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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

oulsetoday.co.uk

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

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 - suggest-



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

drawn up impact assessment of all associated costs, but will not publish until after decision

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.

ing revalidation could identify even fewer doctors requiring remediation than the current

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

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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Practices forced to fight for LES payments

CQC fees to rise year on year

Peverley Leave me out of the bedroom

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 PCF 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 COGs had led to administrative 'choos' 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

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 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 suid: '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

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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 traince 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 traince GPs had reported they were straggling 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 fourmonth [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'

INSIDE

GP practices will be expected to stump up £6m towards the cost of CQC registration in 2013/14

The week in general practice

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GPs will lead the vaccination of 730,000 pregnant women against whooping cough

page 6

The DH has announced funding for the rollout of personal budgets before pilots conclude

page 9

Dr Peter Swinyard





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



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

EDITORIAL

Hard truth about the fall in GP funding 22

hear about this and would urge the practice to speak to their local PCF in the first instance."

GPC negotiator Dr Chaand Nagpaul said his own practice in Harnow, 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. (a.sofialind_Pulse

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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 sumple' of views from LMCs.

BMA Council decided against action than GPs.

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, vicechair 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

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.

PULSENEWS

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 COC'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

Under the third, recommend-



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

ed, 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).

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 increas-

CQC's preferred fees structure

For GP practices with one location:

Small practice £550 (fewer than 5,000 patients) Medium practice (5,000-10,000 patients) £750 Large practice (10,000-15,000 patients) £850 Very large practice

(15,000+ patients)	
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

es: 'This is unfair as we have no route to increase income or fees so have to pay out of our

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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GP registration with the CQC

When do GPs have to

The deadline for GPs to register with the regulator is December.

What happens from

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

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.



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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If twice daily dosing results in recurrent daytime hypoglycaemic reactions the morning dose can be split into morning and funchtime doses and thrice daily dosing instituted. Only consider combination of NovoMix® 30 with ploglitazone 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 LVkg/day and may be fully or partially supplied with MovoMix® 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. NovolVik® 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 NovoMix⁶ 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^e 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 δ 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 glucuse 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 deserrumber of injections. Injection sité 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 progitazione 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, dedema and local hypersensitivity reactions on instituting therapy and are usually of transitory nature; diabetic retinopathy with intensification may result in temporary worsening. Ipodystrophy; 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. 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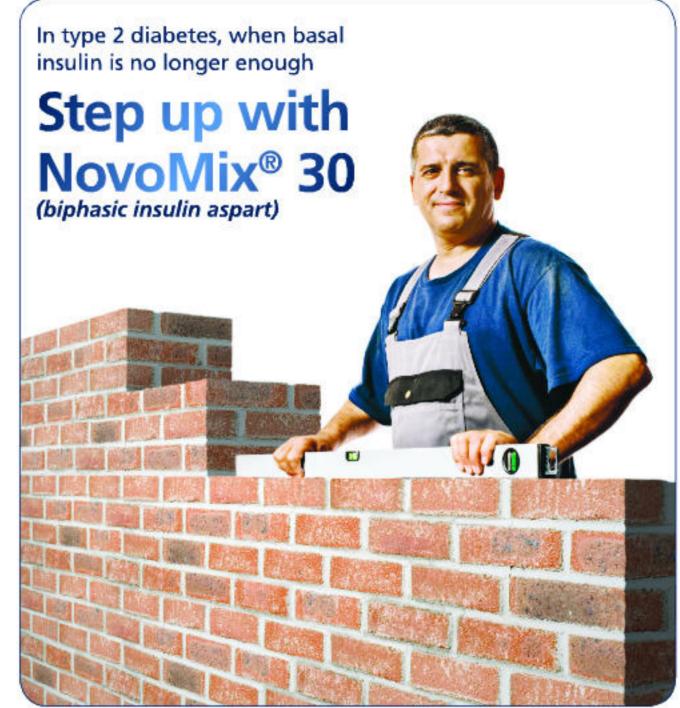
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PULSENEWS

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 wheoping 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 Whoeping 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-



Pregnant women across the UK will be vaccinated against pertussis

service fee of £7.67 for doing so.

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

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."

how much GPs will be paid per

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.

gipulsetoday

The new

numbers

programme in

in UK targeted annually

Vaccine administered

Source: Department of Health

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

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. the RCGP's immunisation

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



CCGs are under intense pressure to cut referrals

influencing or changing doctors' behaviour."

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 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 psychia-

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,

The efficacy of amisulpride for this indication is unproven

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

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



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Adverse events should be reported. Reporting forms and information can be found at new wyellow condigerals. Adverse enems should also be reported to P12er Medical Information on 01284616161.

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ABRIDGED PRESCRIBING INFORMATION Inactivated Influenza Vaccine (Split Virion) BP

Refer to Summary of Product Characteristics for full product information. Presentation: hactivated Influence Vaccine (Split Virian) BP contains 15 micrograms of antigen (per 0.5 millitine) from each of the three virus strains recommended by the World Health Organization for the present influenze season. It is supplied as single dose prefilled syringes each containing 0.5 millitre of syspension for injection. The voccine may contain traces of eags. such as avallamin, rearryon, familialityde and activinal 9 which are used during the manufacturing process. Indications: Prophylaxis of influenza especially in those who run an increased S risk of associated complications, Inactivated Influenza Vaccine

(Split Virian) BP is indicated in adults and children from 6 months of ago. Dosage and administration: Adults and children from 36 months should receive one 0.5 millithe dose. In children aged 6 months to 35 months clinical data are limited and dasages of 0.25 or 0.5 millitre 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. Dases should be administered intramuscularly or deep subculaneously. Contraindications: Hypersensitivity to the active substances, to any of the excipients, to eggs, chicken protein, nearrycin, formaltieflyde, and actorinal Immunisation should be postponed in patients with fearle These or acute infection. Warnings and precautions: Do not administer intravescularly. Medical treatment should be available in the event of rare anaphylactic reactions following: thrombocylapenia, vascultis with transient rend involvement and 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 lactorien. Undesirable effects: Common side effects include: injection site reactions (redness, swelling, pain, eachymasis, induration) and systemic reactions (fewer, malaise, shivering, forgue, headache, sweating, myalgia, arthrolgia). These usually disappear within 1 to 2 days. Other serious side effects have been resorted and include, ellergic reactions (in rare cases leading to shock, angioedema), convulsions, transient

neurological disorders such as encephalomyelitis, neuritis and Guillain-Bané syndrome.

For a complete list of undesirable effects please refer to the Semmery of Product Characteristics. Package quantities and basic NHS cost: Single dose prefilled syringes in single packs, basic NHS cast £6.59; packs of 10 single dose prefilled syringes, basic NHS cost £65.90. Marketing authorisation holder: Sonafi Posteur MSD Limited, Mallards Reach, Bridge Avenue, Maidenhead, Berkshire, 516-10P, Marketing authorisation number: PL 6745/0095

Legal category: POM. Date of last review: April 2012 Reference: 1, Sonofi Posteur MSD, Date on file 2012 UK15877

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

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 COGs.

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.

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

But the proposals have proved controversial, with a DH interim report on the pilots showing patients had been al-



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

lowed to use NHS funds to buy theatre tickets, frozen meals and complementary therapies.

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

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." @pulsetoday

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 volved in the design of services." 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

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 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

president of NHS

local people should be fully in-

CONSTITUTIONS

CCGs urged to consider 'ethics'

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

The group suggests amendments to various areas, includ-

Campaign group 38 Degrees is ing allowing COGs 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 COGs' 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'.

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into these areas, advise the patient to go immediately to the nearest emements from or haspital casualty department for treatment. Patients must be instructed in the proper use of EpiPen. Use with extreme caution in patients with heart disease and those taking digitals, mercural digretic or quinking. The effects of adrenaline may be potentiated by tricyclic antidepressants and monoamine oxidase inhibitors. Adminaline should be used in premancy only if the potential benefit justifies are potential rick to the foetus. Side effects: May include pulpitations, tachycardia, sweating, nausea and vomiting, respiratory difficultly, pallor, dizziness, nervousness and arrelety. Cardiac arrhythmias may follow administration of adrenaline. Overdoses of adrenaline may cause cerebral haemorthage or arrhythmias. For a complete list of warnings and side effects, you should consult the Summary of Product Characteristics, Legal category: POM Package quantity and basic NHS price: EpiPen and EpiPen It are available as single unit closes at £26.45 each or as a twin pack of 2 Auto-Injectors at £52.90. Product licence number: EpiPen Auto-Injector Pt. 15142/0245. EpiPen Jr. Auto-Injector Pt. 15142/0246. Marketing authorisation holder: Meda Pharmaceuticals Ltd. Skyway House, Parsonage Road, Takeley, Bishop's Stortford, CMZZ 6PU. Tel: 0845-4600000 Date of preparation of prescribing information: February 2012.

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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 Cen-

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 £9,849m 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 £335m 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 Funding for extended hours halved last year

to £37.5m during 2011/12.

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 E362.5m - its highest level for five years.

Premises funding also continued to rise and reached a fiveyear 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 matches feedback we're getting from GPs on the ground.

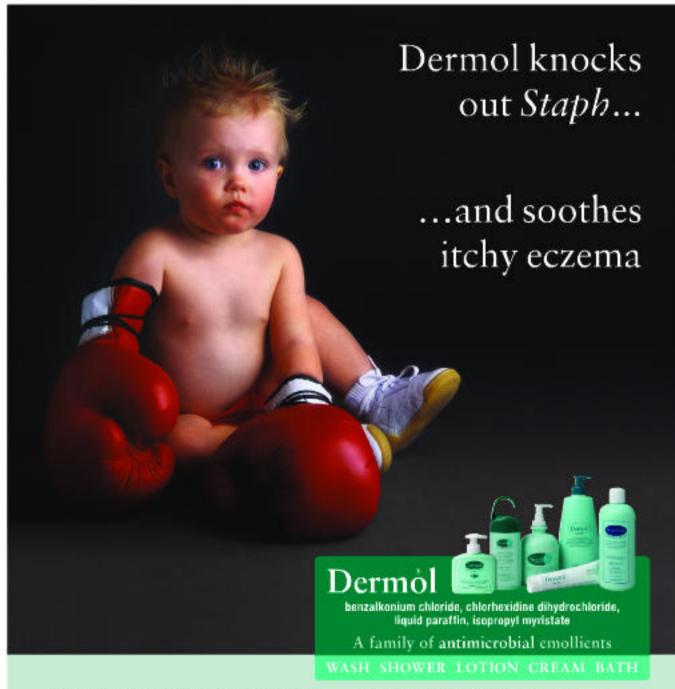
'It's also likely to be counterproductive. We know that Investment via enhanced services is key to delivering the cost efficiencies the Government wants to see. If anything, we need to be seeing far greater investment in

'It illustrates the shorttermism 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 overce and threaten.

