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BriefingMedia

At the heart of general practice since 1960

CCGs railroad practices into signing constitutions

GPC hands dossier of complaints from eight LMCs to ministers and urges GPs to scrutinise agreements

EXCLUSIVE
By Alisdair Stirling

CCGs are attempting to force through constitutions and rush practices into signing unsuitable agreements within a matter of weeks, according to a damning new GPC dossier.

The file of complaints – gathering evidence from eight separate LMCs and sent to ministers as part of an escalating row over constitutions – claims GPs are being invited to meetings managers know they cannot attend, and are facing tight deadlines to sign documents with warnings that the CCG may fail authorisation if they do not.

GPC negotiators fear GPs are being bullied into signing constitutions that fail to recognise the representative role of LMCs and contain potentially draconian performance management clauses – and are warning practices not to sign them without careful scrutiny.

Pulse understands that in one area not covered by the dossier, GPs have refused to sign a constitution because it contains a gagging clause which would block them from making 'any public statement or disclosure concerning the CCG or any members without prior written consent'.

Dr Andrew Mimnagh: constitutions rollout 'a total mess'

The dossier obtained by Pulse shows:

- Practices are being pressured into signing constitutions at short notice, with some given only three to four weeks to consider 'significant documents'
- Practices have been invited to CCG meetings 'that knowingly start before the end of evening surgery'
- One CCG elected two board members unopposed 'through a simple show of hands in a closed meeting consisting of the old PBC consortium'
- An LMC was told its position on the CCG would be 'limited to that of a layperson' – a move the GPC claimed 'essentially alienat[ed] the whole of the local GP profession'
- One CCG is insisting all GP representatives must work at least four sessions a week
- One CCG has claimed it is under pressure from the NHS Commissioning Board authorisation team to use a template constitution instead of a shorter version reflecting local consultation.

The dossier comes a week after Pulse revealed CCGs are struggling to involve GPs in their decision-making, with 360-degree practice surveys showing many GPs feel frozen out by the new groups.

GPC negotiator Dr Chaand Nagpaul told Pulse the rollout of constitutions was like 'mis-selling of insurance policies in the 1970s'.

'CCG boards are rushing GPs into signing them under duress by a certain deadline, with the threat that the CCG won't get authorised,' he said.

Dr Richard Vautrey, GPC deputy chair, said 'every practice' should read its proposed constitution carefully.

Dr Andrew Mimnagh, chair of Sefton LMC, said a CCG constitution on his patch was now in its third draft after being rejected as 'overly intrusive': 'It was old-school NHS management – nothing about membership organisation. The whole thing has been a total mess nationally.'

Dr Clive Shaw, chair of South Sefton CCG, said there had been 'real involvement and debate'.

Dr Una Duffy, chair of Bedfordshire LMC, said the LMC had initially been excluded from local draft constitutions, and had only been able to negotiate acceptable agreements with the help of lawyers. She said: 'It has taken a lot of work. The problem has been things imposed from the top.'

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MORE ONLINE
Read the full dossier
pulsetoday.co.uk/commissioning

BMA green light for revalidation after remediation deal

Scotland, Wales and Northern Ireland yet to guarantee funding

By Sofia Lind

The NHS Commissioning Board has revealed it expects only 'a very small number' of GPs to require remediation away from their practice as part of the revalidation process, after agreeing a landmark deal with the BMA to fund additional training for GPs who require it.

The deal, announced last week, has prompted the BMA to formally back the GMC's timetable to begin revalidation from December, after resolving one of its biggest concerns.

But despite the agreement in England, governments in Scotland, Wales and Northern Ireland have yet to guarantee they will fund the process, with the BMA urging ministers in the devolved nations to follow suit as soon as possible.

Despite the breakthrough, GP leaders said there remained 'hurdles' to overcome, including how much funding would be available, and how it would be paid to GPs who need it.

In England, the NHS Commissioning Board has established a remediation working group, chaired by medical director Sir Bruce Keogh, to explore the details.

Other outstanding issues include ensuring locum GPs can gain sufficient evidence for revalidation, with particular concern over how they will collect 360-degree feedback from colleagues and patients.

But the BMA said some issues would have to be ironed out as the process was being rolled out.

BMA chair Dr Mark Porter said: 'This does not mean that revalidation is currently in a perfect state. There will be problems on the way, which will be sorted out by practical people who are determined to implement something we all recognise is a good principle.'

In 2009, Pulse revealed LMCs had been told to expect anywhere between 5% and 14% of all GPs to fail at least one element of revalidation.

But a spokesperson for the NHS Commissioning Board Authority said it was unlikely that substantial numbers would require remediation: 'We recognise that, in the very small number of cases where a GP requires remediation and supervision away from their practice, there will be some circumstances in which funding is needed for backfill.'

This does not mean that revalidation is currently in a perfect state
Dr Mark Porter

GPC chair Dr Laurence Buckman said: 'One of our key concerns was that GPs were being penalised by being taken out of practice. So we had to get this sorted out. It has been difficult but I'm now pleased to say the placement, and the backfilled cost of doctors to be taken out of practice, will be funded. There's a set of hurdles to go through and we are going to have to discuss this at length with the NHS Commissioning Board.'

Dr David Bailey, chair of GPC Wales, urged devolved governments to follow suit as quickly as possible: 'I have been in contact with the deputy chief medical officer for Wales to seek clarity and I know my Scottish counterpart has done the same. The BMA would expect it to be mirrored in all four countries.'

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Dr Laurence Buckman: still some hurdles to overcome

Q&A: revalidation

Q When will revalidation start?
A In early December, subject to an imminent final decision by health secretary Jeremy Hunt

Q Who will be revalidated first?
A Responsible officers and other medical leaders by March 2013; then about a fifth of doctors between April 2013 and March 2014; the majority by the end of March 2016; all remaining doctors by the end of March 2018

Q How many doctors will need remediation?
A The NHS Commissioning Board says 'very few' will require remediation but has not given a precise estimate

EDITORIAL

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The week in general practice

INSIDE

Dr Mark Sanford-Wood

MORE ONLINE
▶ pulsetoday.co.uk/news

The GMC is to trial a new system to improve how complaints against GPs are investigated as part of its wider fitness-to-practise reforms
▶ pulsetoday.co.uk/practice-news

Download of the week
Read the GPC's dossier of complaints from LMCs about CCG constitutions
▶ pulsetoday.co.uk/downloads

Video of the week
Watch the Big Interview with NASGP chief executive Dr Richard Fieldhouse
▶ pulsetoday.co.uk/the-big-interview

Patients 'in pain' as referrals delayed

INVESTIGATION

By Gemma Collins

Patients have been left in 'unbearable' pain while waiting for surgery because of delays incurred by local referral restrictions, GPs have reported.

The second part of Pulse's two-week investigation into NHS rationing reveals nearly half of GPs believe patients are suffering as a result of delays caused by referral management schemes, with some patients going on to develop serious complications.

Of 252 doctors who responded to Pulse's survey, 44% said their patients had experienced adverse impacts from delays caused by local schemes over the past year, while only 35% said patients had not suffered.

Reports from around the country included patients facing 'unbearable' delays on hernia surgery, a delay in the diagnosis of a baby with significant visual problems, and a patient who developed a carcinoma after being blocked from receiving an oesophagogastroduodenoscopy.

Dr Tim Cantor, a GP in West Malling, Kent, said a patient developed 'severe cholecystitis requiring hospital admission for IV antibiotics' as a result of not being referred for gallstones in line with PCT policy.

Dr Bob Bowes, chair of West Kent CCG, said current criteria were for patients to experience two acute episodes, treated in primary or secondary care, before gallbladder removal, to get a 'consistent, equitable service'.

A GP in Bangor, Wales, who asked not to be named, claimed his referral centre had cancelled referrals without telling his patients. 'The patient will be waiting, thinking they're going to be seen and they're not,' he said.

A spokesperson for Betsi Cadwaladr University health board said: 'Where it is identified that a referral would not offer any benefit to the patient, the GP is advised of this.'

Dr John Hughes, honorary secretary of Manchester LMC, said GPs were being blocked from referring patients who need gastric banding by restrictions in excess of NICE guidance, with referrals considered by the 'effective resources team'.

