peverley's ready to go part time' (pulsetoday.co.uk/letters) says everything I would have liked to.

With two more years to go to 65, I will probably stick it out till then, but the prospect no longer pleases. I now work harder than ever, even allowing for the first 15+ years in rural practice, when on-call was one night in three or four, and an additional one in six for the local maternity unit, where I was an obstetrician.

The pace was less onerous, and we had time to look after the patients. Being freed from the out-of-hours burden was welcome, but sadly we have been replaced by a vastly inferior service.

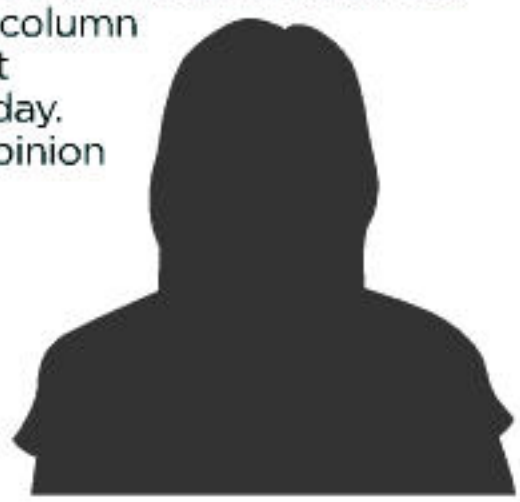
It is no wonder that recruitment is flagging. Young doctors are savvy and have clocked that general practice is in a downward spiral, characterised by ever-increasing workload demands coupled with reduced resources, eroded pay and increased bureaucracy, the snoopervision of PCTs – to be followed and probably outdone by CCGs – and the loss of autonomy and the option of using one's judgment. Revalidation will be the final straw for GPs old enough to retire, so we can look forward to a new manpower crisis.

The only really worrying thing is the thought that once retired, I will have lost what pull I have with my consultant colleagues and will depend on a GP of my own. Then what?

Oh, and the writing of this letter was interrupted by the request to rewrite a TIA referral because the form was out of

The nightmare of an unfounded complaint: your response

Last week's case study from an anonymous GP who faced a GMC fitness-to-practise investigation after an unfounded patient complaint prompted a huge response from readers. Read the original column online at pulsetoday.co.uk/opinion



Anonymous GP

I too was the subject of a completely unfounded complaint – where a child I had seen over two years previously with simple viral gastroenteritis was diagnosed with cancer.

While I felt deep sympathy for the child and family, the father turned his obvious distress against me.

All the paediatric notes clearly stated the cancer symptoms had just started the month before the child attended A&E and he hadn't seen anyone at the surgery – including me – for the past two years.

But the father decided I was to blame and news spread in the local community that 'the GP had missed his child's cancer'.

The damage that was done to my self-esteem was irreparable. Although most of my patients know how conscientious and hardworking I am, there are always a few who love to hear and pass on gossip. I just wanted everything to be over and to move on, but what happens the next time?

I have almost had enough and am on the brink of changing career. I cannot stay in a job where you give everything you have to do the right thing for your patients, and on the whim of an angry patient or relative your life can come crashing down.

Anonymous GP

I had a complaint to the GMC from a patient with a histrionic personality disorder two years after they left the list – for my temerity in diagnosing their condition correctly.

The first and only GMC contact stated that while the

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date. The new one is almost identical and requires the same information, but it is clearly more than their job's worth to accept the original. Says it all, really.

Becoming a locum offers real freedom

From Dr Balbir Virik
Luton, Bedfordshire

My intention was to work another three years at least. However the constant changes, increasing workload and hog-tying bureaucracy meant that I had to balance my health against all that ('Burnout sees more GPs resigning to become locums', pulsetoday.co.uk/news).

There was no contest. So I simply took my pension. Now I am free, free, free. I can work as a locum when and if I want to.

● **From Dr Robert Hallwood**
Bolton, Lancashire
via pulsetoday.co.uk

To be an authentic human being and a full-time GP in the NHS has become increasingly, mutually exclusive. The system is highly structured with micromanagement processes and political direction fed by excessive data collection and onerous regulation and accountability.

There is little sense of freedom to be yourself and there is no hope of change coming from our professional representatives. They too have bought into the dualistic nightmare. Individuals will have to have courage if they want freedom to be who they truly are.

● **From Dr Ian McClure**
Mossley, Lancashire
via pulsetoday.co.uk

I wasn't surprised to read your story. After 25 years as a GP principal, I'm now a freelance locum.

It's the best move I ever made.

Fracture screening requires cash

From Dr David Bush
Wolverhampton
via pulsetoday.co.uk

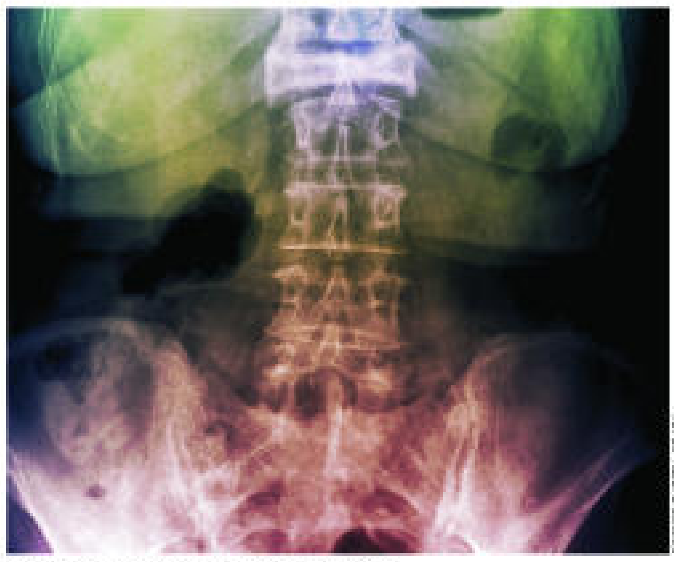
NICE's recent guidance on carrying out risk assessments for osteoporosis offers an ideal opportunity for the profession to say 'if you want us to do this we need to see how you will resource it' ('NICE fracture screening advice a "huge task" for GPs', pulsetoday.co.uk/news). Work out how many extra appointments, GPs and nurses we will need, cost them and describe how you will help to action the plan. This should then be the template for all new work.

● **From Dr Sunil Bhalla**
Birmingham
via pulsetoday.co.uk

We are paid to deal with sick patients. But although screening for many diseases, as NICE says, is good practice, this has never been funded properly by the Government. We should not be forced to do endless screening without full funding.

● **From Dr Andrew Mimnagh**
Chair, Sefton LMC
via pulsetoday.co.uk

The contract states we are to provide sufficient healthcare for the needs of our patients who are ill or believe themselves to be ill. This is a different quantity of work and resource from that required by screening. It has been the attitude of PCT managers that once someone has 'found an illness' by screening, the primary



Will the NHS fund fracture screening?

care can absorb the capacity without funding. No secondary care trust would see twice as many people in outpatients without screaming to the commissioners for cash to meet it – 'over-performance against block contract'. So why does the myth persist that primary care can work this miracle?

In praise of the tools of our trade

From Dr Alistair Conwery
Aberdeen
via pulsetoday.co.uk

Independent thought, clinical autonomy and medical self-sufficiency were once the cornerstones of the rural quack – now these qualities mark you as a heretic and fair game for the jackbooted revalidation police ('Screw these so-called "toolkits"', pulsetoday.co.uk/peverley).

If there's any hope for the future artisans of our once-noble trade we need to ditch all the e-portfolio baloney and get back to a craft apprenticeship model. I'm open to offers...

For the record

A recent plug for an online opinion piece by Dr Robert Morley was incorrectly headlined, and should have said that Dr Morley was arguing for a 10% uplift in practice funding. We apologise for the error – you can read the full piece online at pulsetoday.co.uk/opinion. Pulse's priority is accuracy. However, in the busy process of preparing a weekly publication, mistakes can occur. To draw our attention to an error, email letters@pulsetoday.co.uk

screener had not found any substance in the complaint, they required me to provide all the information they needed to determine if there was any issue anywhere they could pursue against me.

I spoke to my indemnity organisation, which reassured me this was indeed common practice, but they could not answer why as a medical registrant I was not subject to a citizen's legal right to decline to act in any potentially self-incriminating manner as a point of principle.

I was told it was my obligation as a medical registrant to follow the direct request of the registering body. An unblemished record ensured I did as requested, but I still feel aggrieved at the tone and the presumption of guilt.

Dr David Simpson

This makes me shudder with fear. There is always an air of uncertainty with any diagnosis you make.

There must be a change in the future but until some doctor takes his own life over a malicious complaint and it gets into the press, nothing will change.

Anonymous GP

I too had an incident in the last few years – not involving the GMC but a particularly nasty complaint with the threat of press involvement. As might be predicted from even a quick look at the facts, there was no substance to the complaint but the whole process was bruising.

Like many others I feel the whole system is loaded against GPs. Any reasonable GP must expect that patients have rights to comment and complain about care. What seems to be lacking is any right of redress the other way.

Dr Clare Gerada
RCGP chair and medical director of the Practitioner Health Programme (PHP)

Please, if you have a complaint and feel the bottom has fallen out of your world, get help – a problem shared is often a problem halved. BMA Doctors for Doctors is piloting a GMC-funded support service for doctors referred to the GMC and the NHS PHP can offer advice.

Even if you are out of the London area we can still signpost you to help. Also remember LMCs often offer support and many will fund counselling.

Dr John Taylor

My heart goes out to all doctors who have been the subject of a malicious complaint.

A complaint of this nature is probably a once-in-a-lifetime experience so whatever you do, don't react by practising defensive medicine. This will corrode your confidence and take the joy out of clinical interaction, which is the reason most of us remain in practice.