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

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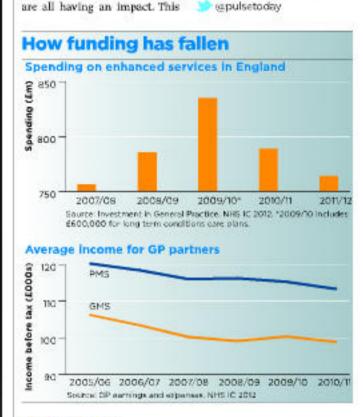
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Expenses take toll on earnings

Soaring practice expenses have total expenses rose by 3.5% from taken a further toll on GP earnings, with GP partners' income falling by an average of 1.5% in the proportion of gross earnings. 2010/11, figures show.

Data from the NHS Information Centre's GP Farnings and Expresses 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 E113,400,down 1.6%.

Overall, average gross earnings rose 1.5%, from £262,700 in 2009/10 to £266,500 last year, but

£156,900 to £162,400. This drove the expenses-to-earnings ratio 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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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).

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





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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 tietropium bromide, atropine or its derivatives, or to the excipient lactose monohydrate which centains 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 flotropium bromide inhalation powder. Caution in patients with narrowangle glaucema, prostatic hyperplasia or bladder-neck obstruction. Inhaled medicines may cause inhalationinduced 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 discemfort, temporary blurring of vision, visual halos or coloured images in association with red eyes from conjunctival congestion and comeal nedema. 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 bremide 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. Tietrepium 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 bramide during breast feeding is not recommended. A decision on whether to continue or discontinue breast feeding or therapy with tistropium bromide should be made taking into account the benefit of breast feeding to the child and the benefit of tiotrepium bromide therapy to the woman. Clinical data on fertility are not available for tictropium. 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 librillation, pharyngitis, dysphonia, cough, gastrooesophageal reflux disease, constipation, orepharyngeal 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 Holden: 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.

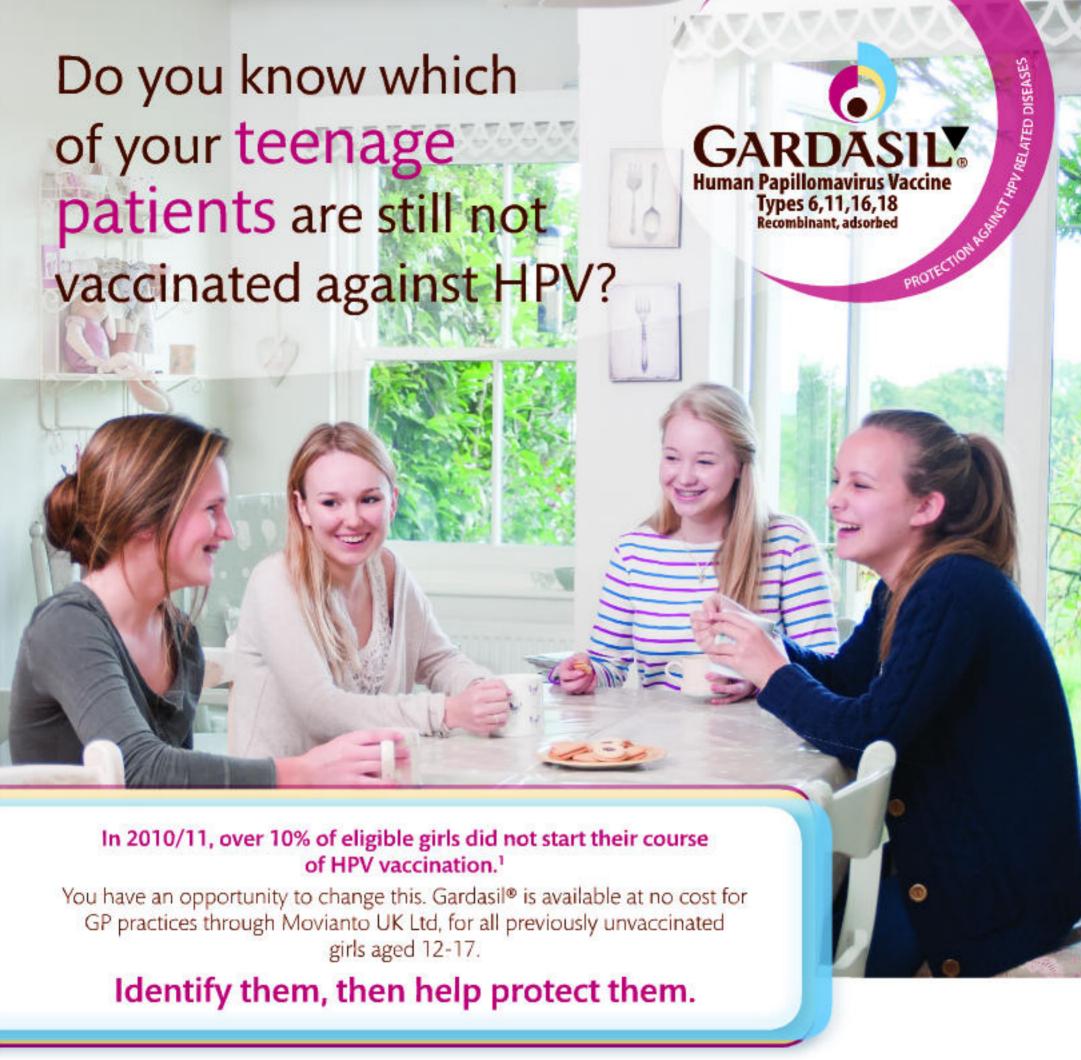
Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard. Adverse events should also be reported to Boehringer Ingelheim Drug Safety on 0800 328 1627 (freephone).

Date of preparation: August 2012

UK/SPI-12133







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, advarted)).

Refer to Summary of Product Characteristics for full product information

Presentation: Gardesi is supplied as a single dose pre-filled syrings containing 0.5 millithe of suspension. Each dose of the guadrivalent vaccine contains highly purified viruslike particles (VLPs) of the major capsid LT protein of Human Papillomavines (HPV). These are type 6 (20 µg), type 11 (40 µg), type 16 (40 µg) and type 18 (20 µg). Indications: Gordasil is a voccine for use from the age of 9 years for the prevention of premalignant genital lesions (convical, valver and vaginal) and convical concer causally related to certain encegenic Human Papillemavirus (HPV) types and genital worts (condylama acuminata) countly related to specific HPV types. The indication is based on the demonstration of efficacy of Cardasil in females 16 to 45 years of age and in males 16 to 26 years of age. and on the demonstration of immunogenicity of Gordosk in 9- to 15-year old children and adolescents. Despace and administration: The primary receipation series consists of 3 separate 0.5 mill little doses administered according to the following schedule: 0, 2, 6 menths. If an alternate schedule is necessary the second close 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 Gordas I. Acute severe febrile liness. Warnings and precontions: The decision to vaccinate on individual should take into account the risk

for previous HPV exposure and patential 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 contain to individuals with thrombocytopaenia or any congulation disorder because bleeding may occur following an inframuscular administration in these individuals. Syncope, same times associated with falling, has accurred after vaccination with Baséasit, vaccinees should be carefully observed for approximately 15 minutes after vaccination. There is insufficient data to recommend use of Gardasil during pregrancy therefore the vaccination should be postponed until after completion of the pregnancy. The vaccine can be given to breastlessing 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 veccine. As with any vaccine, veccination with Gordes'l may not result in protection in all vaccine recipients. There are no safety, immunogenicity or efficacy data to support interchangeability of Gordasil with other HPV vaccines. Undestrable effects: Yery common side effects include: headache and at the lajection site, erythema, pain and swelling. Common side effects include brusing and pruntus at the injection site, pyrecia, noused, and pain in the extremity. Rarely orticate and very rarely branchaspesia. has been reported. Idiopathic thrembocytopenic purpura, Guillein-Barré Syndrome and hypersensitivity reactions including, anaphylactic/anaphylactoid reactions have also been reported. For a complete list of undestrable effects please refer to the Summary of Product Characteristics. Package quantities and basic NHS cost: Single pack containing one 0.5 mill the dose prefilled syrings with two separate needes. NHS cost: \$86.50 per dose. Marketing authorisation holder: Sandi Posteur MSD SNC, 8 me lones Salk, F-69007, Lyan, France Marketing authorisation number: Ell/1/06/357/007 (pre-filled syrings with two separate needles) Legal category: POM ® Registered holderrock Date of last review: Nov 2012

References: 1. Department of Health, Third Annual Report on HFV coverage. http:// immunisation.ch.gov.uk/annual-kovvacche-coverage-in-england-in-201011-report/ Bate recessed August 2012.

Adverse events should be reported.

Reporting forms and information can be found at www.mhra.gov.uk/yellow.card

Adverse events should also be reported to Sanafi Pasteur MSD, telephone number 01628 785291.



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 Gannymede from the UK primary care

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. Tollowing 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 contract-



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

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

ing, 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

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

being dumped on primary care are developing a 'pricing basket' to present to PCTs to ensure the work is funded.

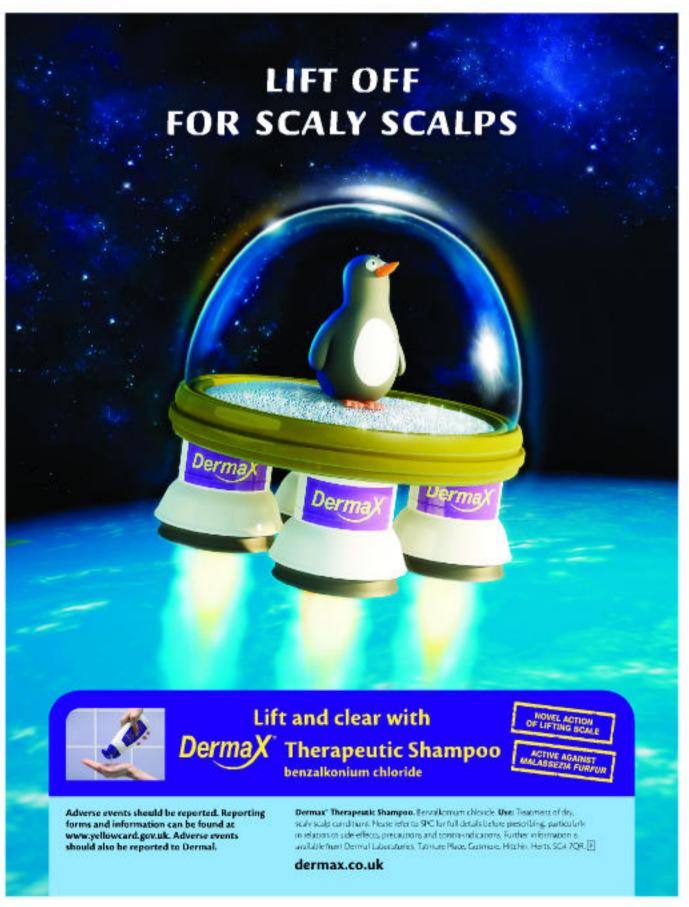
Dr Paul Roblin, chief executive of Buckinghamshire, Oxfordshire and Berkshire LMCs, said GPs in the Thames Valley area were 'universally irritated' by increasing requests 'bounced' to GPs from secondary care, and as a result had initiated plans to draw up a LES, with a menu of options to fund this work.