'We have to refer four times when we've given clear clinical reasons why the procedure is necessary,' he said. 'It can take up to a year and these patients may develop diabetes or suffer a cardiac arrest in that time.'

NHS Manchester said patients could apply under 'exceptional circumstances' if they fell outside eligibility criteria.

The survey also found 61% of GPs had witnessed an increased use of non-doctors to review their referrals in the past 12 months.

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Dr John Hughes: some GPs have had to make the same referral four times

Restrictions hit patient care

Have any of your patients suffered from delays caused by referral management schemes in the past 12 months?

Yes 43%
No 35%
Don't know 22%

Source: Pulse survey of 252 GPs

RCGP to facilitate records access

The Department of Health has enlisted the RCGP to help implement its ambitious plans for patients to have electronic access to GP services and their GP record by 2015.

As part of the Government's 10-year Information Strategy, launched in May, the DH announced that practices will have to appoint a lead GP to co-ordinate better electronic access, secure lines of communication for patients and direct access to GP records within the next three years.

The DH has now asked the college to lead a partnership of professional and patient groups to produce achievable plans by the end of 2012, setting out how this goal can be achieved.

The move comes despite the RCGP voicing concerns about the plans in its response to the DH's strategy, raising questions over confidentiality, security, the erosion of professional boundaries, potential cost and workload, and the loss of the holistic benefits of face-to-face consultations.

The programme is being led by Dr Imran Rafi, medical director of the RCGP's Clinical Innovation and Research Centre (CIRC).

The group will also contain representation from the GPC, and will oversee seven smaller working groups with specific remits.

A DH spokesperson said: 'Implementing this successfully requires the active involvement of professionals as well as the public.'

RCGP chair Dr Clare Gerada said: 'Critical issues such as information governance and safeguarding will be carefully considered, as will the implications for health inequalities and the protection of vulnerable individuals and groups.'

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After an unfounded GMC complaint, I feel at the mercy of my patients
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Partners quitting to become locums

NASGP claims stress is prompting a growing number of GPs to opt for a better work-life balance

EXCLUSIVE
By Gemma Collins

A growing number of GPs are resigning from their practices to become locums mid-way through their careers because they are burning out from rising stress and workload, the head of the country's largest group of sessional GPs has claimed.

Dr Richard Fieldhouse, chief executive of the National Association of Sessional GPs – which represents 1,000 locum and salaried GPs – said financial pressures and a desire to go 'back to basics' was driving an increasing number of partners to resign.

Speaking to Pulse in this week's Big Interview, Dr Fieldhouse said around 20 partners had joined his network of 70 GPs in eight locum chambers in the south west of England.

It comes amid soaring demand for locums as partners take on commissioning work, with Pulse reporting in January the average cost of hiring locums rose 9% in the last year. And one medical accountant had been approached by three salaried GP clients in the past month who wanted to become locums.

Dr Richard Fieldhouse: a lot of GPs are 'burning out'

Dr Fieldhouse, a GP in Chichester, said: 'Unfortunately you have lots of GPs burning out. Over the past couple of years we have had 20 or so partners who have resigned from their local partnerships to join the chambers.'

Possible reasons for the shift included pressure from CCGs to make savings, 'instability' caused by the NHS reforms and an improved work-life balance, he said: 'Practices are finding it hard to actually get people to become partners.'

Medical accountants said they had also noticed the trend. Rosemary Smith, senior partner at RS Medical Accountancy, said: 'Salaried GPs are not getting paid like partners but because they are still experiencing the politics and the extra work in their surgeries, they are thinking they would be better off becoming a locum. I have had three GPs contact me in a month.'

Bob Senior, head of medical services at RSM Tenon, said while he was not aware of any partners having made the transition, a number had said they would like to: 'GPs say locums have a better time of it as they don't have the stress.'

Dr Peter Swinyard, chair of the Family Doctor Association, said a number of his members had made the switch: 'The day job has become very hard'.

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What is driving locum demand?

- **Commissioning – a Pulse poll in January found one practice in 10 had taken on regular locums to cover for commissioning work**
- **Recruitment problems – the same poll found a quarter of practices using more locums because of difficulties recruiting partners or salaried GPs**
- **Tax banding – recent changes have prompted partners to work fewer sessions and hire locums**

THE BIG INTERVIEW
Watch the full video
pulsetoday.co.uk/the-big-interview

BMA begins crunch talks on pensions

The BMA has opened crunch talks with NHS Employers and union representatives as it strives to exert leverage on the Government over controversial changes to doctors' pensions.

The parties met last week with the technical advisory group of the NHS Pension Scheme governance group, in the first talks to be held since the BMA suspended industrial action in July and agreed to inter-union discussions on contribution rises due in April 2013.

The Department of Health said an agreement for 2013/14 rates must be reached by January 2013.

Dr David Bailey, deputy chair of the BMA pensions committee, said last week's meeting covered: existing contribution rates and contributions under the CARE (career average re-valued earnings) scheme from 2015.

'We're putting forward our evidence on these,' he said. 'The system stands to be unfair to higher paid workers from 2015 as doctors will have to pay a higher proportion of their earnings than less-well paid staff.'

The BMA will also shortly begin separate talks on the Working Longer Review, examining whether NHS workers should work until 68, if they can move into back-office roles and how the DH can make it easier to purchase earlier retirement.

GPC calls for GMC to probe incentive schemes

The GPC has asked the GMC to investigate 'appallingly unethical' incentive schemes which reward GPs for cutting referrals or reducing prescribing costs – including the quality premium central to GP commissioning.

GP leaders said they had written to the regulator in a bid to clarify where such schemes represent a conflict of interest, and clarified the incentives, increasingly used by both PCTs and shadow CCGs to help achieve daunting efficiency savings targets, risked interfering with GPs' duty to care for patients.

GPC chair Dr Laurence Buckman said the concerns also applied to the planned quality premium payments.

'Being cost-effective doctors and looking at what you're doing to attempt to reduce inappropriate or unnecessary referrals is reasonable,' he said. 'But the act of cutting a fixed number of referrals implies that at some point you are going to apply an arbitrary cut in patient care.'