MORE ONLINE
Read all the responses from dozens of GPs
pulsetoday.co.uk/opinion

BMA Doctors for Doctors can be reached on 08459 200 169 or at bma.org.uk/doctorsfordoctors. The Practitioner Health Programme is on 0203 049 4505 and at php.nhs.uk

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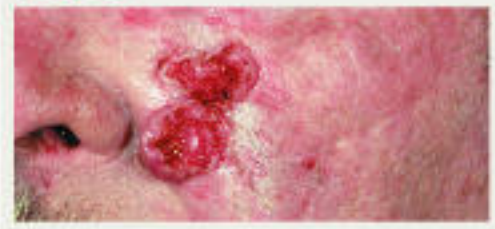

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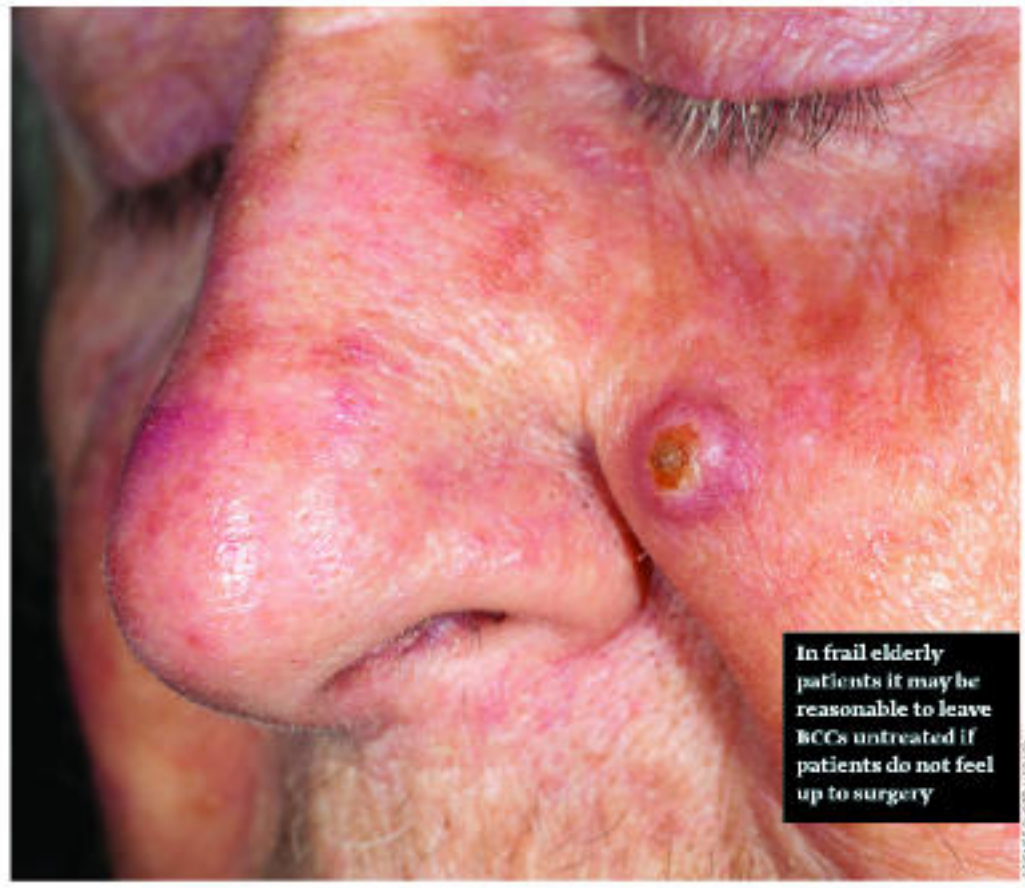
After reading this week's Ten Top Tips article, go to Pulsetoday.co.uk/tools-and-resources to download a handy guide to spirometry from the Primary Care Respiratory Society UK.

KEY QUESTIONS

Skin cancer

Consultant dermatologist Dr Conal Perrett answers questions from GP Dr Mandy Fry on sunbeds, Bowen's disease and actinic keratosis



In frail elderly patients it may be reasonable to leave BCCs untreated if patients do not feel up to surgery

1 Has the increased emphasis on avoiding excessive sun exposure influenced the incidence of skin cancer?

In January 2011, definitive clinical research from Australia showed for the first time that sunscreen can drastically reduce melanoma incidence.[1] Researchers found that daily application of sunscreen to the head, neck, arms and hands reduced melanoma incidence by 50% in subjects studied for more than a decade.

Invasive melanomas – which penetrate beyond the skin surface – were reduced by 73% and those that were found in the sunscreen group were smaller on average and more readily curable.[1]

There is also strong evidence that sunscreens protect against development of precancerous actinic keratosis, as well as squamous cell carcinoma.

Studies in Australia and in the US have shown that regular use of sunscreen significantly decreases actinic keratosis development.[2,3] Because actinic keratoses can be precursors to SCC it seems likely that sunscreen may also prevent development of SCCs. A study involving 1,300 individuals over a four-and-a-half-year period showed regular sunscreen use was associated with fewer SCCs, but did not appear to reduce basal cell carcinoma development significantly.[4]

2 What is the current consensus on the risks of sunbeds?

Sunbed use is associated with an increased risk of melanoma as well as premature ageing of the skin. Sunbeds are the second most significant environmental cause of skin cancer, after exposure to UV radiation from the sun itself. The International Agency for Research on Cancer includes UV tanning devices on its list of the most carcinogenic substances – a list that also includes solar UV radiation, cigarettes and plutonium.

Sunbed users are 74% more likely to develop melanoma, 2.5 times more likely to develop SCCs and 1.5 times more likely to develop BCCs than those who've never used a sunbed. A recent systematic review and meta-analysis examined data from 27 studies across Europe.[5] It estimated that more than 5% of the 63,942 new cases of melanoma diagnosed in 2008 were associated with sunbed use. It also demonstrated that sunbed use was associated with a 20% higher risk of skin cancer and this figure rose to 87% for individuals who used sunbeds before the age of 35 years. This study provides the strongest evidence yet of the link between sunbed use and skin cancer.

Despite this, indoor tanning is still popular, especially among females aged 16-29. The clear message is to stay away from sunbeds.

ABCDE moles checklist

Any of the following signs should raise suspicion of malignancy

- **A** Asymmetry of the mole
- **B** Border – irregularity
- **C** Colour – variation within the lesion
- **D** Diameter – more than 7mm or increasing rapidly
- **E** Extra features – bleeding, inflammation, crusting, itching, elevation or a palpable nodule

3 Many GPs use the ABCDE rule when assessing moles. Is this helpful? Are there any other tips you can provide to enable us to spot malignancy?

See the box below for a quick reminder of the ABCDE checklist for moles.

The ABCDE checklist is a simple and effective means of assessing pigmented lesions. Normal moles can be monitored by patients themselves using the ABCDE checklist, and you may want to suggest that they regularly photograph their moles to monitor any changes. But the most important advice I can give here is to refer to a dermatologist under the two-week wait rule for suspected cancer if you have any element of doubt about a pigmented lesion.

Such lesions should only be excised by a specialist dermatologist or plastic surgeon. More than 2,000 people die from melanoma in the UK every year, so early diagnosis is essential. The survival rate for patients whose melanoma is detected early is much better than those with advanced disease.

4 How quickly do BCCs develop? Is it safe to leave them alone in very elderly, frail patients or would you always advise excision?

BCCs are typically slow-growing lesions and can develop over many years. Normally, they should be treated otherwise they can enlarge and cause destruction of local tissue including muscle and bone, and invade nerves. This is particularly relevant on a high-risk site, such as the face, where Mohs micrographic surgery is the gold standard treatment.

But in very elderly, frail patients with multiple co-morbidities it is sometimes entirely reasonable to leave BCCs untreated if the patient does not feel up to surgery – indeed, the prospect of surgery might cause the patient more distress than the BCC itself. This decision should always be made after an informed discussion with the patient and their family, if appropriate. In some cases

32

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30 surgery may be essential, for example if a BCC is obscuring vision, but in this instance, the tumour could just be debulked and not formally removed. This may provide a lifeline for a patient who would otherwise be visually impaired.

5 How important is family history in the development of common skin cancers? Is there any association between skin cancer and other common cancers?

Around one in every 10 patients diagnosed with melanoma has a family member with a history of melanoma.

A patient with a first-degree relative diagnosed with melanoma has a 50% greater chance of developing the disease than a patient without a family history of the disease. If you have a melanoma and a parent who has had melanoma, your risk of developing another melanoma is 30 times higher than the general population.

The most common mutation seen in familial melanoma occurs in the p53 gene, which functions as a tumour suppressor gene in its normal state. Mutations in other genes, including BRAF and CDKN2A, may also be important in melanoma. In some families with a strong family history of melanoma, there is also an increased risk of pancreatic cancer. So patients with a strong family history of melanoma should be referred to a specialist familial cancer clinic.

6 How often does Bowen's disease progress to SCC? Is there any way of predicting which cases will undergo malignant transformation or should we be referring all these patients?

Bowen's disease (also known as SCC-in-situ) is characterised by a scaly red plaque and full thickness dysplasia on histopathology. About 20% of cases develop into invasive SCC.

Clinically there is no definitive way of predicting development into SCC, but progression is more likely in certain patient groups – for example solid-organ transplant recipients on chronic immunosuppressive therapy. These patients have a 40% risk of developing Bowen's disease five years post-transplant and approximately a 100-fold higher risk of SCC compared with the normal immunocompetent population.

Some GPs are confident treating Bowen's disease but if you're not sure of the diagnosis or if initial treatment – for example with cryotherapy, 5-fluorouracil cream, surgery or photodynamic therapy – fails, you should refer to a dermatologist.

7 How likely is it that an actinic keratosis will develop into malignancy? Should all actinic keratoses be treated? What is the best treatment?