He said GPs were receiving requests concerning patients with eating disorders or ADHD referred through child and adolescent mental health services.

GPs 'irritated' by the increasing They were being asked to take amount of secondary care work 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."







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 frontloaded 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 costeffectiveness 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 approisal 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
- £475m cost at 10 years but NHS savings of £682m
- Only 1.5 million not screened after 10 years

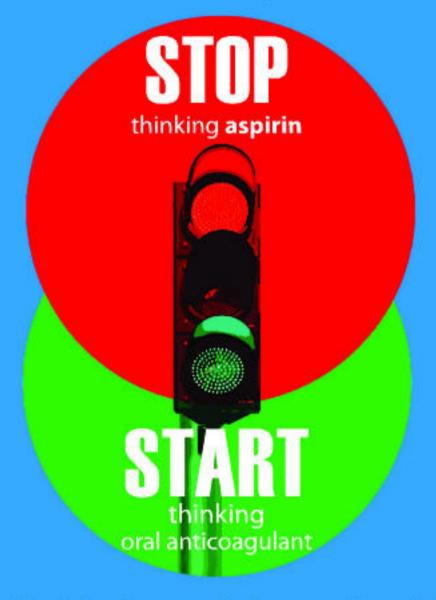
The authors said: 'Our model suggests that opportunistically screening patients on next GP consultation would be costeffective compared with current DES guidance, but this must be balanced against the challenge of implementing on such a scale.'

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 lacum 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.' 'apulsetoday

For stroke prevention in your moderate to high risk Atrial Fibrillation patients



Oral anticoagulation is three times more effective at preventing stroke than aspirin' It is estimated that there are over 230,000 AF patients treated with aspirin'

To find out more about how to deliver the new QOF to benefit your patients and Practice, attend SPAF Academy's regional workshops

Leeds • Birmingham • Manchester • Bristol



www.stopstart.org.uk

An online resource for stroke prevention in atrial fibrillation for UK Healthcare Professionals



pulse-learning could the online learning resource for UK GPs





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



Shingles (herpes zoster) vaccine (live)

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

ABRIDGED PRESCRIBING INFORMATION

ZOSTAVAX® pawder and solvent for suspension for injection (shingles (herpes zoster)) vaccine (live)] Refer to Summary of Product Characteristics for full product information. Presentation: Viol containing a lyophiked preparation of the attenuated varicella-zaster virus (Oka/Morck strain) and a pre-filled syringe containing water for injections. After reconstitution, one dose contains no less than 19400 PFU (Plaque-forming units) varicella-Zester virus (Oka/Werck strain). Indications: Active immunisation for the prevention. of herges zaster ("zaster" or shingles) and herges zaster-related post-hergetic neuralgia (PHN) in individuals 50 years of age and older. Dosage and administration: A single dose should be administered by subcutaneous injection, prefembly in the deltaid. region. Contraindications: Hypersensitivity to the vaccine or any of its components Uncreasing neonworks, marviouses receiving mirriumosuppressive meropy, Unduring righ dose should be considered in the presence of fever. In direct trials with Zostavax, transmission of has shown hypersensitivity reactions including engalylactic reactions, joint and muscle pain,

the vaccine virus has not been reported. However, post-marketing experience with varicellavaccines suggest that transmission of vaccine virus may occur rarely between vaccinees who develop a varicella-like rash and susceptible contacts (for example, VZV-susceptible infant grandchildren). Transmission of vaccine virus from varicella vaccine recipients without a varice la-zaster virus (YZV)-like rash has been reported but has not been confirmed. This is a theoretical risk for vaccination with Zastavax. The risk of transmitting the attenuated vaccine virus from a vaccinee to a susceptible contact should be weighed against the risk of developing natural zoster and potentially transmitting wild-type VZV to a susceptible contact. As with any vaccine, vaccination with Zastavax may not result in protection in all vaccine recipients. Pregnancy and lociation: Zostavax is not intended to be administered to pregnant women. Pregnancy should be avoided for three months following vaccination. Coution should be exercised if ZOSTAVAX is administered to a breast-feeding woman. conficusteroids) or who have a primary or acquired immunodoficiency. Individuals with active Undestrable effects: Very common side effects include: pain/tendemess, erythema, unitested tuberculesis. Pregnancy: Warnings and precoutions: Appropriate fucilities swelling and pruntus at the injection site. Common side effects include warmth, basmatoma and medication should be available in the rare event of anaphylaxis. Deferral of vaccination and industrian at the injection site, pain in extremity, and headache. Post marketing use

fever, swallen glands, rash, also hives and rash at the injection site. For a complete list of undestrable effects please refer to the Summary of Product Characteristics. Package quantities and basic cost: Vial and prefilled syringe with two separate needles. The cost of this vaccine is \$99.96. Marketing authorisation holder: Sanoti Pasteur MSD SNC, 8 Tue Jones Solk, F-69007 Lyon, France Marketing authorisation number: EU/1/06/341/011 Legal category: POM * Registered trademark Date of last review: June 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.

References: 1. Willer E, Marshall R, Vudien J. Epidemiology, autoome and control of varicella-aaster infection. Rev Med Microbiol 1993; 4: 222-30. 2. Bowsher D. The lifetime. occurrence of Herpes zoster and prevalence of post-herpetic neuralgia: A retrospective survey in an elderly population. Eur / Pain 1999; 3: 335-42. 3. ZOSTAVAX® SmPC. The need for a second dose is currently unknown.





PULSENEWS CLINICAL RO NICAL ROUND-UP

Anxiety in elderly could be first sign of 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

Risk factors

Increased risk of future dementia diagnosis

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

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 - potients may present with anxiety symptoms as a direct cause of the insight they have into their early experiences of cognitive impair-

'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

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

@pulsetoday

Online CPD

Key questions on dementia



pulse-learning.co.uk



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, ac-

cording 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 albumincreatinine ratio (ACR) measure-

ment 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

ABBREVIATED PRESCRIBING INFORMATION

Relax, Urgency controlled

10 mg soliferacin succinate. Indication: Symptomatic treatment of urge incontinence and/or increased urinary frequency and urgency as may occur in patients with overactive bladder syndrome. Dosage: Adults: Recommended dose: 5 mg once daily. needed, the dose may be increased to 10 mg once daily. Children and adolescents: Should not be used. Contraindications: Urinary retention, severe gastrointestinal condition (including toxic megacolon), myasthenia gravis or narrow-engle gleucoma and in patients at risk for these conditions. Patients hypersensitive to the active substance or to any of the excipients, or undevolving haemodialysis, or with severe hepatic impairment, or with severe potent CYP3A4 inhibitor. Warnings and Precautions: No clinical data are available from women who became pregnant while taking soliferacin. Caution should be exercised when prescribing to pregnant women. The use of Vesicare' should be avoided

Presentation: Vesicare" film-coated tablets containing 5 mg or - before prescribing. Use with caution in patients with clinically significant bladder outflow obstruction at risk of urinary retention, gastrointestinal obstructive disorders, risk of decreased gestrointestinal motility, autonomic neurogethy, severe renal or moderate hepatic impairment idoses not to exceed 5 mg), concomitant use of a potent CYP3A4 inhibitor, histus hernia/gastroesophageal reflux and/or patients currently taking mediones that can cause or exacerbate desophagitis. Angicedema with airway obstruction has been reported with some patients on Vesicare: Fatients with rare hereditary problems of galactose intolerance, the Lapp lactase deficiency or glucose-galactose malabsorption should not take this medicinal product. Interactions: Concomitant medication with other medicinal products with anticholinergic properties may result in more pronounced therapeutic effects and undestrable effects. Allow one week after stopping Vesicare' before commencing other anticholinergic therapy. Therapeutic effect may be reduced by during breast-feeding. Assess other causes of frequent urination - concomitant administration of cholinergic receptor agunists. Can

PULSENEWS CLINICAL ROUND-UP

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 bis-

phosphonate 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 34% 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 caneer 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 ques-

tionnaire, 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 impairment,

Cochrane review has concluded. The review included eight randomised controlled trials in-

volving 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 apilepsy 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



solifenacin

reduce effects of stimulators of gastmintestinal tract motility. If October 2011, Further information available from Astellas used concomitantly with ketoconszole or other CYP3AA potent. inhibitor, maximum dose should be 5 mg due to 2-3 fold increase. in AUC of Vesicare! Pharmacokinetic interactions are possible with other CYP3A4 substrates with higher affinity and CYP3A4 inducers. Adverse Effects: Bry mouth, blurred vision, constigation, nausea, dyspepsia, abdominal pain, urinary tract infection, peripheral cedema, colonic obstruction, rash, uninary retention, halfactnations, confusional state, angioedema. In worldwide postmarketing experience, QT prolongation and Torsade de Pointes have been reported in association with Vesicare" use, but the frequency of events and the role of Vesicare" in their causation. cannot be reliably determined. Prescribert should consult the Summary of Product Characteristics in relation to other side effects. Basic NHS Cost: Vesicare" 5 mg blister packs of 30 tablets 627.62; Vesicare 10 mg blister packs of 30 tablets 635.91. Legal Category: POM. Product Licence Number: Vesicare' 5 mg - Date of preparation: April 2012.

Pharma Ltd, 3rd Floor, Future House, The Glanty, Eghani, Surrey, TW20 9AH, Vesicare' is a Registered Trademark. For full rescribing information please refer to the Summary of Product Characteristics. For medical information phone 0800 783 5018.

> 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 Astelias Pharma Ltd. Tel: 0800 783 5018.

Pt. 00166/0197; Vesicare* 10 mg Pt. 00166/0198. Date of Revision: VES12142UK



CPD 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.