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Presentations: Nasal spray suspension containing mometasone furoate (as monohydrate) 50 micrograms/actuation, a synthetic topical corticosteroid. **Uses:** *Adults and children aged 18 and over:* Treatment of nasal polyps. *Adults and children over the age of 12 years:* For the treatment of the symptoms of seasonal allergic rhinitis or perennial rhinitis. *Children 6 to 11 years of age:* For the treatment of the symptoms of seasonal allergic rhinitis or perennial allergic rhinitis, in patients who have a history of moderate to severe symptoms of seasonal allergic rhinitis, prophylactic treatment with Nasonex may be initiated up to four weeks prior to the anticipated start of the pollen season. **Dosage:** Nasal Polyposis: *Adults and children aged 18 and over:* The usual recommended starting dose for polyposis is two actuations (50 micrograms/actuation) in each nostril once daily (total daily dose of 200 micrograms). If after 5 to 6 weeks symptoms are inadequately controlled, the dose may be increased to a daily dose of two sprays in each nostril twice daily (total daily dose of 400 micrograms). The dose should be reduced following control of symptoms. If no improvement in symptoms is seen after 5 to 6 weeks of twice daily administration, alternative therapies should be considered. Efficacy and safety studies of Nasonex Nasal Spray for the treatment of nasal polyposis were four months in duration. Seasonal or Perennial Allergic Rhinitis: *Adults and children over the age of 12 years:* Two sprays (50 micrograms/spray) in each nostril once daily (total dose 200 micrograms). Once symptoms are controlled, dose reduction to one spray in each nostril (total dose 100 micrograms) may be effective for maintenance. If symptoms are inadequately controlled, the dose may be increased to a maximum daily dose of four sprays in each nostril (total dose 400 micrograms). Dose reduction is recommended following control of symptoms. *Children 6 to 11 years of age:* One spray (50 micrograms/spray) in each nostril once daily (total dose 100 micrograms). Clinically significant onset of action occurs in some patients within 12 hours after the first dose. Full benefit of treatment may not be achieved in the first 48 hours. Regular use is recommended to achieve full therapeutic benefit. **Contraindications:** Hypersensitivity to any of the ingredients. Do not use in the presence of untreated localised infection involving the nasal mucosa. Patients who have experienced recent nasal surgery or trauma should not use a nasal corticosteroid until healing has occurred. **Precautions and Warnings:** Use with caution, if at all, in patients with active or quiescent tuberculous infections of the respiratory tract, or in untreated fungal, bacterial, systemic viral infections or ocular herpes simplex. There was no evidence of atrophy of the nasal mucosa following 12 months of treatment. Patients using Nasonex over several months or longer should be examined periodically for changes in the nasal mucosa. If localised fungal infection of the nose or pharynx develops, discontinuance of Nasonex therapy or appropriate treatment may be required. Persistence of nasopharyngeal irritation may be an indication for discontinuing Nasonex. The concomitant use of additional therapy may provide additional relief particularly of ocular symptoms. There is no evidence of HPA axis suppression following prolonged treatment with Nasonex. Patients who are transferred from long-term administration of systemically active corticosteroids to Nasonex require careful attention. The safety and efficacy of Nasonex has not been studied for use in the treatment of unilateral polyps, polyps associated with cystic fibrosis, or polyps that completely obstruct the nasal cavities. Unilateral polyps that are unusual or irregular in appearance, especially if ulcerating or bleeding, should be further evaluated. Patients who are potentially immunosuppressed should be warned of the risk of exposure to certain infections. Very rarely, nasal septum perforation or increased intraocular pressure have been reported following the use of intranasal corticosteroids. Systemic effects of nasal corticosteroids may occur, particularly at high doses prescribed for long periods. These may include Cushing's syndrome, Cushingoid features, adrenal suppression, growth retardation in children and adolescents, cataract, glaucoma and more rarely, a range of psychological or behavioural effects including psychomotor hyperactivity, sleep disorders, anxiety, depression or aggression (particularly in children). Nasonex should only be used in pregnant women, nursing mothers, or women of child-bearing age if the potential benefit justifies the potential risk to the mother, foetus or infant. It is recommended that the height of children receiving prolonged treatment with nasal corticosteroids is regularly monitored. If growth is slowed, therapy should be reviewed with the aim of reducing the dose of nasal corticosteroid, if possible, to the lowest dose at which effective control of symptoms is maintained. In addition, consideration should be given to referring patient to a paediatric specialist. Safety and efficacy of Nasonex Nasal Spray for the treatment of nasal polyposis in children and adolescents under 18 years of age have not been studied. Treatment with higher than recommended doses may result in clinically significant adrenal suppression. If there is evidence for higher than recommended doses being used, then additional systemic corticosteroid cover should be considered during periods of stress or elective surgery. In a placebo-controlled clinical trial in which paediatric patients (n=48/group) were administered Nasonex 100 micrograms daily for one year, no reduction in growth velocity was observed. **Interactions:** A clinical interaction study was conducted with loratadine. No interactions were observed. **Side Effects:** Adverse effects commonly reported in clinical trials in adult and adolescent patients include headache, epistaxis, pharyngitis, nasal burning, nasal irritation and nasal ulceration. Other less common and rarely reported side effects are listed in the SPC. **Package Quantities:** 18g per bottle, supplied with a metered-dose manual spray pump actuator which delivers 50 micrograms per actuation. NHS Price £7.88. **Legal Category:** Prescription Only Medicine. **Marketing Authorisation Number:** PL 00025/0537. **Marketing Authorisation Holder:** Merck Sharp & Dohme Limited, Hertford Road, Hoddesdon, Hertfordshire, EN11 9BU, UK. **Date of Revision of Text:** January 2012

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References: 1. IMS Health, HPA/SPI RDTA, November 2010 - October 2011

02-14 REF-1027062-0002

Date of preparation: February 2012

Copperfield: A recipe for QOFtastrophe
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CQC mulls 10 days' notice for visits

Regulator could spare practices unannounced inspections after pilots found too little notice was 'disruptive'

By Sofia Lind

The Care Quality Commission could extend the notice period given to GP practices before routine inspections to as much as 10 days, after pilots suggested that allowing inadequate time to prepare could prove 'disruptive'.

The move comes after LMCs raised concerns of a lack of 'fair notice' in some pilot inspections that were run over the summer.

The regulator tested a range of notice periods with participating practices, including no notice, 48 hours' notice, five days' notice, and, at the behest of practices, 10 days' notice.

It said it was considering granting GPs a longer notice period to ease the burden, but has reserved the right to make unannounced inspections if it has been alerted to a specific problem.

Dr Mark Sanfood-Wood: '10 days seems a reasonable time'

Cambridgeshire LMC wrote in a newsletter to its members: 'The LMC has advised the CQC that a maximum of five days is not considered to be a fair amount of notice in general practice, therefore a 10-day notice period should also be trialled.' The LMC said its concerns were shared by LMCs across England.

A CQC spokesperson told Pulse: 'All other sectors registered with the CQC receive unannounced inspections. We are aware that this may be disruptive to clinicians and patients in GP practices, particularly smaller practices, so are considering short-notice inspections instead.

'We are still collating feedback from the pilots and have not yet reached a decision about the notice period we will use when inspecting GP practices.'

Dr Mark Sanford-Wood, chair of Devon LMC, said: 'Ten working days seems a reasonable amount of time to prepare and get all the documentation ready for the inspectors.'

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FEEDBACK FROM PILOTS

Practice asked to provide CRB check on cleaner

One key issue flagged up by practices in the CQC pilots was an apparently inconsistent approach from inspectors over which staff members should undergo a CRB check.

A Cambridgeshire LMC newsletter summarising the experience of some LMCs across the country reported 'some inspectors insisting that all staff should be CRB checked (including the cleaner!)'.

LMCs also raised concerns that inspectors were basing their traffic-light risk profiles on inaccurate data.

The CQC said it was currently developing better guidance for inspectors following the feedback. CRB check requirements were dependent on roles and the 'contact the person will have with children and vulnerable adults,' it said. It insisted it used 'the latest available published data' for risk profiles.

But overall, LMCs concluded that the pilot visits had been 'very thorough but positive, and nowhere near as daunting as many practices had first thought'.

Medical defence subs soaring

Medical defence indemnity costs have risen far faster than inflation over the past 12 months, Pulse has learned.

The Medical Defence Union (MDU) said average subs for a salaried GP doing eight sessions a week increased to £5,605 in 2012/13 from £5,040 in 2011/12, a rise of 11.2%, while subs for an eight-session GP partner have increased to £6,300 from £5,995, up 3.4%.

The Medical Protection Society (MPS) declined to provide equivalent figures, but conceded its fees had also increased.

Dr Edoardo Cervoni, a locum GP on Merseyside, said his fees with the MDU had increased to £6,690 from £4,561 in 2011/12. He said he was left 'speechless' by what he called an 'astonishing' rise.

'I don't know of any other industry where you pay 10% of your salary in professional insurance,' he said.

But Dr Stephanie Bawn, director of policy and communications at MPS, said: 'Subscription rates for GPs have increased over the last year as a result of the rising number and value of GP claims.

'Subscription rates vary based on the individual's needs and scope of practice.'

The MDU said it had opened 17% more medical claims files, compared with the previous year.

It has also seen an 18% rise in requests for MDU assistance with GMC investigations, and a 56% increase in disciplinary cases against GP and hospital doctor members.

GPs support more QOF indicators for children

GPs would support the inclusion of more indicators for children in the QOF but are concerned they could be judged on outcomes that are beyond their control, a study has found.

Researchers interviewing GPs in the Thames Valley found the majority supported the idea of bringing in quality markers for children in primary care as they were seen as setting standards to 'systematically document the state of health of the child'.

At present, only 3% of QOF indicators relate to children and young people.

In the qualitative study, published in *BMC Family Practice*, most of the 20 GPs interviewed suggested audits, clinical templates, questionnaires, A&E visits and antibiotic prescribing rates could be used to measure quality.

NEW data demonstrates superiority of CHAMPIX over single and combination NRT for quit success at 1 year

The systematic review and multiple treatment comparison (MTC) meta-analysis reviewed 146 smoking cessation randomised controlled trials (RCTs), consisting of 53,412 patients, using direct and indirect comparisons of treatments.