The risk of malignant transformation varies, even in similar populations, depending on which studies you read. I usually quote a figure of 1 in 1,000. Some actinic keratoses resolve spontaneously, but I usually treat them all, rather than waiting to see whether they resolve.

Treatment is with one of a variety of modalities including cryotherapy, photodynamic therapy, 5- fluorouracil cream, imiquimod cream, surgery or diclofenac gel. All of these are of proven efficacy and can either be administered in the outpatient clinic or, in some cases, at home by the patient.

8 Is it reasonable to use imiquimod or fluorouracil creams in primary care? What precautions should we take?

Both 5-fluorouracil cream and imiquimod cream are commonly used to treat precancerous lesions such as actinic keratosis and Bowen's disease – 5-fluorouracil is an antimetabolite drug that inhibits DNA synthesis, while imiquimod is an immunomodulator which prompts an immune response against precancerous or cancerous cells in the skin.

I know a number of GPs with dermatology experience who regularly use 5-fluorouracil cream in patients, while other GPs do not feel comfortable using it.

Imiquimod tends to be initiated by dermatologists rather than in primary care. The key points are to ensure patients are clear about the likely inflammatory reaction – which can sometimes be severe – associated with use of 5- fluorouracil or imiquimod cream and to be confident about the diagnosis before embarking upon treatment.

If there is any doubt about the diagnosis, the patient should be referred to dermatology for assessment and for possible biopsy or excision. A delay in the diagnosis of an SCC can have serious consequences for patients.

9 A number of my GP colleagues have started using dermatoscopes in practice to look at questionable skin lesions. Do you think this is a good idea?

Dermoscopy has become increasingly popular over the last 10 years, and in the dermatology outpatient clinic my colleagues and I routinely use it. With training and experience it can improve the clinical diagnosis of melanocytic, non-melanocytic, benign and malignant skin lesions. It can influence the decision to remove a lesion or not.

One concern is that relying too heavily on dermoscopic criteria might mean a necessary biopsy of a melanoma is not done, which would of course be disastrous.

It is also important to remember that melanoma is relatively uncommon and so the opportunity to develop diagnostic skills is limited in primary care.

It is still best to refer any lesions where there is a suspicion of melanoma under the two-week wait rule.

▶ **Now test your diagnostic skills with our picture quiz on skin tumours (opposite)**

More Q&As

▶ **pulse-learning.co.uk**

View the online version of this article for extra questions:

- Is there any truth in the view that melanomas are being clinically overdiagnosed because so many boderline lesions are being excised?
- What is the epidemiology of melanoma?

Dr Conal Perrett is a consultant dermatologist, dermatological surgeon at University College Hospital, London, and lead clinician for skin cancer at London Hospitals NHS Foundation Trust.

Dr Mandy Fry is a GP in Cirencester, Gloucestershire, and senior primary care lecturer at Oxford Brookes University

This article was produced in collaboration with The London Clinic. For more information go to thelondonclinic.co.uk.

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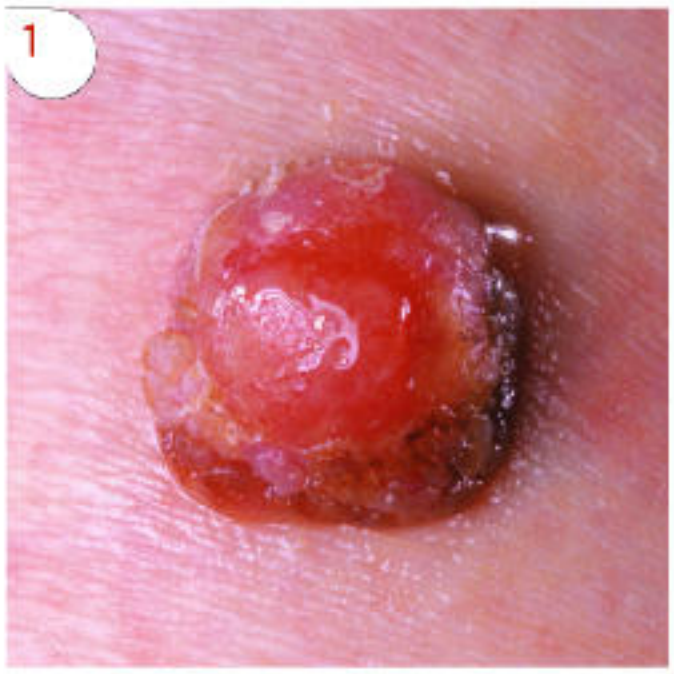
PICTURE QUIZ

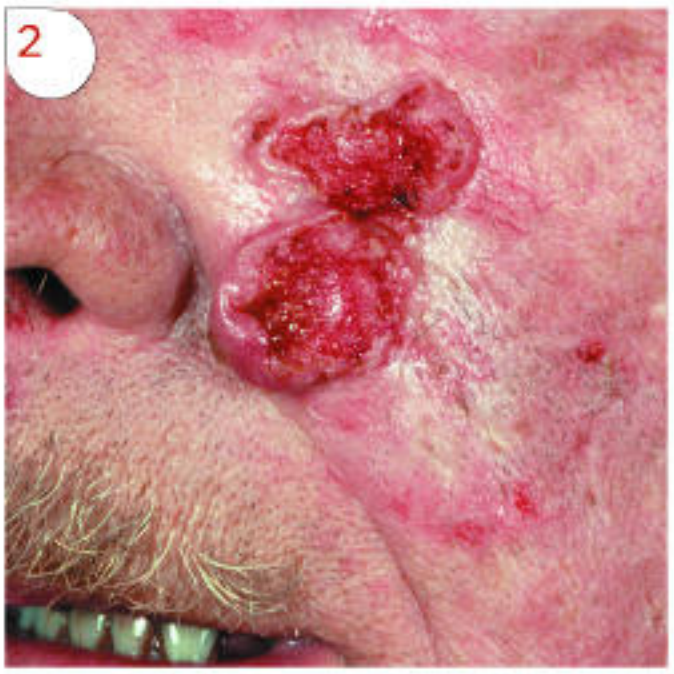
Skin tumours



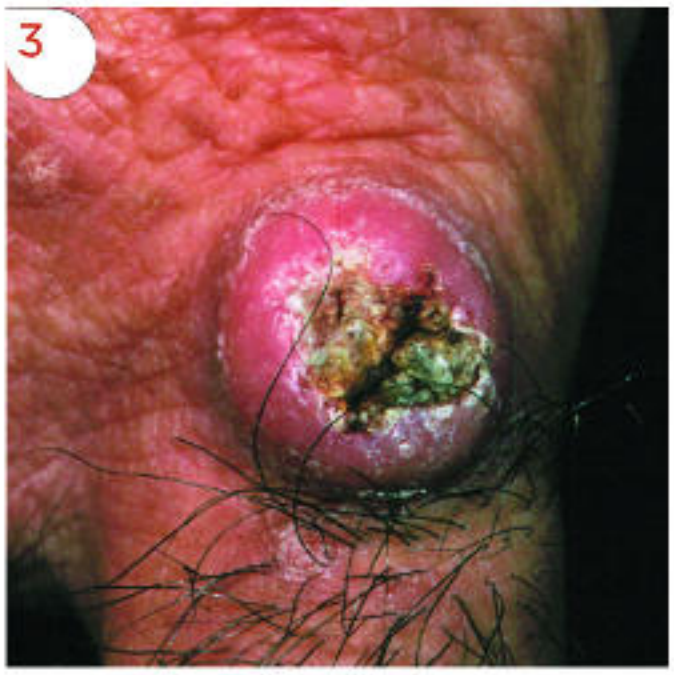
This lesion arose spontaneously on a woman's leg about four months ago. It has slowly been increasing in size and has recently shown signs of ulceration. Examination reveals an enlarged groin node on the same side.

These five patients presented with skin tumours – can you accurately diagnose them, and distinguish which are malignant? The answers are at the bottom of the page

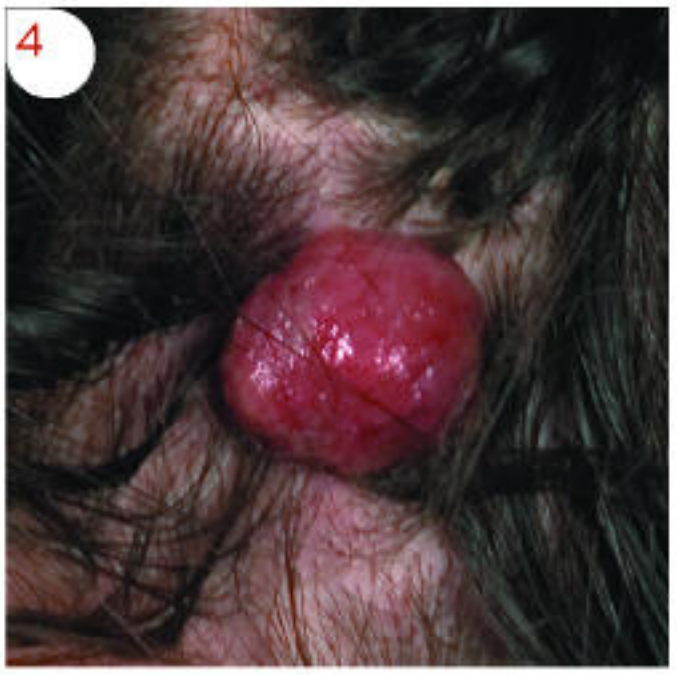
These cases are taken from Acute Adult Dermatology – A Colour Handbook by Daniel Creamer, Jonathan Barker and Francisco A. Kerdel. ISBN 9781840761023 (Manson Publishing); available from www.mansonpublishing.com/colour_handbooks and all good booksellers priced £29.95