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 possi-



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: Sever P. Strategies to get useful biomarkers in CV disease. European Society of Hypertension 2012, Pienary session, 29 April 2012.

Online CPD

Lipid modification: a case-based learning module



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

'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

(a: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: tachling 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 fore-

ing underperforming hospitals to merge with other underperforming hospitals would fail because it creates larger underperforming hospitals.

กรอด



ELECT is indicated for paramits aged from 2 years with mild-to-moderate atopic screens when cleroids are ineffective or containdicated.

Information about this product, including adverse reactions, precautions, contra-indications and method of use can be found in the product SPC or at environmental tags includes any unknown togget contra-indications and method of use can be found in the product SPC or at environmental tags in the product SPC or at environmen

Adverse exects should be reported. Reporting forces and information can be found at wawwithin grouply playment.

Adverse exects should also be reported to Meda Pharmacouticals Ltd.

UNGLITZ/0046 September 2012

JANUVIA: More prescriptions than any other DPP-4 inhibitor¹

TOTAL PRESCRIPTIONS DISPENSED WORLDWIDE²

SITAGLIPTIN FAMILY: 46.6 MILLION (JANUVIA & JANUMET)

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- As monotherapy when metformin is not appropriate
- As add-on to metformin
- As add-on to sulphonylurea (SU)

- 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.



Januvia® (sitagliptin)

JANUVIA® Sitagliptin JANUMET® Sitagliptin/metformin hydrochloride

PRESCRIBING INFORMATION

Refer to Summary of Product Characteristics (SmPC) before prescribing

Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/ yollowcard. Adverse events should also be reported to MSD (tel: 01992 467272).

PRESENTATION

Januaria: - 25 ang film-coated tablet containing 25 mg of sitsgliphin my film-posted tablet containing 50 mg of elapitotic 100 mg Sim-coated behind containing 100 mg of a tapliptin.

Janumet - 50 mg/t000 mg tablets each containing 50 mg sitagliptin 1000 mg metformin hydrochlaride

For adult patients with tops 2 diabetes melities

as monotherapy · in patients inadequately controlled by diet and everyise alone and

- for whom metermin is inappropriate due to contraindications or
- as dual and therapy in combination with
- · methornin where died and exercise plus methornin alone de not provide adequate discount is control
- · a sulphorylurea when diet and exercise plus maximal tolerated dose et a suiphonsturez alone do not provide adequate glycaemic control and when metitornin is inappropriate due to contra-indications or intrivence
- · a PPARy agonist die, a thissolichnodicard when use of a PPARy agorist is appropriate and when elet and resercise plus the PRARy agonist alone do not provide adequate glycaernic control.
- as trigle oral therapy in combination with a sulphorylures and metformin when dist and evercise give dual
- therapy with these medicinal products do not provide adequate glycaemic centrol · a PFARy agonist and methornin when use of a FPARy agonist is
- appropriate and when diet and exercise plus dual therapy with these medicinal products de not provide adequate glycaemic control. Januaria is also indicated as add-on to insulin (with or without

methornin) when diet and esercise plus stable disage of insulin do not provide adequate plycaemic control.

Janunet

as an adjunct to diet and exercise to improve glycaennic control in gazents reviewably controlled in their resulted tolerated dose of motionnin alone or those already being treated with the combination all sites plin and mellomes.

- · is combination with a subflorglume (i.e., triple combination therapy) as an adjunct to det and exercise in patients hadequately controlled on their maximal tolerated dase of metharmin and a sulphonylures.
- · as triple combination thesely with a MARy against (i.e., a this printered as an adjunct to that and exercise in patients inadequately controlled on their maximal telerated dose of metformin and a PRARy agorest.
- as add-on to insulin (i.e., triple combination therapy) as an argunot. to det and exercice to improve plycaemic control in patients when stable desage of insulin and metformin alone do not provide adequals grycamic contol.

DOSAGE AND ADMINISTRATION

Januaria - One 100 mg tablet once duly, with an without load. Janumet -One 50/1000 mg lablet taken timbe a the with meals Januaria and Januariet -in combination with a subtraviures or with insulin, consider a lower close of submonytures; or insulin, to reduce tisk of hypoglycannile. Book impairment: For Januaria only - when considering use in combination with other anti-clubetic products, shock conditions for use in patients with renal impatement. No date adjustment is required for patients with militirenal impatement. (used nine clearance [D/D] a56 ml/min). For patients with moderate ronal impairment (CrCl >30 to <50 mt/min), the dose of Janusia is 50 mg once daily. For potients with severe renal impairment (CrCl <30 milimin) or with end-stage renal disease (ESR0) requiring traemodialysis or performal dialysis, the dose of Januvia is 25 mg once daily. Januaris may be administered without regard to the String of dialysis. Because there is a design adjustment based upon rotal function, assessment of renal function is recommended. prior to initiation of Jamwia and periodically thematter. For Jacobset only should not be used in patients with imoderate or severe renal Impairment (creativine degrance < 60 mil/min). Hepatic impairment: For January, only the desage adjustment necessary for patients with mild to increately hepatic incomment. Januaria has not been stated in patients with severe hissale impairment. For January only – do not use. Either is $\sim 75~\rm years$. For Januarie evey –ne descape adjustment necessary. For Januaries only –use with causion as age increases. Monitoring of renal function is necessary to aid prevention of metions reasociated factic acidesis. Elderly is 75 years: Exercise care as there are limited safety data in this population. Children red recommended below 16 years of age.

CONTRA-INDICATIONS

For Januaria + impensors fluity to active substance or exclipionis. For Januariet Hypersensitivity, Disbetic ketoscidosis and disbetic pre-corns. Moderate and severe roral impairment (creatinities dearance < 60 mil/min). Acute conditions with the patential to alter notal function such as delightedion, severe infection, sheek Introvoscular administration of ledinated contrast accests. Acute or divortic disease which may cause tissue hypoxia such as cartiles or respiratory failure, recent injucardial infarction, shock. Hepatic impairment. Acute alcohol intrologication, alcoholism, Lactation.

For Jameria and Januariot - Seneral: do not use in patients with type diabetes or for diabetic ketolocidosis.

Pancreatitis: Post-marketing experience - spontaneously reported adverse reactions of acute paracreable, inform patients of the symptom of scale parcrealitis; possistent, severe abdominal pain. Secolation of parcreatitis has been observed after discentinuation. of sitagliptin, but very rare cases of necrotizing or licementagic parcreatits and/or death have been reported. If pancreatitis is suspected, Javavia and other potentially suspect medicinal products should be discontinued.

Happy is been a subservated with other anti-hyperphysicanic agents: Fates of hypoglycaemia reported with staglight were generally similar to rates in patients taking placebo. When oftagliptin was added to a sulphonylurea or to health, the incidence of hypophycaetria was increased over first of placeho; therefore consider a lower dose of sulphosphores or insulin to reduce the risk

of hypoglycaemia when administering Japanest or Januaria. Hypersons thirty reactions: Serious hypersonshivity reactions have been reported, including anaphylaxis, angicevienta, and extrilative skin conditions including Slevere-Johnson syndrome Disett accurred within the first 3 months after inflation of beatment with some reports occurring after the first does. It suspected, discontinue. Januaria or Januarias.

For Januaria only -Renal impairment; Januaria is renally excreted. To achieve plasma concentrations of Januaria similar to those in patients with period raind function, lower decades, are increased in patients with mosterate and severe roral impairment, as well as in ESBD potients requiring harmedialesis or portonnal dialysis (see section 'Dosage and administration' above and section 4.2 and 5.2.

For Janumet only -Lacits acidosis and renal functions a very rare, but serious, metabolic complication can occur due to metformin percentification. Owner in patients on multipress have received princely in diabetic patients with significant renal failure. Reduce incidence by searcaing other associated risk factors. It suspected, discontinue treatment and tespribilise patient immediately.

If changes in clinical status of patients with previously controlled type 2 diabetes occurs, evaluate promptly for evidence of keltoacidasts or lactic acidosis in any patient with type 2 diabetes previously well controlled on Janumet who develops laboratory abnormalities or dirikal filmess (especially vague and poorly defined Bleech. It soldbeis of either form occurs, stop Januariet immediately and initiate constitute measures.

Determine serum creativing concentrations regularly, i.e. at least once a year in patients with normal renal function and at least two to four times a year in patients with serum creatinine levels at or above the upper limit of normal and in elderly patients. Decreased renal function in elderly potients is frequent and asymptomatic. Exercise special castion where renal function may become impaired, e.g. when initiating antitype density or disnetic therapy or when starting treatment with a non-stero ead anti-inflammatory drug (NSAID).

Surgery: due la mellarmin hydrachlaride content al Janumat, discontinue treatment 48 hours before niective surgery with general, spinal or epidural anaesthesia. So not resume earlier than 48 hours afterwards and only after renal function is normal.

DRUG INTERACTIONS

For Januariel crity - Approx avoid algohol and medicinal products centaining stochol due to risk of factic acideals. Callanic modicinal products that are elevisected by renet behales secretor (e.g., olvedished these may interact with methods in by competing for common renal tubular transport systems. Consider close monitoring of plypaemic central, dose adjustment within the recommended poorings and changes in statetic treatment when these agents are co-administrate. Assistant contrast agents in raciological afurfeer introvescular seministration of these agents incy lead to rired failure, rissulting in metformin accumulation and a risk of factio quirks is. Discontinue Januaries prior to, or at the time of the test and do not relestitute until 48 hours attenwards, and only after renal function is found to be normal. Combination requiring precautions for use: plucocorticolds (given by systemic and local reutes) beta-2agenists, and disretice have intrincte hyperphicaemic activity. Inform the patient and perform more frequent blood glucose monitoring, expecially at the beginning of freetheast. If recessory, adjust close of the anti-hyperphycaemic medicine during therapy with or on discontinuation of the other medicine. ACE-inhibitors as these may decrease the bloce placese levels. If recessary, rejust dose of the untilege glycuernic during therapy with, or on a scontinuation of the other medicine.

For Januaria and Januariet -Low risk of clinically meaningful interactions with methannin and ciclosporin. Meaningful interactions would not be expected with other p-glycapidisis inhibitors. The primary enzyme recognishs for the limited metabolism of allogiptimic CVP3A4 with contribution from CVP2C8.

Dipovic attagliptin had a small affect on plasma digorin concentrations, and may be a mild inhibitor of p-plycogratein in view No storage adjustment of diopsin is recommended, but monitor potients. at risk of elgosts looksity if the two are used together

Programmy and facilities: Do not use during pregnancy or breast-feeding.

SIDE EFFECTS.