CHAMPIX showed statistically significant improvements in smoking abstinence at 1 year vs.:

- Standard-dose NRT patch (≤22 mg)
- High-dose NRT patch (>22 mg)
- Combination NRT (NRT patch PLUS one additional NRT formulation*)

Statistical significance in smoking abstinence over time

CHAMPIX vs.	4 weeks	3 months	6 months	12 months
Standard-dose NRT patch (≤22 mg)	✓ OR 2.06 (CrI 1.54–2.76)	✓ OR 1.86 (CrI 1.36–2.54)	✓ OR 1.53 (CrI 1.20–1.97)	✓ OR 1.89 (CrI 1.38–2.63)
High-dose NRT patch (>22 mg)	✓ OR 1.64 (CrI 1.22–2.20)	✓ OR 1.63 (CrI 1.07–2.50)	– OR 1.06 (CrI 0.76–1.47)	✓ OR 1.60 (CrI 1.07–2.43)
NRT patch plus another NRT formulation*	✓ OR 1.72 (CrI 1.04–2.89)	✓ OR 2.66 (CrI 1.22–5.74)	– OR 1.44 (CrI 0.94–2.23)	✓ OR 2.14 (CrI 1.32–3.48)

✓ = statistically significant – = not statistically significant

Adapted from Mills EJ *et al. Ann Med* 2012. OR = Odds Ratio (OR>1 favours CHAMPIX)

CrI = 95% Credible Interval (Credible Intervals are the Bayesian equivalent of classic Confidence Intervals)

The meta-analysis only included open-label and blinded RCTs with at least 3 months follow-up post-target quit date together with biochemical confirmation of smoking abstinence.

Limitations with the MTC approach are that assumptions are made that the trials measure a similar outcome, study populations are appropriate to combine, and direct and indirect evidence is consistent.

Safety was not investigated in this meta-analysis. There are special warnings and precautions in relation to CHAMPIX regarding neuropsychiatric and cardiovascular risks – for further information please see the SmPC.

The results from this meta-analysis provide additional evidence to support the use of CHAMPIX as a first-line treatment option for smokers.

*The additional NRT formulation included gum, lozenge, inhalator and nasal spray

 Date of Preparation: August 2012 CHA1360

CHAMPIX® Film-Coated Tablets (varenicline tartrate) ABBREVIATED 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, capsular-shaped, biconvex tablets debossed with "Pfizer" on one side and "CHX 0.5" on the other side and light blue, capsular-shaped, biconvex tablets debossed with "Pfizer" on one side and "CHX 1.0" on the other side. **Indications:** Champix is indicated for smoking cessation in adults. **Dosage:** The recommended dose is 1 mg varenicline twice daily following a 1-week titration as follows: Days 1-3: 0.5 mg once daily, Days 4-7: 0.5 mg twice daily and Day 8-End of treatment: 1 mg twice daily. The patient should set a date to stop smoking. Dosing should usually start 1-2 weeks before this date. Patients who are not willing or able to set the target quit date within 1-2 weeks, could be offered to start treatment and then choose their own quit date within 5 weeks. Patients who cannot tolerate adverse effects may have the dose lowered temporarily or permanently to 0.5 mg twice daily. Patients should be treated with Champix for 12 weeks. For patients who have successfully stopped smoking at the end of 12 weeks, an additional course of 12 weeks treatment of 1 mg twice daily may be considered. Following the end of treatment, dose tapering may be considered in patients with a high risk of relapse. **Patients with renal insufficiency:** *Mild to moderate renal impairment:* No dosage adjustment is necessary. *Patients with moderate renal impairment who experience intolerable adverse events:* Dosing may be reduced to 1 mg once daily. *Severe renal impairment:* 1 mg once daily is recommended. Dosing should begin at 0.5 mg once daily for the first 3 days then increased to 1 mg once daily. *Patients with end stage renal disease:* Treatment is not recommended. **Patients with hepatic impairment and elderly patients:** No dosage adjustment is necessary. **Paediatric patients:** Not recommended in patients below the age of 18 years. **Contraindications:** Hypersensitivity to the active substance or to any of the excipients. **Warnings and precautions:** *Effect of smoking cessation:* Stopping smoking may alter the pharmacokinetics or pharmacodynamics of some medicinal products, for which dosage adjustment may be necessary (examples include theophylline, warfarin and insulin). Changes in behaviour or thinking, anxiety, psychosis, mood swings, aggressive behaviour, depression, suicidal ideation and behaviour and suicide attempts have been reported in patients attempting to quit smoking with Champix in the post-marketing experience. Not all patients had stopped smoking at the time of onset of symptoms and not all patients had known pre-existing psychiatric illness. Champix should be discontinued immediately if agitation, depressed mood or changes in behaviour or thinking that are of concern for the doctor, the patient, family or caregivers are observed, or if the patient develops suicidal ideation or suicidal behaviour. In many post-marketing cases, resolution of symptoms after discontinuation of varenicline was reported, although in some cases the symptoms persisted; therefore, ongoing follow up should be provided until symptoms resolve. Depressed mood, rarely including suicidal ideation and suicide attempt, may be a symptom of nicotine withdrawal. In addition, smoking cessation, with or without pharmacotherapy, has been associated with the exacerbation of underlying psychiatric illness (e.g. depression). In a trial of patients with stable cardiovascular disease (CVD) certain cardiovascular events were reported more frequently in patients treated with CHAMPIX. Patients taking CHAMPIX should be instructed to notify their doctor of new or worsening cardiovascular symptoms and to seek immediate medical attention if they experience signs and symptoms of myocardial infarction. The safety and efficacy of Champix in patients with serious psychiatric illness has not been established. There is no clinical experience with Champix in patients with epilepsy. At the end of treatment, discontinuation of Champix was associated with an increase in irritability, urge to smoke, depression, and/or insomnia in up to 3% of patients, therefore dose tapering may be considered. There have been post-marketing reports of hypersensitivity reactions including angioedema and reports of rare but severe cutaneous reactions, including Stevens-Johnson Syndrome and Erythema Multiforme, in patients using varenicline. Patients experiencing these symptoms should discontinue treatment with varenicline and contact a health care provider immediately. **Fertility, pregnancy and lactation:** Champix should not be used during pregnancy. It is unknown whether varenicline is excreted in human breast milk. Champix should only be prescribed to breast feeding mothers when the benefit outweighs the risk. There are no clinical data on the effects of varenicline on fertility. Non-clinical data revealed no hazard for humans based on standard male and female fertility studies in the rat. **Driving and operating machinery:** Champix may have minor or moderate influence on the ability to drive and use machines. Champix may cause dizziness and somnolence and therefore may influence the ability to drive and use machines. Patients are advised not to drive, operate complex machinery or engage in other potentially hazardous activities until it is known whether this medicinal product affects their ability to perform these activities. **Side effects:** Adverse reactions during clinical trials were usually mild to moderate. Most commonly reported side effects were abnormal dreams, insomnia, headache and nausea. Commonly reported side effects were increased appetite, somnolence, dizziness, dysgeusia, vomiting, constipation, diarrhoea, abdominal distension, stomach discomfort, dyspepsia, flatulence, dry mouth and fatigue. See SmPC for other less commonly reported side effects. **Overdose:** Standard supportive measures to be adopted as required. Varenicline has been shown to be dialyzed in patients with end stage renal disease, however, there is no experience in dialysis following overdose. **Legal category:** POM **Basic NHS cost:** Pack of 25 11 x 0.5 mg and 14 x 1mg tablets Card (EU/1/06/360/003) £27.30. Pack of 28 1mg tablets Card (EU/1/06/360/004) £27.30. Pack of 56 0.5 mg tablets HDPE Bottle (EU/1/06/360/001) £54.60. Pack of 56 1mg tablets HDPE Bottle (EU/1/06/360/002) £54.60. Pack of 56 1mg tablets Card (EU/1/06/360/005) £54.60. Natal pack sizes may be marketed / marketed at launch. **Marketing Authorisation Holder:** Pfizer Limited, Sandwich, Kent, CT13 9NJ, United Kingdom. **Further information on request:** Pfizer Limited, Walton Oaks, Dorking Road, Tadworth, Surrey KT20 7NS **Last revised:** 03/2012. Ref: CI 10_0

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 Pfizer Medical Information on 01304 616161.