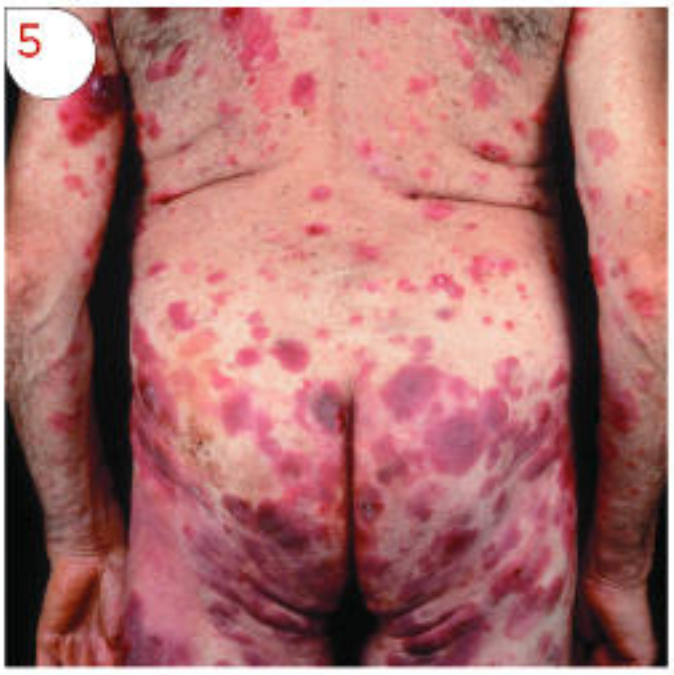
It wasn't until this facial ulceration started to bleed that this elderly doctor-avoider decided to consult his GP. There are no lesions elsewhere.



This man was alarmed when a small nodule appeared on the back of his hand and then grew rapidly over three to four weeks.



According to her mother, this young girl had accidentally jabbed a bristle of her hair brush into her scalp a few weeks previously. Since then, this lesion had appeared. It bleeds easily when touched.



This middle-aged man had been diagnosed with eczema a few months ago on the basis of these widespread, mildly itchy erythematous plaques. But they haven't settled with treatment, are becoming more marked and extensive and he is starting to feel unwell.

ANSWERS

1 Amelanotic malignant melanoma

Malignant melanoma is a tumour of melanocytes, predominantly of the skin. Risk factors include: fair skin (especially with red hair and freckles), a history of excessive exposure to strong sunlight, the presence of numerous melanocytic naevi, and a family history of malignant melanoma. Melanomas greater than 4mm in depth at presentation are associated with a markedly poor 5-year survival rate of 50% at five years.

Any new pigmented lesion or any pre-existing pigmented lesion undergoing change in size, shape or colour should be considered a malignant melanoma until proven otherwise. Melanotic malignant melanomas have no pigment. Prognosis tends to be poor as they typically present, or are referred, late.

A suspected malignant melanoma should prompt examination of regional lymph nodes for lymphadenopathy and urgent referral to a dermatologist. Since there is no effective treatment for disseminated malignant melanoma, it is imperative that tumours are recognised promptly and excised.

2 Squamous cell carcinoma

SCC is a malignant tumour arising from keratinocytes in the epidermis and stratified squamous mucosa. It is locally invasive and has the potential to metastasise. SCCs occur most commonly in fair-skinned individuals who have received a high cumulative exposure to strong sunlight. Patients taking immunosuppressive medication (for instance solid organ transplant recipients) also have a greater risk of developing cutaneous SCC. All patients with a suspected SCC should be referred urgently to a dermatologist.

SCC usually arises on sun-exposed sites in patients aged 50 years and above. The surrounding skin often shows evidence of sun damage. An SCC may develop within a patch of Bowen's disease or at a chronic scar or ulcer. Commonly affected sites are the helix of the ear, the nose, the lower lip, and the dorsal aspect of the hands and forearms. The tumour is usually a nodule but may present as a papule, plaque or ulcer. SCCs can be painful and on palpation are often firm and indurated.

Surgical excision of the SCC with a margin of surrounding normal skin is the optimal treatment.

3 Keratoacanthoma

A keratoacanthoma is a well-differentiated, low-grade SCC which has the capacity to undergo self-healing. Clinically a keratoacanthoma is a skin-coloured, dome-shaped nodule with a central keratin plug. Keratoacanthomas tend to grow rapidly to 1–2cm in diameter. The presence of a suspected SCC should prompt the examination of regional lymph nodes for lymphadenopathy.

4 Pyogenic granuloma

A pyogenic granuloma is a vascular nodule (benign capillary haemangioma) which grows rapidly, often following minor skin trauma. Pyogenic granulomas have a tendency to bleed causing patients to seek an urgent opinion. There is an association with pregnancy.

A pyogenic granuloma is most commonly situated on a finger or a lip. The lesion is a dark red nodule measuring 0.5–2.0 cm in diameter. The base may be pedunculated, the surface is often eroded and sometimes covered by impetiginised crust. Pyogenic granulomas are usually painless but tend to bleed when knocked.

Immediate management is with excision or curettage and cautery carried out under local anaesthetic. Some pyogenic granulomas will recur following surgical removal and necessitate further, more aggressive surgical intervention.

5 Mycosis fungoides

Mycosis fungoides is a cutaneous T-cell lymphoma that can develop at any age but has a higher incidence in the fifth and sixth decades. It generally runs a chronic, indolent course involving the skin alone, but, a few cases progress rapidly with development of cutaneous tumours and systemic involvement.

There are four stages – stage 1 consists of patches or plaques with a predilection for the breasts and buttocks, and may have angulated margins. Lesional skin may demonstrate erythema, fine scaling, atrophy and poikiloderma. In pigmented skin the patches can be hypopigmented. Lesions can be itchy or sore, but many are asymptomatic. Stage 2 has the same cutaneous features as stage 1 but with incontinent lymphadenopathy or cutaneous nodules. The tumours are firm, indurated, and may become ulcerated (as in this case). Stage 3 is erythrodermic skin involvement. Stage 4 is accompanied by malignant infiltration of lymph nodes and viscera.

Relapse is common so long-term control can be achieved using intermittent courses of phototherapy or topical chemotherapy

TEN TOP TIPS

Spirometry

Dr Azhar Saleem, respiratory GPSI, and Dr Noel Baxter, GP and co-lead of the London Respiratory Team, offer their top hints and tips on lung function testing

1 Throw away out-of-date spirometers

If you have an old spirometer, with no option to read or upload flow-volume or volume-time curves, please ditch it. Without seeing the graphical traces, you cannot accurately detect spurious or inconsistent results and you can't be sure whether the blow from the patient is sufficient. You will run the risk of missing important diagnoses.

2 Avoid spirometry during an infection or COPD exacerbation

Spirometry for diagnosing COPD needs to be done when a patient is at their best to avoid over-diagnosis – that's why we bronchodilate beforehand. Never carry out spirometry during a respiratory infection or exacerbation. Ideally wait for six weeks after an infection to allow it to resolve, especially if making a first diagnosis. Use your discretion for patients who continuously exacerbate or require long-term steroid maintenance. Spirometry for suspected asthma should be done pre- and post-bronchodilator and often needs repeating as it can be normal at a planned visit if symptoms are absent.

3 Calibrate your spirometer

An instrument is only as accurate as its calibration. Although annual calibration should be carried out for instruments, best practice advises all operators to calibrate the spirometer prior to each session.

4 Check exhalations meet BTS criteria

There must be full-volume blows with good effort to meet BTS criteria. At least three good blows are required and at least two blows must have a vital capacity within 5% or 100ml of each other. Each forced manoeuvre must last six seconds minimum. Coughing is okay at the end but not at the beginning.

5 The flow-volume curve slope is concave in obstructive disease

Typically a flow-volume curve – as shown in the flow-volume curve diagram top right – should have a high peak and then a gradual consistent slope down. In an obstructive defect, the peak is often lower and the sloping decline tends to have a concave shape inwards toward the centre of the axis.

6 In restrictive disease the flow-volume slope is steeper

In restrictive defects the peak may be normal or reduced but the slope tends to be steeper

and terminates earlier – see diagram, right. If the curves don't match the numbers, consider technical error or other pathology and seek specialist help if you cannot interpret it.

7 Look for a slow rise in the volume-time curve in obstructive disease

The volume-time curve should have a quick rise to a reasonable volume and then a plateau. In obstruction, the rise is quite slow and reaching a plateau often takes time. See the volume-time diagram below.

8 A quick rise in the volume-time curve suggests restrictive disease

In restriction, the rise on the volume-time curve is quick, but to a much smaller volume than normal and then it reaches a plateau. See the volume-time diagram right.

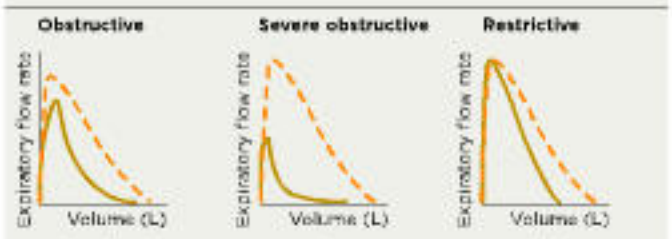
9 Use the first blow as a practice

Many patients will not be able to perform the test adequately and will need to be trained, which may take many attempts and be time consuming. It may help to use the first blow as a practice to reduce the chance that results will be skewed. Bring patients back for another appointment if you run out of time, rather than using unacceptable results. If it's tricky to get a result you are happy with or the clinical picture and results don't fit, refer to the local hospital lung function or chest clinic.

10 Ensure you have the right training

Everybody who carries out spirometry should have training and ongoing assurance of quality. The Association for Respiratory Technology and Physiology provides a high level of certification that might be suitable for a GP taking a special interest, or developing a diagnostic service. You could also ask your local hospital lung physiologist what spirometry training days they hold.