Refer to SmPC for complete information on side effects

There have been no therapeutic clinical trials constacted with Janumet tablets however Janumet is bioequivalent to co-administered shapilgrin and metformin. Serious adverse reactions including pancreatitis and hypervensitivity reactions have been reported. Hygaglycomia has been reported in combination with sulphorylures and insulin.

Silagiphia industrienza: Common (> 1/100 to < 1/10) tape respiratory tract infection, resophoryreptis, calcourthilis, pain in cotomic, hypophosomic, handache, Uncomme p. 277,000 to

c1/900 dizzinner, constipation.
Methornin only: Christi Trial Bata and Post-marketing data: Very common (a 1/16): gestreintestinal disorders; Common (a 1/190 to < 1/10/t metalic taste; Very rare /c 1/10/000: unicarta, erythemo, prunitis, lactic acideate, vitamin 812 deficiency, liver function. distribute, hepatitis

Situation with methors of Convers & 1780 to <1780 hypoglycaeria, fictulesia, versiting, results. (Newsterns) 1/1,000 to <1/100; sometimes, constipation, upper abdominal pain, Starthess, blood placose decreased. Staglighth with a selection during: Covereur (c. 1/100 to <1/10; hepoglysaemia. Stagilptin with medicinals and a substanytures. Pery common le 1/10): hypophysaenika: Common (e. 1/100 to <1/10): conditionin Situatiotis with a PPWAy appealed (aloui belone): Convivour (a. 1/100 to <7/10 hypogycaenis, fistalinos, seriphera petieros à codighaces decreased. Sitagi al rivello a PAR, agentat and restionnin. Governor. 1/100 to <1/10) upper requiratory tract infection, headache, danhocu, somiting, hypoglycueniu, perpheral cedemii, coupt; Becarveror & 1/1,000 to <1/100): fungal skin infection. Staplotin with insulin with/ without medicinin: Coronvol (c. 1/100 to <1/100 headache, hypoghypaeria, influence: Unconstant & 1/1,000 is <1/100) dy maith, continuous. Staglobs with methorisms and insulin. New common (>1/10) higosylposimic. Ohtorismum (>1/1,00) to <1/1,000 to <1/1,000 to <1/1,000 to supplies the production of the production.</p>

Adverse arents with situations alone in chains studies, or during post-approval use alone and/or with other distretes medicines where frequency is not known hypersensitivity reactions including anaphylactic responses (see precautions), interstital long disease, verniting, acute pancreatitis, fatal and non-fatal haemorrhanic and neurotaing concreation augmentum, realt, unicaria, culturerum of the state of the orefficies building syndrome, arthrolois, regolois, poin in extremity, back pain, impaired

PACKAGE QUANTITIES AND BASIC NHS COST Januaria: 28 Tablets: E38 26 Januariet: 56 Tablets: E34.56

Marketing Authorization Number

Januaria 100 mg: 88/1/07/282/014 Januaria 25 mg: 88/1/07/282/002 Januaria 50 mg: RJ/1/07/385/008 Januariet 50 mg/1000 mg/EU/1/08/455/010

Marketing Authorisation Holder

Merck Sharp & Bohme Limited, Hertford Road, Hoddesdon,

[PCM] Date at review of prescribing information: September 2012 @ Merck Sharp & Dolane Limited, 2012. All rights reserved. PLAN & JMT12.JK3814

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The hard truth about the fall in GP funding

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 beforetax 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 Crieste 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.



Steve Nowottny

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



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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.

Fer Christ's sake, I'm a middle-aged working-class bloke from Hartlepool. What do I know about burn 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 pointyfaced, 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

l only know two positions: socks on or socks off for a minute. With a face like a wasp with a grievance, she complied.

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.' 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

l would happily bet we work more hours than our contract demands than men. In 2009, it was found that women worked on average 60% full-time equivalent compared with men's 80%. Acurologists reported the same thing in 2007. In 2006, it was found that in Scotland, male GPs spent 18% more time on GMS but 50% more time on non-GMS services. 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. As far back as 1997, the Department of Health noted that flexible working was now a 'general trend'.

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. 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

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24 PULSEVIEWS OPINION

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

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

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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



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26 PULSEVIEWS OPINION

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 lan King is a GP in Redhill, Surrey



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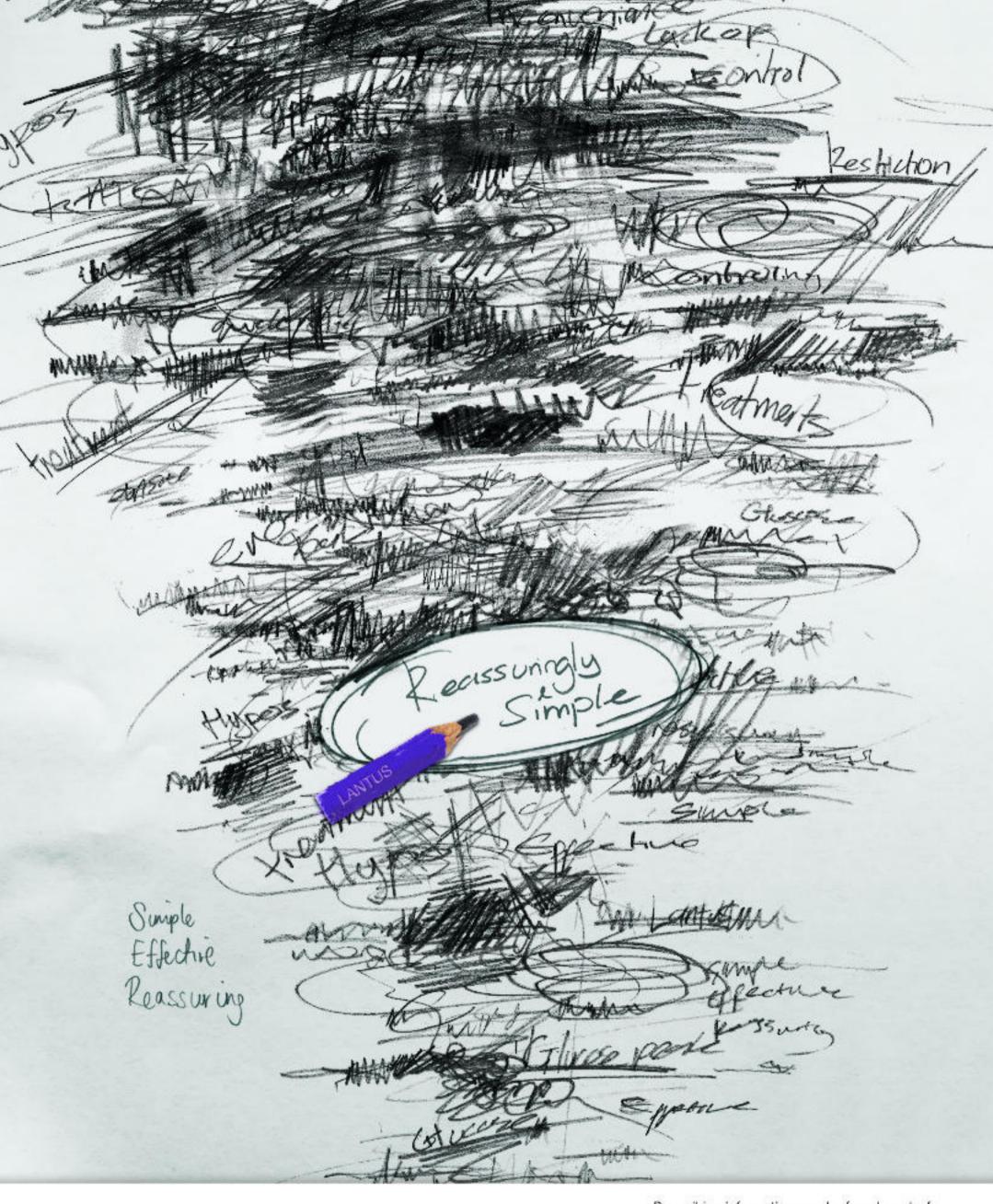
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The Government must recognise the burden on GPs in the next round of contract talks and award the profession an equivalent increase in

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.



Prescribing information may be found overleaf





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28 PULSEVIEWS LETTERS

3 October 2012 | pulsetoday.co.uk

We need an honest debate on 'rationing'

From Dr Jeremy Platt

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

co.uk/news).

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

drive accelerates', pulsetoday.

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 estecarthritis should have one. The body mass index threshold for bariatric surgery



How can GPs ensure patients only get necessary procedures?

is debatable, but there must be

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

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.

GPs are in a downward spiral

From Dr Thomas Bloch

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 everincreasing 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



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

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

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,

Becoming a locum offers real freedom

From Dr Balbir Virik

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

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 Hailwood vla 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

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

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

From Dr Sunil Bhalla

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 Convery

via pulsetoday.co.uk

Independent thought, clinical autonomy and medical selfsufficiency 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 oncenoble 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@pulsetoolay.co.uk

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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 selfincriminating 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 Dectors is piloting a GMCfunded 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/ dactorsfordoctors. The Practitioner Health Programme is on 0203 049 4505 and at php.nhs.uk

Pulse Clinical

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Hot topics in back pain

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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

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.

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



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

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

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.

...... 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.

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



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Dr Conal Perrett is a

consultant dermatologist,

dermatological surgeon at

London, and lead clinician

for skin cancer at London

Dr Mandy Fry is a GP

in Cirencester,

Trust.