For further information, please contact Pfizer Medical Information on 01304 616161 or email medinfo.uki@pfizer.com

Reference:

1. Mills EJ *et al.* Comparisons of high-dose and combination nicotine replacement therapy, varenicline and bupropion for smoking cessation: a systematic review and multiple treatment meta-analysis. *Ann Med* August 2012.

CHAMPIX® varenicline tartrate

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Prescribing information

***flutiform*® ▼ (fluticasone propionate and formoterol fumarate) pressurised inhalation suspension**
Prescribing Information, United Kingdom
Please read the Summary of Product Characteristics before prescribing.

Presentation: Pressurised inhalation suspension, in a pressurised metered dose inhaler (pMDI), containing fluticasone propionate and formoterol fumarate dihydrate at strengths of 50 µg/5 µg, 125 µg/5 µg or 250 µg/10 µg per actuation. **Indications:** Regular treatment of asthma where the use of a combination product (inhaled corticosteroid and long-acting β_2-agonist) is appropriate: For patients not adequately controlled with inhaled corticosteroids and 'as required' inhaled short-acting β_2-agonist (SABA), or for patients already adequately controlled on both an inhaled corticosteroid and a long-acting β_2-agonist (LABA). ***flutiform*** 50 µg/5 µg and 125 µg/5 µg per actuation are indicated for use in adults and adolescents 12 years and above. ***flutiform*** 250 µg/10 µg per actuation is only indicated for use in adults. **Dosage and administration:** For inhalation use. The patient should be shown how to use the inhaler correctly by a physician or other healthcare professional. Patients should be given the strength of ***flutiform*** containing the appropriate fluticasone propionate dose for their disease severity (note that ***flutiform*** 50 µg/5 µg per actuation is not appropriate in patients with severe asthma). The appropriate strength should be taken as two inhalations, twice-daily (normally in the morning and evening) and used every day, even when asymptomatic. ***flutiform*** should not be used in children under 12 years. Prescribers should be aware that in asthmatics, fluticasone propionate is as effective as some other inhaled steroids when administered at approximately half the total daily microgram dose. Total daily dose can be increased if asthma remains poorly controlled by administering a higher strength inhaler. Appropriate doses of the β_2-agonist and inhaled corticosteroid (ICS) in separate inhalers, or the ICS alone, should be prescribed if a patient requires doses outside the recommended dose regimens. Patients should be assessed regularly and once asthma is controlled, treatment should be reviewed and stepped down to the lowest effective dose, or an ICS alone. It is extremely important to regularly review patients as their treatment is stepped down. ICSs alone are first line treatment for most patients. ***flutiform*** is not intended for initial treatment of mild asthma. For patients with severe asthma the ICS therapy should be established before prescribing a fixed-dose combination product. Patients on ***flutiform*** must not use an additional LABA. An inhaled SABA should be taken for immediate relief of asthma symptoms arising between doses. The ***AeroChamber Plus*®** spacer device is recommended in patients who find it difficult to use inhalers; re-titration should always follow the introduction of a spacer device. Patients should be advised to contact their prescriber when the ***flutiform*** dose indicator is getting near zero. **Contra-indications:** Hypersensitivity to any of the active substances or excipients. **Precautions and warnings:** ***flutiform*** should not be used for the first treatment of asthma, to treat acute asthma symptoms or for prophylaxis of exercise-induced asthma. It should not be initiated during an exacerbation, during significantly worsening or acutely deteriorating asthma, and should not be stopped abruptly. Patients should use their ***flutiform*** maintenance treatment as prescribed, even when asymptomatic. If a patient experiences serious asthma-related adverse events or exacerbations, they should continue treatment but also seek medical advice. Patients should be reviewed as soon as possible if there is any indication of deteriorating asthma control. In the case of sudden and progressive deterioration, which is potentially life-threatening, an urgent medical assessment should be carried out. Use with caution in patients with: pulmonary tuberculosis; quiescent tuberculosis; fungal, viral or other infections of the airway; thyrotoxicosis; phaeochromocytoma; diabetes mellitus (consider additional blood sugar controls); uncorrected hypokalaemia; predisposition to low levels of serum potassium; impaired adrenal function (monitor HPA axis function regularly); hypertrophic obstructive cardiomyopathy; idiopathic subvalvular aortic stenosis; severe hypertension; aneurysm or other severe cardiovascular disorders. There is risk of potentially serious hypokalaemia with high doses of β_2-agonists or concomitant treatment with β_2-agonists and drugs that can induce or potentiate a hypokalaemic effect. Particular caution is recommended in unstable or acute severe asthma and other conditions when the likelihood for hypokalaemia adverse effects is increased. Monitoring of serum potassium levels is recommended during these circumstances. Formoterol may induce prolongation of the QTc interval. Caution must be observed when treating patients with existing prolongation of QTc interval. ***flutiform*** should be discontinued immediately if there is evidence of paradoxical bronchospasm. Systemic effects with an ICS may occur, particularly at high doses for prolonged periods or when combined with potent CYP3A4 inhibitors, but are less likely than with oral corticosteroids. Use of a spacer device may also cause an increased systemic exposure. Increased exposure can be expected in patients with severe hepatic impairment. Prolonged treatment with high doses of corticosteroids may result in adrenal suppression and acute adrenal crisis, particularly in adolescents and children or potentially as a result of trauma, surgery, infection or rapid dose reduction. Patients should be advised that ***flutiform*** contains a small amount of ethanol; however this negligible amount does not pose a risk to patients. ***flutiform*** is not recommended in children under 12 years of age. **Interactions:** Caution is advised in long-term co-administration with strong CYP3A4 inhibitors (e.g. ritonavir, atazanavir, clarithromycin, indinavir, itraconazole, nelfinavir, saquinavir, ketoconazole and telithromycin); co-administration should be avoided if possible. Ritonavir in particular should be avoided, unless the benefits outweigh the risks of systemic side-effects. Caution is advised with use of non-potassium sparing diuretics (e.g. loop or thiazide), xanthine derivatives, glucocorticosteroids, L-Dopa, L-thyroxine, oxytocin, alcohol or other adrenergic drugs. There is an increased risk of arrhythmias in patients receiving concomitant anaesthesia with halogenated hydrocarbons. Hypokalaemia may increase the risk of arrhythmias in patients being treated with digitalis glycosides. Concomitant use of β-adrenergic drugs can have a potentially additive effect. Extreme caution should be taken when using formoterol fumarate with drugs known to prolong the QTc interval, such as tricyclic antidepressants or MAOIs (and for two weeks following their discontinuation), as well as antipsychotics (including phenothiazines), quinidine, disopyramide, procainamide and antihistamines. Concomitant use of an MAOI or a similar agent, such as furazolidone or procarbazine, may precipitate hypertensive reactions. β-blockers and formoterol fumarate may inhibit the effect of each other. β-blockers may produce severe bronchospasm in asthma patients, and they should not normally be treated with β-blockers including those that are used as eye drops to treat glaucoma. Under certain circumstances, e.g. as prophylaxis after myocardial infarction, cardioselective β-blockers could be considered with caution. **Pregnancy and lactation:** ***flutiform*** is not recommended during pregnancy. It should only be considered if benefits to the mother outweigh risks to the foetus. It is not known whether fluticasone propionate or formoterol are excreted in breast milk; a risk to the breast feeding infant cannot be excluded. A decision should be made on whether to discontinue breastfeeding or discontinue/abstain from ***flutiform***. **Side-effects:** Potentially serious side-effects: hyperglycaemia; depression; aggression; behavioural changes (predominantly in children); paradoxical bronchospasm; agitation; vertigo; palpitations; ventricular extrasystoles; angina pectoris; tachycardia; hypertension; dyspnoea; peripheral oedema; Cushings Syndrome; adrenal suppression; growth retardation; cataract and glaucoma; hypersensitivity reactions and QTc interval prolongation. Please consult the SPC for details of non-serious side-effects and those reported for the individual molecules. **Legal category:** POM **Package quantities and price:** One inhaler containing 120 actuations 50 µg/5 µg - £18.00, 125 µg/5 µg - £28.26, 250 µg/10 µg - £45.56 **Marketing Authorisation numbers:** PL 16950/0167 PL 16950/0168 PL16950/0169 **Marketing Authorisation holder:** Napp Pharmaceuticals Limited, Cambridge Science Park, Milton Road, Cambridge CB4 0GW UK Tel: 01223 424444. Member of the Napp Pharmaceutical Group. For medical information enquiries, please contact medicalinformationuk@napp.co.uk

Date of preparation: August 2012

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

UK/FLUT-11019

References

1. ***flutiform*®** – Summary of Product Characteristics. Napp Pharmaceuticals Limited.
2. Bodzenta-Lukaszyk A et al. BMC Pulm Med 2011; 11:1-28.
3. Mansur A. Eur Respir J 2008;32:634S (abstract P3625).
4. Napp Pharmaceuticals Limited. Data on file. ***flutiform*** cost effectiveness analysis.