Flow-volume curve patterns: obstructive and restrictive



Spirometry: Abnormal patterns

Dr Azhar Saleem is a GP in south London with a special interest in respiratory and allergy medicine

Dr Noel Baxter is a GP in south London and co-lead of the London Respiratory Team

The Primary Care Respiratory Society UK (PCRS-UK) is the UK-wide professional society committed to improving respiratory care in primary care. PCRS-UK is a registered charity, led by their members through a range of committees and faculties dedicated to meeting the vision of 'optimal respiratory care for all', providing education, policy support and research. As a member you'll have unlimited access to a wealth of specialist respiratory care information, expertise and resources, plus practical everyday tools to help you make a difference in respiratory care. For more information about PCRS-UK and how to join, go to pcrs-uk.org/join.

Resources

PCRS-UK opinion sheet on spirometry. pcrs-uk.org/resources/ost_spirometry.pdf

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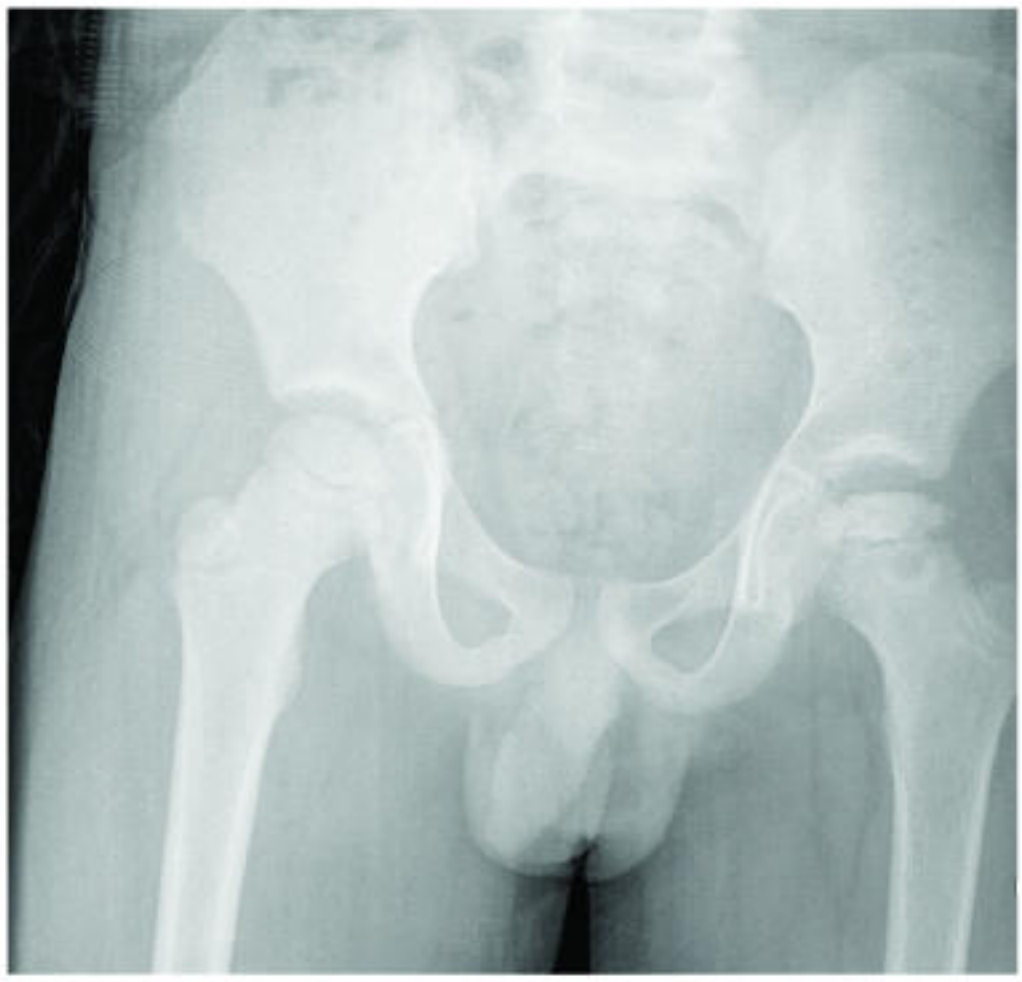
Consultant paediatric orthopaedic surgeon Mr Colin Bruce and colleague Mr Amit Bidwai continue our series on uncommon but serious conditions



PAEDIATRIC CLINIC

Perthes' disease

THE CASE

A five-year-old Caucasian boy presents to an inner-city GP with a left-sided limp, which has developed over the past week.

The child does not have a fever and is generally well. Pain on internal rotation of the leg suggests hip joint pathology. Bloods – including FBC, CRP and ESR – are all normal. A plain X-ray of the hips shows some flattening of the femoral head and an ultrasound of the hip shows a small effusion.

The patient is referred to the paediatric orthopaedic surgeon and when seen a few days later, the limp has improved, but there is still some restriction of internal rotation and abduction of the left hip. The surgeon makes a working diagnosis of transient synovitis. At two-week review the patient still has a modest limp and restriction of movement. The surgeon orders a bone scan, which reveals a 'cold' area in the left femoral epiphysis consistent with Perthes' disease.

The problem

Perthes' disease is caused by a disturbance to the blood supply of the femoral head growth plate, causing avascular necrosis.

The blood supply gradually returns and the dead bone in the epiphysis is regenerated.

During this period the cartilaginous ball of the femoral head can become deformed and treatment is directed towards trying to minimise this deformity.

The exact aetiology is unknown. Perthes' disease presents most commonly in boys aged four to nine and is associated with Caucasian race, attention deficit disorder, social deprivation and a growth disturbance of the limbs. Prognosis is more favourable when the onset is before the age of five years and is worse in children over eight years.

Features

Children normally present with pain and a history of a limp, but are otherwise well.

Early examination shows loss of abduction and internal rotation of the affected hip.

Differential diagnoses

The most common differential is transient synovitis. This condition often presents in a similar manner to Perthes' disease and is accompanied by a small effusion on ultrasound, but symptoms usually subside after a few days.

Other important differentials include septic arthritis, which would present in a systemically unwell child with fever and raised inflammatory markers, slipped capital femoral epiphysis in the older child (over 10 years), and juvenile rheumatoid arthritis.

Management

The aetiology is unknown so the condition cannot currently be prevented. 'Containment' of the lateral part of the epiphysis under the acetabulum is the key treatment strategy. Many young patients – under five years – achieve this without the need for intervention because they maintain good abduction, which moves the epiphysis in and out of the acetabulum. In older patients – over five years – hip abduction is frequently lost and containment can only be achieved by intervening to position the lateral epiphysis further under the lateral edge of the acetabular roof.

The most common surgical intervention is a varus femoral neck osteotomy. The goal of treatment is to maintain a congruent femoral head and acetabulum and reduce deformity, so that the femoral head can remodel once the blood supply is restored. The long-term goal is to prevent early degeneration and osteoarthritis.

Mr Colin Bruce is a consultant paediatric orthopaedic surgeon and Mr Amit Bidwai is an SpR in orthopaedics at Alder Hey Children's Hospital, Liverpool

Alder Hey is one of Europe's busiest children's hospitals, providing care for over 275,000 children and young people each year. Alder Hey has a broad range of hospital and community services for direct referral from primary care. It is the designated national centre for head and face surgery and a Centre of Excellence for children with cancer, spinal and brain disease. Alder Hey has been chosen to be a national centre for heart surgery, a respiratory ECMO surgery centre and one of just four specialist centres to provide surgery for drug-resistant epilepsy.
More information can be found at alderhey.nhs.uk.

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Still to come in this series:
- Acute leukaemia
- Cystic fibrosis
- Juvenile arthritis

Consultant urologist Mr Justin Collins launches our new series with his advice on managing haematuria

NEW SERIES PRIMARY CARE UROLOGY

Haematuria

Haematuria – the presence of red blood cells in the urine – is a common presenting symptom for patients with underlying urological conditions, including urological malignancy. It is also one of the most common findings on urinalysis in patients presenting to their GPs, with an incidence of four per 1,000 patients per year.[1] Patients with haematuria represent about 6% of new referrals seen by urologists.[2]

Haematuria can be idiopathic or because of benign or malignant causes of bleeding or inflammation in the urinary tract. Most patients investigated for haematuria do not have a significant underlying cause, and in two studies, red blood cells were documented in the urine of 9% to 18% of asymptomatic adults.[3,4] Evidence shows that up to 13% of patients with haematuria end up with a diagnosis of urological cancer, but other studies conclude that up to 53% of those initially considered to have benign conditions have urological cancer.[5,6]

Although there is consensus that visible haematuria requires further investigation,[7,8] patients with haematuria are under-referred.[9] In July 2008 the British Association of Urological Surgeons and the Renal Association published a joint consensus statement on the initial assessment of haematuria, which was written to be consistent with NICE CKD guidelines. These guidelines are for the management of haematuria once detected – urine testing for haematuria should only be performed for identifiable clinical reasons, and there is currently no evidence to support opportunistic screening of the general population.[7,8]

The terminology for haematuria was updated in the joint consensus statement. See the boxes, right.

Urine dipstick analysis

Urine dipstick analysis should be done on a fresh voided urine sample, containing no preservative. False positives can be caused by oxidising agents and microbial peroxidase.

Community-based urine samples sent for microscopy have a high false negative rate and are not useful in establishing a diagnosis of haematuria, so routine microscopy for confirmation of dipstick haematuria is not necessary. Other causes of false negatives include captopril and ascorbic acid. A high urine specific gravity, protein level or nitrite level can all delay reaction, leading to a false negative.

The sensitivity of urine dipsticks varies between manufacturers, but the joint consensus statement says that significant haematuria is 1+ or greater and that trace haematuria should be considered negative. There is no distinction in significance between non-haemolysed and haemolysed dipstick-positive haematuria.