Hospitals NHS Foundation

Gloucestershire, and senior

Oxford Brookes University

Clinic, For more information go to

primary care lecturer at

This article was produced in collaboration with The London

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University College Hospital,

CHAMPIX has more than 18 million treatment courses initiated worldwide⁶

CHAMPER® ▼ Film-Coated Tablets (varenicline tartrate) ARREVIATED PRESCRIBING INFORMATION - UK (See CHAMPIX Summary of Product characteristics for full Prescribing Information) Please refer to the SmPC before prescribing CHAMPIX 0.5 mg and 1 mg. Presentation: White, aspector-shaped, biconvex tablets debassed with "Plice" on one side and "CHX 0.5" on the other side and light blue, capsularshaped, biconvex table is debased with "Plizer" on one side and "CHK 10" on the other side. Indications: CHAMPIX is indicated for smolong cessation in adults. Dosage: The recommended dase is 1 mg repending twice daily following a 1-week (Mation as follows: Days 1-3, 0.5 mg times daily, Days 4-7, 0.5 mg twice daily and Day 8 – End of treatment. Timg twos daily. The patient should set a date to stap smoking. Otsing should usually start 1-2 weeks before this date. Patients who are not willing a able to set the larget quil obte within 1-2 weeks, could be affered to start teatment and then choose their own quit date within 5 weeks. Patients who cannot take ate adverse effects may have the dase lowered temporarily or permanently to 0.5 mg trace daily. Parlients should be treated with CHWMPIX for 12 weeks. For patients who have successfully stepped smoking at the end of 12 weeks, an additional course of 12 weeks healment of Ting twice daily may be core dered. Following the end of teatment, dose topering may be considered in gottents with a high risk of relapse. Patients with renal insufficiency, Mild Comaclerate renal importment Na dispage adjustment is necessary Actions with moderate renal impairment who experience intolerable adverse events. Draing may be reduced to 1 mg ance daily. Severe renal impairment 1 mg ance daily is recommended. Oosing should begin at 4.5 mg arce daily for the list 3 days then increased to 1 mg ance abily. Patients with end stage renal disease. Treatment is not recommended. Patients with hepatic impairment and elderly patients; No dasage adjustment is necessary. Foediatric patients; Not recommended in patients below the age of 16 years. Contraindications, Hyperpensitivity to the active substance or to any of the excipients. Warnings and precautions: Effect of smoking consistion, Stopping smoking may after the pharmocokinelics or pharmocodynamics of some medicinal products, for which dasage adjustment may be necessary texamples include fleephyline, worldrin and ireuint. Changes in beliavour arthinking, arraidy, psychosis, mood swings, aggressive behaviour, depression, suicidal idealian and behaviour and suicide altempts have been reported in polients alternating to get smoking with CHAMPK in the post-marketing experience. Not all patients had stapped smaking at the time of orset of symptoms and not all patients liad known pre-existing psychiatric illness. CHWMPIX should be discontinued immediately if agilation, depressed mood or changes in behaviour or frinking that are of concern for the doctor, the patient, family or congivers are observed, or if the gatesi develops suicidal ideolari ar suicidal behaviour. In mone post-marketing cases, resolution of symptoms after discontinuation of varanicine was reported, although in some cases the symptoms persisted, therefore, angoing follow up should be gravided until symptoms resolve. Depressed mood, rarely including suitabilities and suicide alterral, may be a symptom of nicoline withdrawal. In addition, smaking dessation, with ar without pharmacotherapy, has been associated with the exacerbation of underlying psychiatric flivess (e.g. depression). In a trial of patients with stable condicyaecular disease ICVCI certain cardiavascular events were reported more frequently in potients treated with CHAMPIX. Patients taking CHAMPIX should be instructed to notify their doctor of new or worsening conclovoscular symptome and to seek immediate medical attention if they experience signs and symptoms of my condial infarction. The safety and efficacy of CHWAPK in patients with serious psychiatric illness has not been established. There is no clinical experience with CHAMPIK in patients with epilepsy. At the end of heatment, discontinuation of CHAMPIK was associated with an increase in imballity, urge to smoke, depression, anal/or insammia is up to 3% of patients. Therefore dose tapening may be considered These liave been post-marketing reports of hypersensitivity reactions including angioedema and reports of rare but severe cutaneous reactions, including Stevens-Johnson Syndrome and Trytherna Walflamme in patients using varenidine. Patients expenencing these symptoms should discontinue freatment with rarendine and contact a health care provider immediately. Fertility, pregnancy and lactation; CHAVPIX should not be used during pregnancy. It is unknown whether varenidine is excreted in human breast milk. D-WMPK should only be prescribed to breast feeding mathers when the benefit authreights the risk. There are no dinical data on the effects of varenicline on fertility. More clinical data rerealed no historial for humans based on standard male and female fertility studies in the rat. Orwing and operating machinery: CHAMPIK may have minor at moderate influence at the ability to drive and use machines. CHWWFX may cause distiness and somnolence and therefore may influence the ability to drive and use machines. Patients are solvised not to drive, operate complex machinery or engage in other potentially liadarabus activities until it is lanour whether this medicinal product affects their oblity to perform these activities. Side-Offects: Adverse reactions during clinical trials were usually mild to moderate. Most commanly reported side effects were abnormal dreams, insormia, headache and nausea. Commonly reparted side-effects were increased appetite, somnolence, distiness, dysgeusia, varning, consipation, alianhoea, abdominal distension, stomach discomfort, dyspiepsia, flatulence, dry mouth and latigue. See 5m PC for other less commonly reported side effects. **Overdose:** Standard supportive measures to be adopted as required. Your nicline has been shown to be dialyzed in patients with end stage renal disease, however, there is no expertence in alalysis following averdase. tegal category: POM Basic NHS cast Pack of 25 TLx 0.5 mg and Mix Img lablets Cord EU/1/06/260/063: E27.36 Rock of 58 ling tablet: Cord EU/1/06/260/00/4 527.50 Pack of 56 0.5 mg lablets HDPE bottle (BLV1/06/360/00). 854.60 Pack of 56 ling tablets HOPE Battle IBW1/06/366/007, ES4 60 Pack of 56 ling tablets Cond. 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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.

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 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 developing another melanoma is 30 times higher than the general population.

familial melanoma occurs in the p53 gene, 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.

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?

is characterised by a scaly red plaque and full thickness dysplasia on histopathology. About

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 posttransplant and approximately a 100-fold

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.

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

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.

.......... 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.

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

Learning until 17 October 2012

with melanoma has a family member with a

parent who has had melanoma, your risk of

The most common mutation seen in which functions as a tumour suppressor gene in its normal state. Mutations in other genes,

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Bowen's disease (also known as SCC-in-situ) 20% of cases develop into invasive SCC.

Clinically there is no definitive way higher risk of SCC compared with the normal immunocompetent population.

·<u>·····</u>

The risk of malignant transformation varies, even in similar populations, depending on

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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



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

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of patches or plaques with a prediection for the breasts and burbocks, and may have angulated margins. Lesional sinn may demonstrate exystrems, fine scaling, skin the patches can be hypopigmented skin the patches can be hypopigmented ears asymptomatic, Stage 2 has the same outeneous reatures as stage i but with normalignant fymphadenopathy or nuturated, and may become ulcerated (as in this case). Stage 2 is exystracted with indurated, and may become ulcerated by the stage of the standard o

indolent course involving the skin alone; but, a few cases progness repidly with development of cutaneous furnours and systemic involvement.

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5 Mycosis fungoides
Mycosis fungoides is a cutaneous T-cell
fungitions that can develop at any age
but has a higher not develop at the fifth and
sixth decades, it generally rurs a chronic,

The lesion is a dark red nodule measuring 0.6-2.0 cm in diameter. The base may be pedunculated, the surface is often enoded pedunculated, the surface is often enoded crust. Pyogenic granulomas are usually peinless but tend to bieed when knocked, immediate management is with excision or curettage and cautery camed out under local anaesthetic. Some pyogenic premiornas will recur following surgical immediate management.

grows rapidly, often following minor skin beauma. Pyogenic granulomas have a bendency to bleed causing patients to seak an uniquent opinion. There is an association with progent control of A pyogenic granuloma is most commonly stuated on a finger or a lip. (poujou cabijes) pecuracijoura) wujch y byočeujo čusurjoura je a vasonja, uogrje typočeujo čusunjoura

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Squamous cell carcinoma

SCC is a malegrant furnour arting
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commonly in fav-slonned individuals
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34 PULSECLINICAL

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.

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

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Prescribing information can be found on the adjacent page.

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.

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.

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.

Use the first blow as a practice

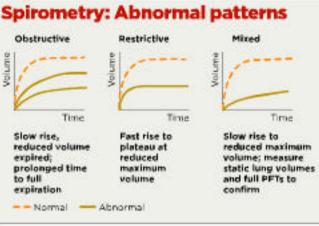
Many patients will not be able to perform the test adequately and will need to be trained, which may take many attempts and be time consuming. It may help to use the first blow as a practice to reduce the chance that results will be skewed. Bring patients back for another appointment if you run out of 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.

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

Flow-volume curve patterns: obstructive and restrictive





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.

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

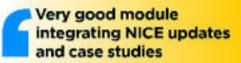
The Primary Care Respiratory Society UK (PCRS-UK) is the UK-wide professional society committed to improving respiratory care in primary care. PCR5-UK is a registered charity, led by their members through a range of committees and faculties dedicated to meeting the vision of 'optimal respiratory care 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 took to help you make a difference in respiratory care. For more information about PCRS-UK and how to join, go topers-uk.org/join.

Resources

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



Case-based learning module COPD 2 CPD hours



Dr Mark Izatt

pulse-learning.co.uk

Prescribing Intermation (UK) film-coated tablets

Film-coated tubiets containing 5 mg Imagligtin Indication: Trajenta is

indicated in the treatment of type 2 dispetes mellitus to improve glycaemic control in adults; as monotherapy - in patients inadequately controlled by diet and exercise stone and for whom mottomin is inappropriate due to intolerance, or contraindicated due to renal impairment; as combination therapy: - in combination with metform in when diet and exercise plus metformin alone do not provide adequate glycaemic control; - in combination with a sulphonylures and metformin when diet and exercise plus dual therapy with these medicinal products do not provide adequate glycaemic control. Dose and Administration: 5 mg once duly. If added to melformin, the dose of nottermin should be maintained and fragiliting administered concomitantly. When used in combination with a sulphanytures, a lower dose of the sulphanytures may be considered to reduce the risk of hypoglycaemia. Palients with renal impairment; no dese adjustment required. Pharmacokinetic studies suggest that no dose adjustment is required for patients with hepatic impairment but clinical experience in such patients is lacking. Elderly: no dose adjustment is necessary based on age however, clinical experience in patients > 75 years of upe is limited. The safety and efficacy of linegliptin in children and adolescents has not yet been established. No data are available. Trajents can be taken with or without a most at any time of the day. If a done is missed, it should be taken as soon as possible but a double dose should not be taken on the same day. Contraindications: Hypersensitivity to the active substance or to any of the excipients. Warnings and Procentions: Trajenta should not be used in patients with type 1 diabetes or for the treatment of diabetic ketoacidosis. Caution is advised when finagiliptin is used in combination with a sulphorphyrea; a dose reduction of the sulphonylurea may be considered. Interactions: Linapliptin is a weak competitive and a weak to moderate mechanism-based inhibitor of CYP isozyme CYP3A4, but does not inhibit other CYP isonymes. It is not an inducer of CVP becomes. Unagliptin is a P-plycopretein substrate and inhibits P-plycoprotein mediated transport of digoral with low potency. Easers on these results and A who interaction studies, linagliptin is considered unlikely to cause interactions with other P-gp substrates. The risk for clinically meaningful interactions by other medicinal products on inadigitin is: low and in clinical studies linegiptin had no clinically relevant effect on the pharmacokinetics of metformin, phytoride, sinvastatin warfarin, digovin or dial contraceptives (please refer to Summary of Product Characteristics for information on divided datas. Fortifity, pregnancy and factation: Avoid see during programmy A risk to the breast-fed child carnot be evoluded. A decision must be made whether to discontinue issuest-fixed no or to decontinue/abstain from Trajenta therapy baking into account the benefit of breest-feeding for the child and the benefit of therapy for the woman. No studies on the effect on human tertility have been conducted for Trajenta. Undesirable effects: Adverse reactions reported in patients who received lineg liptin 5 mg daily as monotherapy or as add-on therapies (pooled analysis of placebo-controlled studies). The adverse reactions are listed by absolute frequency. Frequencies are defined as very common (x1/10), common (x1/100 to <1/10), uncommon (x-1/1,000 to < 1/100), rare ($\ge 1/10,000$) to < 1/1,000), or very rare (< 1/10,000). not known (cannot be estimated from the available data) Very commerc hypoglycaemia (combination with/add on to metform in and eulphonylurea). Uncommon: resopharyngitis (moretherapy, combination with/acid on to methannin's hypersensitivity (combination with/add on to melformint; cough importherapy; combination with/ add on to metternin). Not known: nasopharyngitis (combination with add on to metformin and sulphonylunes); hypersensitivity