Date of preparation: September 2012.
UK/RES-11058e

NAPP
RESPIRATORY

Four-year training a step closer

Assessment of economic case gets under way after Medical Education England backs RCGP's case

By Sofia Lind

The RCGP has cleared the next major obstacle in its bid to extend GP training to four years, after receiving approval from Medical Education England to take the plans forward.

RCGP chair Dr Clare Gerada told Pulse she was 'over the moon' with the news, which comes after extensive lobbying by the college, but warned the real work to put the plans into action would start now.

This will include the challenge of ensuring that the project is financially viable, with the plans yet to be approved by the Treasury. The college will now hold further discussions with key stakeholders such as the BMA and the Department of Health on how to implement the plans.

GP specialty training is currently three years in length and under existing regulations trainees only have to complete 12 months of general practice experience, although it is recommended that they complete 18 months.

General practice training is the shortest of all UK medical specialties.

The RCGP believes extended training is essential to take account of GPs' expanded role, with increased public health promotion and commissioning responsibilities.

The DH invited the RCGP to submit a case to Medical Education England for an extension of GP training after it was recommended in the 2008 Tooke Report.

The DH will now assess the affordability and implementation of the plans, with the GMC also due to review the proposals.

Dr Gerada said: 'Clearly there is a long way to go yet but I am absolutely delighted that we have got approval from the highest education body in England.

'The work really starts now. It's like building a house – now we have planning permission.'

Discussing the news on the social networking site Twitter, Dr Ben Riley, the RCGP's clinical lead for enhancing and extending GP training, said the college was pushing for 'an integrated four-year programme with at least 24 months based in primary care and [the] rest in relevant hospital, integrated and community posts.'

A DH spokesperson said: 'We want GPs to have the best possible training and we will examine the Medical Education England board's recommendations carefully. Any decision on an extension must be made by all four UK health departments. Work is already under way to consider the economic issues of an extension.'

@sofialind_Pulse

Dr Ben Riley: trainees need at least two years in primary care

How GP training is being reshaped

- Proportion of training places taken by GP registrars to increase from 41% to 50% by 2015
- Local Education and Training Boards (LETBs) will take over deanery functions from SHAs in April 2013
- DH rethinking plans for all practices to pay a new levy to LETBs to fund training
- RCGP progressing case for extending length of training to four years

ANALYSIS

Building blocks in place

Gareth Iacobucci
Chief reporter

RCGP chair Dr Clare Gerada could barely contain her excitement as she announced via Twitter that the college had received approval from Medical Education England for plans to extend GP training.

'Can't keep it quiet any more,' she said, before adding wryly: 'Only taken 50 years.'

The clearing of this major hurdle marks a significant step in the college's quest to extend general practice training.

But there is still a huge amount of work to do before the plans become reality, with Dr Gerada neatly describing the latest step as like gaining 'planning permission' to build a house.

The college hopes four-year training can begin from 2014, but must first convince the Treasury to back the plans. Dr Gerada has insisted they will be cost neutral – although one suggestion by education leaders that a national tariff could be developed for service provision by fourth-year trainees has proved controversial.

The house might not yet have been built, but the foundations can now be laid. As chief architect, Dr Gerada may need a hard hat for the work ahead.

IN BRIEF

Flu vaccine drive

The Department of Health has urged GPs to achieve a higher uptake of flu vaccination among both staff and patients this winter.

Full story ▶ pulsetoday.co.uk/clinicalnews

Domestic abuse advice

The MDU has issued new advice to GPs on supporting victims of domestic abuse, after it emerged that the defence body had received a spate of inquiries on the issue.

Full story ▶ pulsetoday.co.uk/practicenews

Theft cuts phone line

A GP practice in north London lost its landline telephone service for four days as a result of a massive cable theft, LMC leaders have reported.

Full story ▶ pulsetoday.co.uk/practicenews

Triptans now first line in migraine

NICE guidance recommends early use of triptans in migraine and acupuncture for tension headaches

By Gemma Collins

GPs should prescribe a triptan, in combination with NSAIDs or paracetamol, first line in patients with acute migraine, new NICE guidelines recommend.

The guidance overturns the 2010 update from the British Association for the Study of Headache (BASH), which recommends reserving triptans for use only after patients have tried several other over-the-counter options such as aspirin and ibuprofen to treat acute migraine.

NICE also said there was 'inadequate evidence' for the effectiveness of amitriptyline in the prophylaxis of migraine, disagreeing with BASH guidelines that recommend this option first line to prevent migraine attacks.

The guidance recommends GPs advise patients with migraine that riboflavin 400mg once a day 'may be effective in reducing migraine frequency and intensity for some people'.

It also urges GPs to consider 'up to 10 sessions of acupuncture over five to eight weeks for the prophylactic treatment of chronic tension-type headache'. Again, amitriptyline is no longer recommended as prophylaxis for this type of headache.

This comes after the Cochrane Collaboration published two reviews that said there was 'consistent evidence' to show that acupuncture benefited patients who had frequent bouts of tension headaches.

What NICE recommends

- **First-line treatment for acute migraine should be triptan combined with NSAIDs or paracetamol**
- **Around 400mg of riboflavin is recommended as prophylaxis**
- **Up to 10 sessions of acupuncture is recommended for chronic tension headaches**

Source: NICE

The NICE guidance also warns GPs to be alert to the possibility of medication overuse in people whose headache developed or worsened while they were taking the following drugs for three months or more:

- triptans, opioids, ergots or combination analgesic medications on 10 days per month or more
- or paracetamol, aspirin or an NSAID, alone or in combination, on 15 days per month or more.

Professor Martin Underwood, a GP and professor of primary care research at Warwick Medical School, who chaired the guidelines' development, told Pulse the recommendation to prescribe the combination of triptan with NSAID or paracetamol was based on evidence showing it was more effective and cost-efficient than taking a single item.

On acupuncture, he said: 'NICE isn't going to make a recommendation unless there is evidence.'

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Faint or anaphylaxis? Our experts help you decide
▶ page24

The guidelines are NICE's first on treating headache

NICE fracture screening advice a 'huge task'

GPs have warned the implementation of recent NICE guidance on carrying out risk assessments for osteoporosis is a 'huge task' and will be impossible to implement without funding.

NICE recommends millions of patients should be assessed with the FRAX or QFracture score, including all women of 65 and over and all men of 75 and over.

Anyone under 65 and men under 75 should also be assessed if they have risk factors for fragility fractures, such as smoking or increased alcohol intake, but NICE said this should not be routinely done in those under 50 years unless they have a serious risk factor, such as premature menopause. NICE calculates more than seven million adults qualify for risk assessment because they smoke, as do seven million because they consume above the recommended alcohol limits – with each assessment taking 10 minutes.

Dr Louise Warburton, a GPSI in Shropshire and president of the Primary Care Rheumatology Society, said GPs did not have the resources. 'It would be an enormous task to screen everyone,' she said.

MORE ONLINE
Guideline debrief: assessing fracture risk
pulse-learning.co.uk

Incentives spark sharp rise in chlamydia tests

A financial incentive scheme for GPs which was recently scrapped in some areas has led to a major increase in chlamydia screening rates, a study has found.