Other diagnostic urine markers

Urine dipstick testing has a sensitivity of 97% but it is not a very specific test for urothelial cancer. Urine cytology is a better screening tool,[10] but the sensitivity of cytology in detecting low-grade tumours is low.

There has been increasing interest in urinary biomarkers that can either supplement or replace these tests, although their role is still not well defined. There are currently several FDA-approved urine-based tests in bladder cancer surveillance, and a variety of other biomarkers are being studied.[11] Urinary biomarkers offer great promise for the future in diagnosing urothelial tumours and helping with active surveillance.

Who to refer to urology

Significant haematuria – a single episode of visible haematuria in a patient of any age, or a single episode of symptomatic non-visible haematuria in a patient of any age, where a UTI or other transient cause has been ruled out – should be referred to a urologist for exclusion of underlying urological conditions.

Patients with persistent asymptomatic non-visible haematuria – two out of three dipsticks positive – without a UTI or other transient cause, should also be referred.

Causes of haematuria that should be excluded prior to referral are:

- UTI – haematuria with associated UTI is a common finding in primary care. After antibiotic treatment, repeat dipstick urinalysis to confirm the absence of haematuria. Also remember that a UTI, regardless of whether haematuria is present, can be the presentation of both benign and malignant genitourinary pathology, and should be investigated further if clinical suspicion remains. UTI as a cause of the haematuria is most readily excluded by a negative dipstick result for leucocytes and nitrites.

Otherwise, a negative mid-stream urine culture is required. Pyuria and LUTS are associated with carcinoma in situ, and in these cases urine cytology is usually positive.

- Renal colic – a diagnosis may be supported by a history of renal calculi.
- Exercise-induced haematuria or rarely myoglobinuria.
- Menstruation.

Patients on anticoagulation with visible or non-visible haematuria are just as likely as patients not on anticoagulation to have an underlying pathology and should be evaluated as normal.

Who to refer to nephrology

If a patient has had negative urological investigations (ultrasound scan, intravenous urography or CT and cystoscopy), or does not meet the criteria for a urological referral, consider a nephrology referral.

Nephrology referral is recommended in patients with:

- Cola-coloured urine and an associated infection – usually upper respiratory tract – if they are younger than 40 years, as they may have an acute glomerulonephritis.
- Declining eGFR (by more than 10ml/min 1.73m² at any stage within the previous five years or by more than 5ml/min 1.73m² within the last year).

3B

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At a glance

Interpreting urine dipstick

- Significant haematuria is 1+ or greater, of either non-haemolysed or haemolysed dipstick-positive haematuria.
- Trace haematuria should be considered negative.

Who to refer

Refer urgently to urology:

- All patients, of any age, with visible unexplained haematuria.
- All patients, of any age, with symptomatic non-visible haematuria.
- All patients aged 40 years or over with asymptomatic non-visible haematuria.

Initial investigations

Initial investigations for patients with symptomatic non-visible haematuria and persistent asymptomatic non-visible haematuria are:

- Exclude UTI or another transient cause. Check serum biochemistry (U&Es) including plasma creatinine/eGFR.
- Measure proteinuria on a random sample and if positive send urine for protein:creatinine ratio or albumin:creatinine ratio on a random sample. To get an approximation for 24-hour urine protein or albumin excretion (in mg), multiply the ratio (in mg/mmol) by 10.
- Blood pressure.

Visible haematuria

Visible haematuria is also called macroscopic haematuria or gross haematuria. In visible haematuria urine is pink or red (or, occasionally, cola-coloured in acute glomerulonephritis). Clots in the urine may also be seen.

Other (rare) causes of discoloured urine include myoglobinuria, haemoglobinuria, porphyria, beeturia and discoloration due to drugs such as rifampicin, doxorubicin, sulphonamides, quinine and phenytoin.

Non-visible haematuria

Non-visible haematuria is also called microscopic haematuria or dipstick-positive haematuria. This should be subdivided as follows:

- Symptomatic non-visible haematuria – where upper or lower urinary tract symptoms are present. Common LUTS are hesitancy, frequency, urgency, and dysuria.
- Asymptomatic non-visible haematuria – incidental detection on urine dipstick testing without associated LUTS or upper urinary tract symptoms.

- Stage 4 or 5 CKD (eGFR less than 30ml/min 1.73m²).
- Significant proteinuria (albumin:creatinine ratio greater than or equal to 30mg/mmol or protein:creatinine ratio greater than or equal to 50mg/mmol).
- Isolated haematuria with hypertension, in patients younger than 40 years.

The role of the GP

Patients who don't meet referral criteria or have negative urological or nephrological investigations still require long-term monitoring, because of the uncertainty about the underlying diagnosis, and referral if any of the following symptoms develop:

- significant LUTS
- visible haematuria
- significant or increasing proteinuria
- progressive renal impairment (falling eGFR)
- hypertension (although the development of hypertension in older people may have no relation to the haematuria).

Mr Justin Collins is a consultant urologist at Ashford & St Peter's Hospitals NHS Trust, Surrey

Still to come in this series

- Lower urinary tract symptoms in men
- Penile conditions
- Urinary tract infections

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Further reading

- Joint statement on haematuria guidelines by BAUS and the renal association baus.org.uk/AboutBAUS/publications/haematuria-guidelines
- Nice guidelines for referral of suspected cancer nice.org.uk/nicemedia/pdf/cg027niceguideline.pdf

The Urology Foundation is the only charity in the UK and Ireland that covers all urological conditions and cancers. It is focused on improving the knowledge and skills of urologists and funding research to improve patient outcomes. It receives no Government funding and relies wholly on donations.
The Foundation's website offers clear, basic information for patients, including signs and symptoms, diagnoses and treatment options. Information about their programmes and grants is also available for urology professionals.
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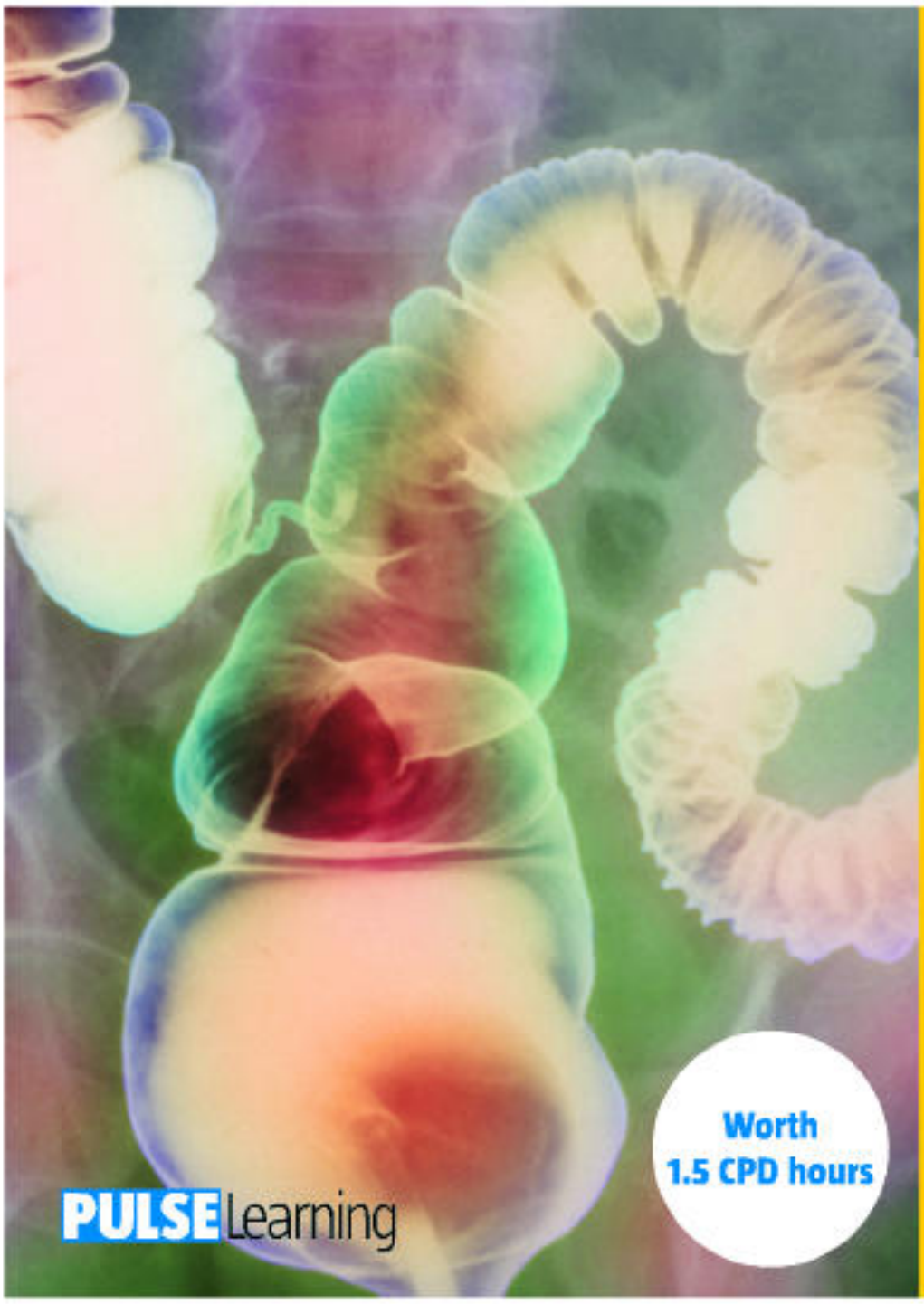

Does fibre really work in irritable bowel syndrome?