(monotherapy, combination with/add on to metformin and sulphonylunes); cough (combination with/add on to melformin and sulphonylures); pencreatitis (monotherapy; combination with/add on to metformin; combination with/add on to metformin and sulphonylures). Prescribers should consult the Summary of Prestact Characteristics for further information on side effects. Pack sizes and NHS price: 28 tablets £33.25. Legal category: PUM. MA number: EU/1/11/707/C03. Marketing Authorisation Holder: Beeininger Ingelheim International Gmielf. D-55218 Ingelheim am Rhein. Germany. Prescribers should consult the Summary of Product Characteristics for full prescribing information. Prepared in September 2011

JENTACUETO* (linagliptin UK Prescribing Information and metformin hydrochloride) 2.5 mg/850 mg film-coated tablets and 2.5 mg/1,000 mg film-coated tablets

Film-casted labiets containing 2.5 mg linapliptin and 850 mg metiormin hydrochlaride or 2.5 mg linagilptin and 1,000 mg metiornin hydrochlaride. Indication: Treatment of askit patients with type 2 diabetes metitus; as an adjunct to diet and exercise to improve glycaemic control in adult patients inadequately controlled on their maximal toleraind close of mettormin alone; or those already being treated with the combination of Inspliptin and melforning in combination with a sulphondures it is triple combination therapy) as an adjunct to diet and exercise in adult gatients inadequately controlled on their exertinal tolerated dose of metformin and a sulphorylunes. Dose and Administration: The dose of Jordaniero should be includualised based on the patient's current regimes, effectiveness and tolerability, not exceeding the maximum recommended daily does at 5 mg linagliptin alus 2,000 mg of mettermin invaractionide. For patients inadequately controlled on maphosil folorated close of metformin monotherapy: The causi starting dase of Jertaducto should provide Frantistin 2.5 mp brice daily (5 mg total delly dose) plus the current dose of metformin. For patients switching from co-administration of linealigity and metformin: Initiate Jentaqueto at the dose of linug is linunci metformin already being taken. For patients inadequately controlled on deal imbinution of the invanious tolerated floor of methodist and a aniphoryAcres: The dose of Jentadueto should provide Imaglistin 2.5 mg twice daily (5 mg total daily dose) and a dose of metformin similar to the door already being taken. When linegiptin plus metformin hydrochlaride is used in contrination with a sulpharuturea, a lower doce of the suiphorylunes may be required to reduce the risk. of hypoglycaemia. Elrierly: As methornin is excreted by the kidney, Jernadueto airculd be used with caution as age increases. Monitoring of respit function is recessory. Clinical experience with patients is 80 years. of age is limited and caution should be electrised. Renal Impairment: Jentaquets must not be used in patients with moderate or sesons renal impairment (creativine degrance < 60 mi/min) due to metformin. Heputic Angulment: Jentadueto is not recommended in patients with hepatic impairment due to mefformis. Clinical experience with Jentadueto in patients with hegatic impairment is lacking. Psediatric population: The safety and efficacy of Jentadueto in children and adolescents (apped 0 to 18 years) have not been extehi ished. He data are excitable. Jentarturio should be taken twice daily with meals. All patients should continue their diet with an adequate distribution of carbotypinite Intake during the sky. Overweight patients should continue their energy-restricted diet. If a dose is missed, it should be taken as soon as the patient remembers. However, a double dose should not be taken at the same ime (the missed dose should be skipped. Contraindications: Hypersensitivity to the active substances or to any of the exciptents; diabello keloacidosis, diabello pre-corra; renal fallare or renal dysfunction screatining descence < 60 intilimits; agute conditions with

infarction, sheek; hepatic impairment, acute alcehol interication, alcoholism. Warnings and Precautions: Jentacueto should not be used in patients with type 1 diabetes or for the treatment of diabetic keloacidosis Caution is advised when Jentaducto is used in combination with a surphospharea due to increased incidence of hypophycaemia. Lactic audosis is a very rare, but excious (high mortality in the absence of prompt treatment, metabolic complication that can occur due to motform's hydrochloride accumulation. Reported cages have occurred oritrarily in diabetic autients with significant renal failure. The incidence of lactic acidesis can and should be reduced by also assessing other associated risk factors. As metformin hydrochloride is excreted by the kidney, serum creatinine levels should be determined before initiating treatment and regularly thematie. Decreased renal function in elderly subjects is frequent and saymptomatic. Special caution should be exercised in situations where renal function may become impaired. As Jentadueta contains matternin hydrochloride the treatment must be discontinued 48 hours before elective surgery with general apinal or epidural anneetheein, or prior to, or at the time of intravascular administration of lodinated contrast agents in raciologic studies and therapy with Jertaducto should usually not be resumed earlier than 48 hours following surgery or test and only after renal function has been reevaluated and found to be normal. The use of Jentadueto in combination with Insulin has not been adequately studied. Cartion should be exercised when treating patients 80 years and sider. As Jertaduelo contains metformin, a patient with previously well controlled type 2 diabetes on Jertudueto who develops laboratory abnormalities or clinical illness jespecially vague and poorly defined (Iness) should be evaluated pramptly for evidence of ketosciobus or factic acidesis. If acidesis of either form occurs, Jertaduete must be alopped immediately and other appropriate corrective measures initiated. In post-marketing experience of Imagligitin there have been spontaneously reported adverse reactions of acute pancrestitis. if pancreatitis is suspected, Juntadurlo should be discontinued. Interactions: Combination requiring procautions for use glucocorticolds joiven by systemic and local routes), beta-2-agonists, and duretics. More frequent blood alucese monitoring should be performed, especially at the beginning of treatment with such medicinal products. If necessaris the dose of Jentadueto should be adjusted during therapy with the other medicinal product and on its discontinuation. Combinations not recommended: There is increased risk of factic asidosis in acute alcohol intoxication. Consumption of alcohol and medicinal products containing alcohol. Carionic substances that are eliminated by renal butstar secretion e.g. cimetidine. The intravascular administration of iodinates contrast agents in radiological studies may lead to renal failure, resulting in metformin accumulation and a risk of lactic acideals (see above) Fertility, pregnancy and lactation; Jertadueto should not be used during pregnancy. If the patient plans to become pregnant, or if prepriately occurs, treatment with Jentadueto should be discontinued and awitched to insulin treatment as soon as possible in order to lower the risk of faetal mailformations associated with abnormal blood glucose levels. A decision must be made whether to discordinue breast-feeding or to discontinue/abstain from Jentadueto therapy taking into account the benefit of breast-feeding for the child and the basefft of therapy for the woman. No studies on the effect on human fertility have been conducted for Jentacletin. Undesirable effects: Adverse reactions reported with the fixed door combination: Adverse reactions reported in all clinical trials with Jentaduete. Uncommon (z 1/1,000 to < 1/100): resophenyogilia; hypersensitivity, cough;</p> decreased appetite; diaminea; nausea; vomiting; pruritus;

the potential to after neural function such as dehydration, severe

infection, shask; zcure or chranic disease which may cause tissue

hypoxia such as cardiac or respiratory failure, recent myocardial

blood arrylase increased. Not known (cannot be estimated from the available data: pancreatitis Adverse reactions known to accur with each active substance given singly but which have not been seen in clinical trials with Jentadueto, may occur during treatment with this medicinal product. Adverse reactions reported when Imagliptin and mettornin were combined with sulphonylarea: additional adverse reaction very common (z. 1/10) hypoglycaemia, Adeličoval information on individual components: Adverse tractions previously reported with one of the individual active substances may be potential adverse reactions with Jentadueto, even if not observed in clinical trials with this medicinal product. Lingslipths All identified adverse reactions of limaglistin monotherapy are also described for Jentadueto. Metforovic Known adverse reactions that were not reported in patients who received Jentaduets. Very common is 1/10: abdominal pain. Common (> 1/100 to < 1/10): taste disturbance. Very rare (< 1/18,000): lactic acidosis; vitumin B12 deficiency; liver function disorders, hepatifis; skin reactions. Post-marketing expervience; additional adverse reactions from post-marketing experience for linegiptin: rare (z.1/10,000 to < 1/1,000); angioesterna: urticaria (frequency estimates are based on the pooled analysis of the lacets controlled trials). Prescribers should consult the Summary of Product Characteristics for further information on side effects. Pack sizes and NHS price: 2.5 mg/850 mg 56 tablets E33.26: 2.5 mg/1,000 mg 58 tallets £13.26. Legal category: POM. MA numbers: 2.5 mg/850 mg (56 tablets) 8U/1/12/78U/005; mg/1,000 mg (56 tablets) EU/1/12/780/019. Marketing Authorization Holder: Boshringer Ingelheim International GmbH. D-55216 togethelm am Rhein, Germany, Prescribers should consult the Summery of Product Districtoristics for full prescribing information. Prepared in August 2012.

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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 Bochringer Ingelheim Drug Safety on 0800 328 1627 (freephone).

PULSECLINICAL

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

THE CASE

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

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

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.

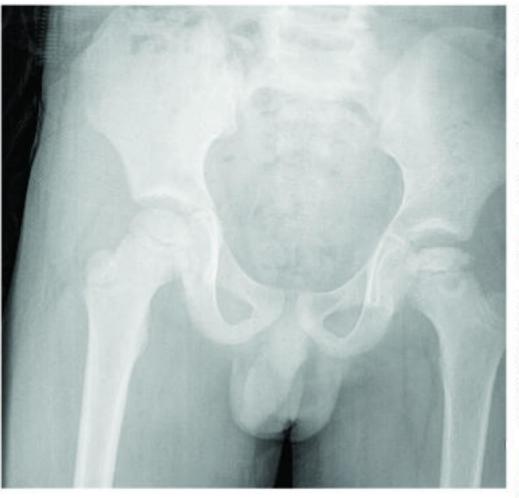
The problem

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 actiology 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.