A review of 94 practices in Lambeth and Southwark, which were involved in the National Chlamydia Screening Programme from 2003 and received up to £6,300 a year in remuneration, found the number of chlamydia tests performed by GPs shot up over eight years.

In Lambeth, where the scheme has since been cut, 51 of 52 practices signed up. The borough recorded the highest percentage of young people being tested in England in 2010/2011, according to the study, published in *BMC Public Health*.

There were 4,813 tests done in 2010/11 in Lambeth compared with 23 tests in 2003/04. In Southwark, where all 43 practices were on board, 4,321 tests were done in 2010/11 compared with just five in 2003/04. A practice screening 5% of its cohort was awarded £100-500 a year; those reaching higher targets between £850 and £2,600 a year.

Dr Richard Ma, a GP in Islington and a member of the RCGP's sex drugs and HIV task group, said GPs should be involved 'but there needs to be reasonable remuneration to encourage them'.

Analysis by GP architect of QOF warns of excessive pressure on GPs to cut emergency admissions

ADMISSIONS

Admissions drives 'hit patient care'

By Gemma Collins

One of the GP architects of the QOF has warned pressure on practices to reduce emergency admissions could have 'unforeseen negative consequences' for patients, in an analysis GPs warned raises fresh questions over the framework's new quality and productivity indicators.

The analysis of the latest evidence - co-authored by prominent GP academic Professor Martin Roland – found 'fundamental flaws' in attempts to task primary care with reducing emergency admissions.

Under QOF indicators introduced last year, GP practices were charged with comparing emergency admission rates in their patients with other local practices and coming up with care pathways to reduce them.

The analysis argued comparisons between practices were based on such small numbers that any variation could be 'simply due to chance' and that undue pressure on practices to reduce admissions was unwise.

Professor Martin Roland: negative consequences possible

Professor Roland, professor of health services research at the University of Cambridge and a GP in the city, said patients who needed admitting could be blocked from being seen: 'It is possible that there would be unforeseen negative consequences for patients if GPs are under excessive pressure to reduce admissions.'

The analysis, published in the *BMJ*, argued for a more 'considered approach' and said commissioners should not assume there was a correct level of admission or referral to hospital, or that fewer admissions and referrals were better.

Professor Roland told Pulse his concerns were not specifically but 'indirectly' targeted at the QOF and said the increasing focus on emergency admissions at practice level in CCGs was often based on 'misunderstandings': 'I think it is valuable for GPs to look at the care they provide through audits but people don't need to get too tied up with numbers.'

Dr Mary McCarthy, secretary of GPC West Midlands and a GP in Shrewsbury, Shropshire, said the analysis reflected GPs' concerns about the new QOF indicators: 'If we want to look at emergency admissions we need to look at health inequalities.'

Dr David Bush, a GP in Wolverhampton, added: 'While I am sure we will all see the need to reduce wastage, it seems every new piece of work we are asked to do has the objective "don't let them through the door".'

GPC negotiator Dr Chaand Nagpaul denied the new QOF indicators were putting undue pressure on GPs, but warned the analysis reflected problems with PCT referral schemes demanding 'arbitrary reductions in referrals'.

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What the QOF says

Under QP9, QP10 and QP11, practices must:

- **Meet to review PCO emergency admissions data**
- **Participate in external peer reviews**
- **Propose areas for commissioning or service design improvements to PCO**
- **Follow three agreed care pathways in management and treatment of patients to avoid emergency admissions**
- **Produce a report of the action taken to the PCO**

Source: NHS Employers

FINANCE

Hospital deficits warning

CCGs must keep a 'tight grip' on NHS finances to avoid 'significant' increases in activity in the coming years, the Audit Commission has warned.

The commission's annual report for 2011/12 set out a positive picture of PCT finance, with only three PCTs failing to achieve financial balance this April.

But it expressed concern at the number of NHS and foundation trusts that were in deficit, which increased from 13 in 2010/11 to 31 in 2011/12, and said there was 'no room for complacency'.

Overall, PCTs, SHAs and NHS trusts reported a combined underspend and surplus of £1.6bn in 2011/12.

But the report said a number of PCTs and trusts were 'facing severe financial problems.'

Andy McKeon, managing director of health at the Audit Commission, said the Department of Health and other bodies needed to focus on 'the minority of organisations whose financial position is deteriorating'.

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

TRAINING

£1.75m CCG training bill

The Government has spent £1.75m so far on assessing and training CCG chair and accountable officer applicants, new figures show.

The size of the selection and training bill for CCG leaders emerged in response to a question from Meg Munn, Labour MP for Sheffield Heeley.

New health minister Anna Soubry said the cash had been spent on a total of 493 applicants, which equated to £3,653 each.

She said: 'By the beginning of September, 493 accountable officer and chair applicants went through the assessment centre and related development at a cost of £1.75m to the NHS Leadership Academy.'

Dr David Jenner, NHS Alliance lead on GMS and PMS and a GP in Cullompton, Devon, said: 'Three and a half grand each will sound a lot to the general public, and times are challenging financially, but I actually don't think it's totally excessive.

'There's that horrible saying: "The fish rots from the head", so it's very important to get these two key roles in CCGs right from the start.'

Ten tips to make the most of non-NHS income
▶ page 29

Cochrane review suggests fewer exacerbations with tiotropium but recommends patients have trial of both

COPD

Tiotropium beats LABA in COPD

By David Swan

Tiotropium is more effective than a long-acting ß-agonist in preventing COPD exacerbations, a new Cochrane review has concluded.

The analysis reviewed data from 12,223 patients with COPD who took part in seven randomised controlled trials of at least 12 weeks duration and received either inhaled tiotropium or a LABA, given in any formulation.

Patients were allowed inhaled steroids and other concomitant COPD medication as required.

The researchers found patients with stable COPD who were prescribed tiotropium were 14% less likely to experience a serious exacerbation, compared with those taking LABAs, and 13% less likely to be admitted because of an exacerbation.

There was also a significantly lower rate of withdrawals in those taking tiotropium – 14.5% compared to 16.3% with a LABA – but no significant differences in mortality rates, quality of life or all-cause admissions between the treatments.

NICE currently recommends tiotropium as an alternative to a LABA

NICE guidelines currently recommend tiotropium as an alternative to a LABA in patients with stable COPD who remain breathless or have exacerbations.

But the Cochrane researchers pointed out that – although they saw some significant differences overall – there was a high level of heterogeneity between the trials and that there remains uncertainty over which treatment is more cost-effective.

The researchers suggested that GPs could consider giving COPD patients a 'substantial' trial of both tiotropium and a LABA and then continue to prescribe the treatment the patient prefers.

Dr Iain Small, a GP in Peterhead, Aberdeenshire, clinical lead for the Grampian Managed Clinical Network for COPD and chair of the Primary Care Respiratory Society, said: 'Both LABAs and long-acting muscarinic antagonists (LAMAs) have reasonable evidence for improving exacerbations in COPD patients, but this evidence suggests tiotropium is probably a little bit better on these outcomes.'

Asked whether it might be worth giving patients a trial of both, Dr Small said: 'I think the majority of GPs prescribe tiotropium first anyway – but you find that LABAs and LAMAs are more effective in certain subgroups of patients, and this idea can help determine if there is a difference in response with the patient.'

He added that it was disappointing that the review did not include trials of a LABA/LAMA combination.

But another Cochrane review published earlier this year suggested adding in a LABA to tiotropium was associated with a small increase in quality of life but no clinically significant improvement.

Cochrane 2012, online 12 September

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Tiotropium compared with LABA

14%
decreased risk of at least one exacerbation

13%
decreased risk of admission due to exacerbation

Source: The Cochrane Collaboration 2012. CD009157

MORE ONLINE
Key questions on COPD
pulselearning.co.uk

CVD

Omega-3 'of little benefit'

Guidelines recommending an increased intake of omega-3 fatty acids to prevent cardiovascular disease in those at high risk are not supported by trials, say Greek researchers.

Their analysis pooled 20 randomised controlled trials looking at the use of omega-3 fatty acids for primary and secondary CVD prevention in 68,680 patients aged 49 to 70 years.