This is one of the many questions answered in our latest case-based learning module, Hot topics in IBS. The NICE guidance on IBS introduced the first evidence-based framework for managing the condition in primary care. In the few years since its publication new evidence and guidance – including dietary studies – have been published and this module uses typical primary care case histories to update you on them all, including:

- Red flags in IBS
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- The role of fibre
- The effectiveness of elimination diets
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Top tips for managing small practices

As profits shrink and funding becomes harder to maintain, four experienced singlehanded GPs give their advice on sustaining business at a small practice

Don't let people make your size out to be a disadvantage

Dr Patrick Craig-McFeely
Salisbury

Our principle has been to offer everything a larger practice offers – no-one can say because we are small our patients are missing out. We offer lots of enhanced services, are open as much as possible, have same-day access irrespective of medical need and listen to what our patients want and then try our hardest to provide it. We shut on Tuesdays at midday and another practice covers emergencies. On Thursday I run a clinic for cryotherapy and medicals instead of opening the surgery.

Get involved, but know when to say no

We have been involved with commissioning from the start of practice-based commissioning, and I work hard on networking with local practices and beyond. I still lead our locality but had to stand down from the CCG board as it was too time-consuming. I wasn't prepared to disrupt the practice by reducing my clinical commitment.

Aim to employ a small permanent staff

I jobshare with my wife: I do all day Monday, Wednesday and Friday from 8am to 7pm and Thursday afternoons, and she does Tuesday and Thursday mornings. You have to work hard as a small practice but we are helped by having a small team with very few changes in staff. We have a GP assistant, and never employ locums. Make sure you have a good team of permanent staff able to cross-cover so you never need additional short-term help and can then develop standard ways of doing things that everyone understands.

Focus on key principles

Our culture is to put patients first and with their help to manage as much of their care as possible ourselves or in the community. It seems to work as we have high satisfaction rates, do very well in all the parameters measured by the PCT (like vaccination and screening uptake rates) and are well within budget for prescribing and hospital care.

The key is to have a very clear idea of what you are trying to do and let this guide the rest of your business. We wanted continuity, quality and accessibility and this means you have to employ enough people to do this. We are continually changing to keep on track.

Maximise income and control expenditure as far as possible

Dr Steven Shepherd
Ashby-de-la-Zouch, Leicestershire

I employ two part-time salaried GPs, which frees me up to devote two to three sessions a week to administration. To achieve a good profit I use my IT system as much as I can – referral letters are generated by the computer so I do not need to employ a secretary.

The main costs to my practice are salaries so I only employ the people I really need. And I find that marketing is not something I have to do. Most people prefer singlehanded practices and my list is growing slowly and steadily without any action on my part.

Look out for new NHS funding streams

Even in today's cash-strapped times there are always packets of money for the latest political or clinical favourite. Sign up for as much as you can.

We all know that NHS health checks have limited clinical value, but they are quick and easy to do and most can be done by nursing or HCA staff. At present there is no cap on the number you can do. These packets of money often move around or change and being singlehanded enables me to respond to change quickly without having to spend valuable time reaching a consensus with other partners.

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Make sure all your work is profitable

It is important to make sure that doing any extra work is cost effective.

My practice has a business cost spreadsheet, which enables me to check that any extra work is profitable in terms of time and other resources. For example, by auditing health checks for those with learning difficulties I discovered they weren't economical, so unfortunately we had to cut them.

Include a record of your administrative work in your appraisal

A lot of commissioning and the QOF work can also go towards my appraisal and revalidation. The key is to write up and reflect on things as you go along.

Start off by supporting your practice income with other work

Dr Krishna Chaturvedi
Westcliff-on-Sea, Essex

I have now been working as a singlehanded GP for 12 years. I had only been a GP for 10 years when I went solo.

Initially when I became singlehanded I did additional work alongside running the practice – mental health act assessments, social security tribunals, occupational health work and medicolegal reports on Saturday mornings.

Other GPs who are in a similar situation can increase their financial stability by taking on portfolio jobs like those mentioned above, provided that they do not overdo it and burn out.

Aim to earn as much from enhanced services as possible

We try to do most of the things that are part of our local, directed and national enhanced services. I do in-house minor surgery, and offer it for other GP colleagues, and have recently started doing intra-articular injections as a part of my role as the local musculoskeletal medicine lead. This kind of work is not only financially rewarding but clinically satisfying.

Network with colleagues at local small practices

We have an excellent reception and clinical team, which helps me to do a lot of networking with colleagues at other small practices.

We have formed a group of like-minded GPs; we meet monthly and discuss clinical and non-clinical issues such as QOF visits, QIPP targets and CQC inspections. It is a great platform to share thoughts about the recent political changes to the NHS.

We share our half-days with other practices. They are a useful resource while we have our well-deserved break or holidays. They are actively involved and are encouraged to participate in the clinical management of the practice and in the educational activities of our GP group. Since I am involved with my LMC as well as the CCG, local GP colleagues who are also solo practitioners are very supportive in covering my clinical responsibility.

Nurses and healthcare assistants share the clinical workload

Keep your practice profile simple

When I started at my surgery in 1994 my list was 400 patients – now it is 3,400. Most of the clinical details and services are on the NHS South East Essex website, where we highlight the services we provide, and that is enough to increase our list gradually.

Keep your practice open as much as possible

Dr John Cormack
South Woodham Ferrers, Essex

We are like the old Windmill Theatre – we 'never close' during normal working hours, except in exceptional circumstances. Nurses and healthcare assistants (all of them part time) share the clinical workload with me – I am there to be called if there is anything that needs a second opinion.

A certain amount of phone triage takes place but by and large we operate a system that could be best described as: 'If you want to be seen, we'll see you'. To facilitate this we have an hour of unbooked appointments between 9am and 10am, an old-fashioned 'sit and wait' surgery and we also have appointment-only surgeries. Two nurses with diagnostic skills run this, with me hovering in the background. They do it very well and the patients are happy with it.

Create strong relationships in and around the practice

We share cover from time to time. The practice managers in the town work well together and share what tasks they can in our lively locality group. As a recent example of collaboration, the practices have joined forces to provide a cryotherapy service, sharing the costs.

Find the time to diversify – if you can

Unfortunately we need to spend most of our time and stamina concentrating on the basic tasks. It can be quite enervating working with an inadequate budget. In 30 years in general practice I've never found it more difficult than it is now to provide even a basic service to my patients. That said, we will need to go out and market the practice if we are to stay in business – but finding the time is next to impossible at present.

MORE ONLINE

The financial pressure that all GPs feel will hit singlehanders hardest, but by engaging with LMCs and the local CCGs, and forming practice networks with neighbours, this vital model of primary care can continue for years to come. Read Dr Laurence Buckman's analysis on the state of play for small practices on pulsetoday.co.uk/analysis.

Are you a singlehanded GP or a partner at a small practice? Go online to comment on these tips and share your own at pulsetoday.co.uk/practice-business.

Four questions you should ask before offering referral incentives

Dr Simon Poole advises GP commissioners on how to avoid a potential conflict of interest

1 What are referral management schemes and why are they important?

The term 'referral management scheme' is ill defined, used to describe a number of activities. In the past we have become familiar with PCTs analysing referral rates and also encouraging the use of specific pathways to attempt to reduce referrals. CCGs are now, however, introducing new schemes known as primary care incentive schemes or primary care investment schemes, which go a step further.

As GPs we 'commission' every time we refer people and in austere times we have a responsibility to use resources wisely. As GP commissioners we will inevitably wish to consider variations in referral rates and it is entirely legitimate to do so, and to engage in discussions with practices as to why such variabilities may exist.

However, recently many incentive schemes have become much more clearly focused on reducing overall rates of referral.

2 How can we avoid a conflict of interest?

The GMC's *Good Medical Practice* is clear doctors must make the patient their first concern. Appropriate investigations and referrals are a necessary undertaking. We are also obliged to use resources wisely.

The GPC strongly urges any doctor considering commissioning or participating in incentive schemes that reward practices for arbitrary reductions to carefully consider the potentially serious professional and ethical implications.

Dr Simon Poole: caution needed over arbitrary referral targets

Such incentives are not grounded in clinical evidence but are motivated by the need to cut costs. Furthermore, it is the GPC's view that they introduce unacceptable conflict into the doctor-patient relationship.

Good commissioning uses clinical evidence to analyse the quality of services and improve patient care. Resources should be used to fund new care pathways and services or, where appropriate, reward improved outcomes. For example, many successful prescribing incentives schemes have incentivised the use of generics over brands, an efficient use of resources with no detriment to patient care.

The new quality and productivity indicators in the QOF are another example: financial rewards to practices arise following analysis of referrals, and are not dependent on specific targets of financial savings or reduced referral rates.

The GPC has consistently expressed concerns about such incentive schemes, and has asked the GMC to investigate the schemes (see their response below).

3 How should commissioners ask for feedback about schemes?

If a practice has any doubts about any incentive scheme being offered, they should address them to the CCG with the help of the LMC. Incentive schemes are ultimately voluntary, and CCGs should not place practices under undue pressure to participate.

On a more positive note, a referral management scheme might be a good opportunity for a CCG to find out whether resourcing for continued professional development such as protected learning times could improve the quality of referrals.

4 How can we draw on expertise from other CCGs or national bodies?

Where I practise in Cambridgeshire the peer review schemes are beneficial to patients and safe – they don't reward practices directly for reducing referrals or cutting costs. I didn't commission them myself but they have been in place for some time. When designing the scheme the PCT listened to recommendations put forward by the LMC, which made sure that the scheme was consistent with our understanding of the ethical principles.

Dr Simon Poole is deputy chair of the GPC's commissioning and service development subcommittee and a GP in Cambridge

What the GMC says

We accept that financial incentives can provide a legitimate way of influencing or changing doctors' behaviour.

Such incentives might be used to improve quality of care... to encourage the responsible use of NHS resources.

Incentive schemes should be focused on encouraging behaviours that will be of overall benefit to a community of patients, or to individual patients.