PAEDIATRIC CLINIC

Perthes' disease

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 actiology 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 ECHO surgery centre and one of just four specialist centres to provide surgery for drug-

More information can be found at alderhey nhauk.

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Consultant urologist Mr Justin Collins

launches our new series with his advice on managing 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. Patients with haematuria represent about 6% of new referrals seen by urologists.

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. We 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. See

Although there is consensus that visible haematuria requires further investigation, ** patients with haematuria are underreferred." 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.38

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, "but the sensitivity of cytology in detecting low-grade tumours is low.

There has been increasing interest in urinary biomarkers that can either



NEW SERIES PRIMARY CARE UROLOGY Haematuria

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CPD hour

this CPD module for a suggested 1 credit. This module will be available free to all members of Pulse Learning until 17 October 2012 pulse-learning.co.uk

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.

supplement or replace these tests, although their role is still not well defined. There are currently several FDA-approved urinebased tests in bladder cancer surveillance, and a variety of other biomarkers are being studied. Urinary biomarkers offer great promise for the future in diagnosing urothelial tumouts 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

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. 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:

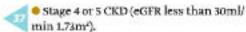
- Cola-coloured urine and an associated infection – usually upper respiratory tract – if they are younger than 40 years, as they may have an acute glomerulonephritis.
- Declining eGFR (by more than 10ml/min 1.73m² at any stage within the previous five years or by more than 5ml/min 1.73m² within the last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

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.

38 PULSECLINICAL



- Significant proteinuria (albumin:creatinine ratio greater than or equal to 30 mg/mmol or protein:creatinine ratio greater than or equal to 50 mg/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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11 Herman MP, Systek RS, Lotan Y et al. Urine-based biomarkers for the early detection and surveillance of non-muscle invasive bladder cancer. Missrva Urol Nefrol. 2008;80:217-05.

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
rice.org.uk/nicemedia/pd(/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

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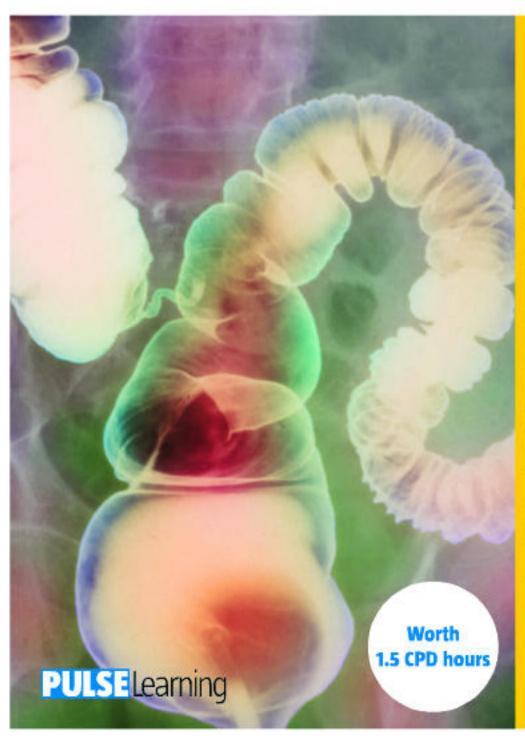
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Dilemma Do my premises constitute a conflict of interest?

What is the future for singlehanded GPs? Analysis from GPC chair Dr Laurence Buckman



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.

PULSEBUSINESS & COMMISSIONING

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

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

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.

when I went solo.

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

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

Nurses and healthcare assistants share the clinical workload

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.

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, Essey

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

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.

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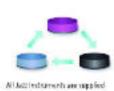
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Four questions you should ask before offering referral incentives

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

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.

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.

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).

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.

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 Or Peter Rubin to Dr Laurence Buckman, 25 September 2012

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

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 recommission enhanced services for the next six to 12 months.

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

 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 Thomley is an associate director of NHS **Primary Care Commissioning**



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· Actively engaged in Commissioning issues Closing date Friday 12th October 2012

For further information please contact: The Practice Manager

Laurel Bank Surgery 216B Kirkstall Lane Leeds. LS6 3DS

T: 0113 2953900

E: LBSmanager@nhs.net

London Road Surgery, Canterbury, Kent

Part/Full time Salaried GP Required

We are looking for an enthusiastic and highly motivated Salaried GP to join our Practice with immediate start.

- . GMS practice using INPS Vision
- 4,300 list size
- Actively engaged in commissioning
- · High QOF points achieved
- Friendly, efficient, patient-centred team Salary according to experience.

The Practice is based in the Cathedral City of Canterbury with good links to London and the Continent.

Please apply in writing with CV to: Mrs Karen Masters, Practice Manager 49 London Road, Canterbury, Kent CT2 8SG Telephone: 01227 463128

16 PULSESERVICES RECRUITMENT

DOCTORS/GPS REQUIRED

THE UPWELL HEALTH CENTRE

Townley Close. Upwell. Wisbech. Cambs. PE14 9BT Telephone 01945 773671 Website: www.upwellhealthcentre.nhs.uk

From April 2013 Two Salaried GPs are Required - For a total of 10 Clinical Sessions per week, ideal job share.

We are a friendly, progressive, well run, rural, PMS, training practice on the Norfolk, Cambridgeshire border. Village setting but within easy reach of main line rail links, excellent schools

- 5 GP partners, 2 Nurse Practitioners
- Dispensing
- Training Practice
- Active Members of West Norfolk CCG
- Fully integrated Nursing Team
- Well equipped purpose built premises
- Paperless Fully computerised (EAUS)
- High QOF achiever
- No OOH
- No involvement in extended hour rota
- Limited involvement in practice on call rota as holiday cover only, extent negotiable
- Excellent administrative support
- 6 weeks annual leave, 1 weeks study leave

Due to an increasing list size, we are seeking the right people to join our team, in return we offer flexibility and a competitive remuneration.

Whether you have just completed your GP training, are experienced or are looking to return to work, we would be very interested to hear from you.

Informal visits or contact prior to the interview process are welcome. Please see our website for practice details www.upwellhealthcentre.nhs.uk

To apply, please send a covering letter and CV-to-Dr Paul Williams at the above address, or by email to paul williams 3@nhs.net

Closing Date: 30 November 2012

Salaried GP Blessing Medical Centre London W9

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

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

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

To apply, please contact Debbie Nimblette Practice covering letter to debbie.nimblette@nhs.net.

Closing Date: 5th October Interviews 15th October

3-6 month FT/PT Locum GP Required ASAP

to work in a well established 5 partner training practice.

- 12000 patients
- High QOF achievers
- Enthusiastic, friendly team
- EMIS LV

If you are interested in this work please telephone or send you CV

Miss A Norfolk or Mrs Frances Rance, Arrwell Street Surgery, 19 Arrwell Street, Hoddesdon, Herts, EN11 8TS

or email: amwell.surgery@nhs.net

College Street Medical Practice, Long Eaton

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 Feens
- 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
- Menturship 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

Please send C.V and covering letter to address above or email to: tracy.fagan@livgp.nhs.uk Closing date: 31st October 2012



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Recruitment & Employment Confederation

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



NZLOCUMS

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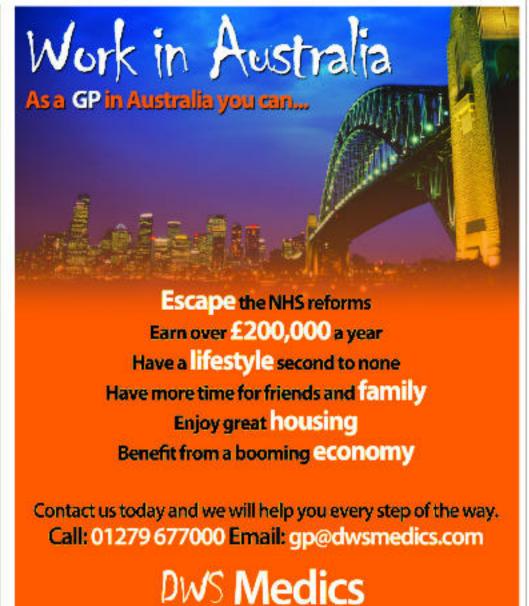
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EDITOR'S CHOICE

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



Dr Virginia Leggatt now writes reports for victims of torture

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 tabous surrounding sexual assault or they may find that flashbacks make it impossible for them to give a coherent account.

Dr Virginia Leggatt is a retired **GP** in Cambridge

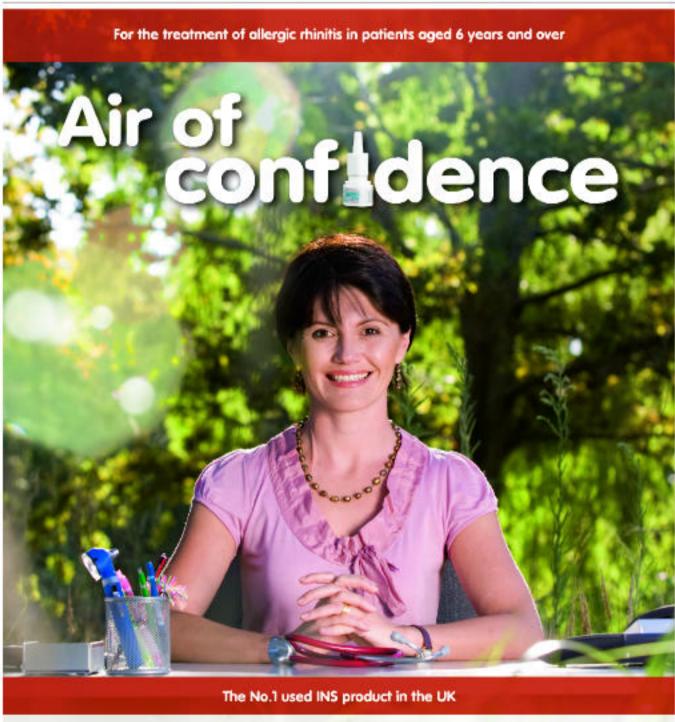
MORE ONLINE

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



'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-biginterview



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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



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.

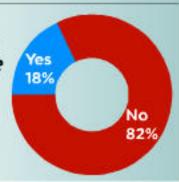
MORE ONLINE Read the debate pulsetoday.co.uk/debates

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 ▶ page 23