They must also ensure that:

- **patient safety is not compromised**
- **patients continue to receive the clinical care to meet their individual needs – they should not encourage a uniform or blanket approach to all patients with the same condition**
- **incentives are paid in relation to decisions or outcomes for large groups or populations of patients; they should not directly reward decisions relating to individual patients.**

In general, we expect that incentive schemes should specify that payments arising from the scheme should be used for improving patient services and not for the financial benefit of individual doctors.

Source: Letter from Dr Peter Rubin to Dr Laurence Buckman, 25 September 2012

Read the full letter online at pulsetoday.co.uk/practice

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5 Minute Digest

Enhanced services commissioning factsheet

NHS Primary Care Commissioning's Rebecca Thornley summarises recent guidance on commissioning enhanced services from the NHS Commissioning Board

What is it?

An update from the NHS Commissioning Board setting out commissioning arrangements for enhanced services until further guidance or legislation is available.

The factsheet describes how enhanced services are commissioned from general practice and other primary care providers, such as community pharmacists, and how they will be commissioned in future by the NHS Commissioning Board. CCGs and local authorities. It explains transitional arrangements for existing services where PCTs will now be consulting with CCGs – and, in the case of public health enhanced services, with local authorities – to decide if services need to continue and what transitional contractual arrangements need to be made. The document also makes it clear that CCGs commissioning community or practice-based services after the transitional period will need to use the NHS standard contract.

Effective from...

Now – it includes transitional arrangements to re-commission enhanced services for the next six to 12 months.

Hot topics

The main concern for GP commissioners is the potential for conflict of interest when commissioning services that fund member practices. No amount of tweaking will eradicate the potential for conflicts of interest when GPs commission services that may be provided by practices in their CCG. Managing these conflicts remains a thorny issue for GPs, whatever their roles locally. Sharing responsibility for commissioning enhanced services between different commissioners could be seen as a fudge. It could result in uncertainty and different approaches throughout the country depending on how the rules are interpreted locally.

What's new?

The NHS Commissioning Board will be responsible for commissioning directed enhanced services through the current GMS contract. Although the NHS Commissioning Board retains the ability to commission local enhanced services through the GMS contract, it is unlikely to use this power, which will devolve to local commissioners. LES funding will be part of CCG budgets. Directed enhanced services (DESs) currently cover childhood immunisation, violent patients, extended access, health checks for patients with learning difficulties, flu vaccination, minor surgery, alcohol misuse reduction and patient participation. The NHS Commissioning Board will take responsibility for these for a year from April 2013.

Why it matters

GPs providing enhanced services will be affected when they move to the CCG's remit, so commissioners must tell local GPs which services will be cut. GPs also need to know when services will be reviewed so they are ready to respond to procurement processes. Practices will want to identify now when contracts end, so they may want to know more about the commissioner's intentions for the service.

Unanswered questions

- Will services procured through PMS agreements be managed by GP commissioners?
- How can CCGs involve patients in decision-making?
- How will opportunities to provide services be advertised in future?
- How will use of the NHS standard contract affect the flow of cash to practices and information to the CCG?

If you only learn one thing

Make sure your PCT publishes information about how and when your enhanced services will be reviewed and starts discussions now with current or potential providers and commissioners.

Rebecca Thornley is an associate director of NHS Primary Care Commissioning

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Mitcheldean Surgery
Brook Street
Mitcheldean
Glos GL17 0AU

Tel: 01594 545320
E-mail: gayle.sykes@glos.nhs.uk

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For further information please contact:

The Practice Manager
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Salaried General Practitioner
4 - 6 Sessions

We are currently looking to appoint a Salaried GP to work four - six sessions, with flexibility for the right person. The ideal candidate needs to be interested in developing and delivering high quality care with enthusiasm and commitment as part of our friendly, well organised clinical team.

- PMS Practice with 2 Partners, 4 Salaried GP's and two Nurse Practitioners
- List size 7150 with a branch site based in Long Eaton Health Centre
- Training Practice with a strong commitment to teaching and education
- High QOF/Enhanced Services achievement
- TPP SystmOne
- Five minutes from J25 of the M1/A52

For an informal discussion regarding the position please contact Dr Sudhir Ramchandran 0115 9734502. Please send CV with covering letter to, Jacob Cooke, Practice Manager, College Street Medical Practice, 86 College Street, Long Eaton, Nottingham, NG10 4NP or e-mail admin.collegestreet@nhs.net

Closing Date: Friday the 26th of October. Interviews will be held week commencing Monday 12th of November

ESSEX SUFFOLK BORDER

We are looking for a replacement
Full-time Salaried GP / Partner

Semi-rural friendly 4 Doctor dispensing practice
GMS, list size 8000
Training practice in spacious new premises
Paper light SystmOne GP
Enthusiastic committed practice team
Special interests encouraged
Six weeks annual leave & one week for study & CPD
Pleasant village location with good schools and easy access to London and the countryside
Starting date negotiable, willing to wait for the right Candidate

Please send a covering letter and CV to:
Mrs Jo Watson, Practice Manager
The Pump House Surgery, Nonancourt Way
Earls Colne, Colchester, CO6 2SW
Tel: 01787 222022 or email: jowatson1@nhs.net

Closing date for applications: 20th October 2012

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.

LONG TERM LOCUM GP(S)
Required 5-9 sessons per week.
Two partners.System one computer High QOF achiever.
Knowledge of Asian language helpful.
Please apply to
Dr Raj Singh 65 Clifford Road Hounslow TW4 7LR
E mail raj.singh@nhs.net

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.

Salaried GP
Up to 6 sessions per week
Dr Bateson and Partners
Grassendale Medical Practice
23 Darby Road L19 9BP

We are looking for an enthusiastic, highly motivated doctor to join our successful, high achieving suburban practice.

Start date: Beginning of January 2013
List size: 8,200
Three partners and two salaried GP's
Emis LV clinical system
Medical Student Teaching
Minor Surgery
CHS

Please send C.V and covering letter to address above or email to: tracy.fagan@livgp.nhs.uk

Closing date: 31st October 2012

Doctors required UK-Wide for insurance medicals.

dc life

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

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

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

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

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Doctors required UK-wide for mobile insurance medicals, especially in the following areas:

London, Bournemouth, Southend, Chelmsford, Reading, Southampton, Leics., Lincs., Cambs., Herts., Dorset, Dundee, Aberdeen & Dublin

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

JOINT EXAMINATION & INJECTION COURSE

24 NOVEMBER 2012,
BARTS HEALTH TRUST, London
Run by Head of Clinical Rheumatology

'Equipping GPs to confidently diagnose and inject'
www.handsonskills.com

PULSE SERVICES RECRUITMENT

LOCUM AGENCIES

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

COURSES/CONFERENCES

PREMISES

OVERSEAS

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

EDITOR'S CHOICE

Helping survivors rebuild lives

In general practice, one is seldom required to write anything longer than a letter, but over the past five years I have written over 250 medicolegal reports on behalf of Freedom From Torture.

Formerly the Medical Foundation for the Care of Victims of Torture, Freedom from Torture is the only nationwide organisation in the UK dedicated to the treatment of survivors of torture and organised violence. Last year more than 1,500 people from more than 80 different countries were referred to us.

In addition to providing practical assistance and a range of therapeutic services to help survivors of torture begin to rebuild their lives, clinical staff and volunteers – many of whom are practising or retired GPs – document evidence of the physical and psychological effects of torture in medicolegal reports at the request of survivors' legal representatives.

The vast majority of torture survivors arrive in the UK seeking refuge and live in fear they may be returned to their home country to face further torture. The Home Office generally only grants the right to remain in the UK to individuals it accepts would be at risk if returned, and this acceptance often hinges on evidence of previous torture. Our medicolegal reports therefore play a vital role in providing torture victims with the protection they need.

We use extended appointments and expert interpreters to get a greater understanding of a patient's overall physical and mental state than may be possible in a few brief GP consultations. Often we need to build up trusting relationships over several sessions before these patients are able to fully describe their experiences, as they may have to overcome strict cultural taboos surrounding sexual assault or they may find that flashbacks make it impossible for them to give a coherent account.

Dr Virginia Leggatt now writes reports for victims of torture

Dr Virginia Leggatt is a retired GP in Cambridge

MORE ONLINE
To find out more read the rest of this article at pulsetoday.co.uk/off-duty

BIG INTERVIEW

'We've made our views about the quality premium very clear – it is inherently unfair.' GPC deputy chair Dr Richard Vautrey was number four in our top 50 GPs list. Here he talks to us about the quality premium, CCGs and whether he's going to stand for GPC chair.
▶ pulsetoday.co.uk/the-big-interview

WHAT YOU'VE BEEN SAYING

▶ pulsetoday.co.uk/forum

"Revalidation has nothing to do with protecting patients
...on the rationale for revalidation

"Another expense that will be ignored by the Government
...on soaring medical defence subs

"Happened to us as well. Best three days of my time in general practice
...on a GP practice that lost its phone line for four days because of a cable theft

DEBATE

King's Fund chief defends report

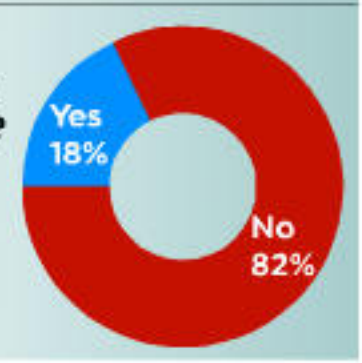
In last week's issue, Dr Michelle Drage responded to the King's Fund's report which dubbed general practice a 'cottage industry'. Now King's Fund chief executive Professor Chris Ham explains the thinking behind the report.

MORE ONLINE
Read the debate
pulsetoday.co.uk/debates

THIS WEEK'S POLL

Are PCTs taking longer to resolve payment disputes?
Vote at ▶ pulsetoday.co.uk/polls

Last week's poll
Should revalidation begin in December?



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