Patients were randomised to a diet high in omega-3 polyunsaturated fatty acids or supplements, and the effects were compared with controls on an alternative diet or placebo, for a minimum of one year.

With supplements the risk of all-cause mortality was reduced by just 4% compared with controls, and this difference was not statistically significant. Risk of cardiac death was cut by 9%, sudden death by 13% and myocardial infarction by 11%. None of these reductions were statistically significant. The results from studies on dietary increases were contradictory and unclear.

The researchers concluded: 'Our findings do not justify the use of omega-3 as a structured intervention in everyday clinical practice or guidelines supporting dietary omega-3 fatty acid administration.'

***JAMA* 2012, online 12 September**

DIABETES

Effect of bariatric surgery

Remission rates for diabetes and hypertension remain high six years after bariatric surgery, according to new research from the US.

Diabetes remission rates of up to 90% have been reported in trials with shorter follow-up of one to two years.

But this study looked at 418 obese adults who underwent gastric bypass surgery and compared outcomes to two control groups: obese patients who sought surgery but did not have it and obese patients from the general population.

Bariatric surgery was associated with a 62% diabetes remission rate at six-year follow-up, compared with 8% and 6% in control groups, respectively.

Surgery was associated with a 42% remission rate for hypertension compared with 18% and 9% in the control groups.

Lead author Dr Ted Adams, associate professor of internal medicine at the University of Utah, said: 'Although maintenance of diabetes remission at six years is less than the 75% to 80% remission rates in studies with shorter follow-up, the dramatic improvement in fasting glucose concentrations at year two remained at year six.'

***JAMA*, online 19 September 2012**

PAIN

Acupuncture 'is mostly placebo'

Acupuncture is a 'good treatment option' for chronic pain, although its effects are similar whether real or sham acupuncture is employed, concludes a major meta-analysis of 29 studies.

Data from 17,992 patients showed 50% had a pain reduction of 50% or more with true acupuncture, 43% with sham acupuncture and 30% with no acupuncture, suggesting most of the response was placebo effect.

Sham acupuncture involves needling areas not associated with a therapeutic effect.

Acupuncture was found to be of 'little or modest clinical value' for osteoarthritis and chronic headache, but 'of significant clinical value' for back, neck and shoulder pain.

Study leader Dr Andrew Vickers, research methodologist at the Memorial Sloan Kettering Cancer Center in New York, said: 'The overall effect of the care received from acupuncturists, including any placebo effects, is large enough for it to be considered a good treatment option.'

Professor Edzard Ernst, emeritus professor of complementary medicine at Exeter University, said: 'This important analysis confirms impressively and clearly that the effects of acupuncture are mostly due to placebo.'

***Archives of Internal Medicine* 2012, online 10 September**

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Types 6,11,16,18
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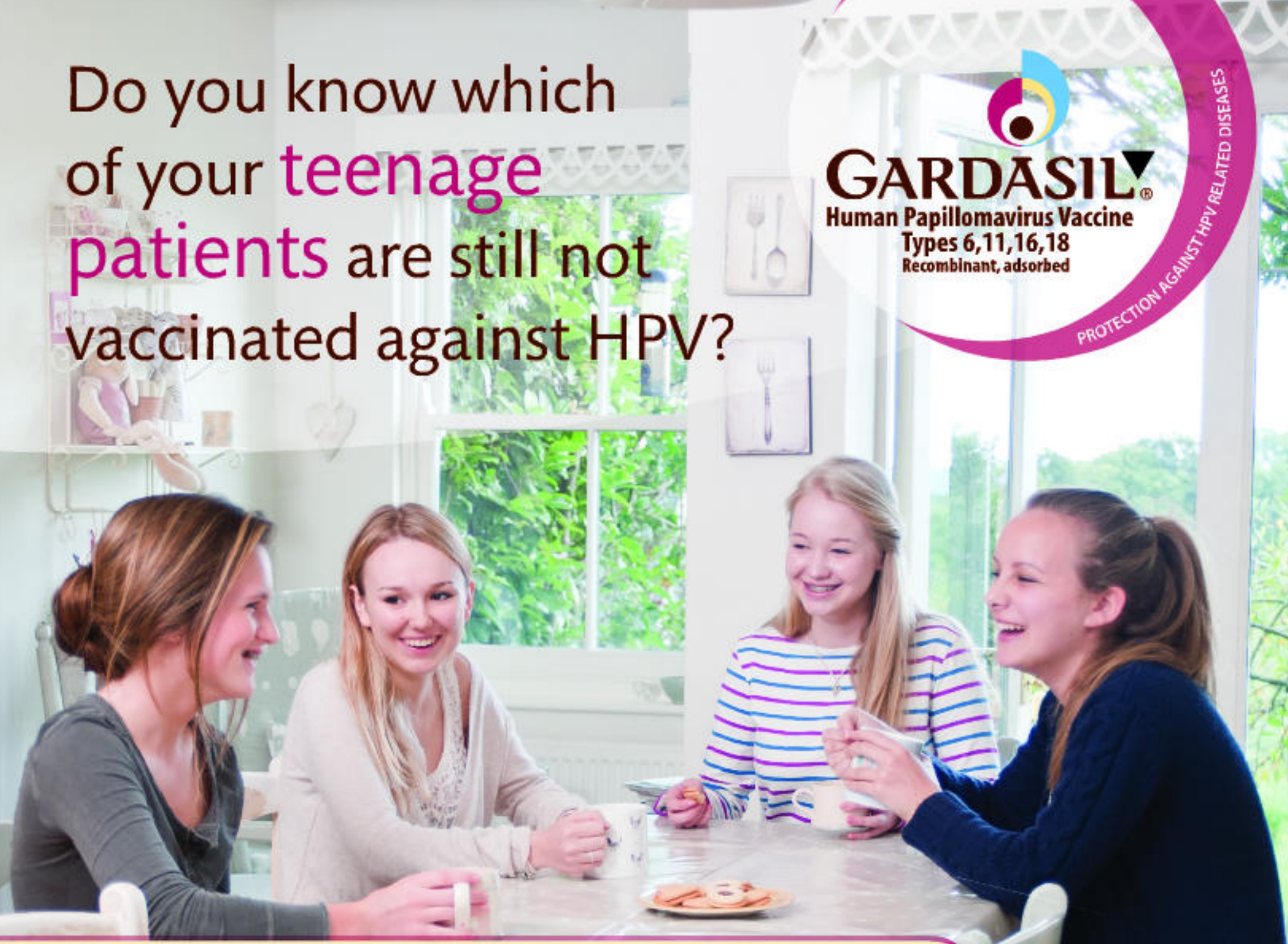

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ABRIDGED PRESCRIBING INFORMATION

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

Refer to Summary of Product Characteristics for full product information.

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

References: 1. Department of Health, Third Annual Report on HPV coverage. http://immunisation.dh.gov.uk/annual-hpv-vaccine-coverage-in-england-in-201011-report/ Date accessed August 2012.

Adverse events should be reported.
Reporting forms and information can be found at www.mhra.gov.uk/yellowcard
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One last question on revalidation

New health secretary Jeremy Hunt hasn't yet formally signed off on it – that's expected imminently. But some 13 years after the GMC first mooted some form of regular checks on the performance and practice of doctors, it seems revalidation is finally here.

While the GMC has been insisting for months the first wave of doctors would begin the process this December, that start date had seemed in doubt until the NHS Commissioning Board announced last week it would fund the remediation process for doctors – in England, at least. With that key sticking point addressed and the BMA giving a grudging green light, the last hurdle appears to have been cleared.

There remains a list of unanswered questions. What about remediation funding for doctors in Scotland, Wales and Northern Ireland? Will locums really be able to gather all the supporting information they require? Are there wider concerns over multi-sourced feedback, given a GMC-commissioned study of draft questionnaires last year found 'potential for systematic bias'? Why will some GPs but not others have to pay for 360-degree feedback themselves? And above all, just how many doctors will be found wanting?

Steve Nowottny
Editor

All this and more will need to be thrashed out – and given planning began in the previous millenium, it's astonishing so much remains unanswered with just two months to go. But there is a more fundamental question: just what is the problem to which revalidation is supposed to be the solution?

The official line is that 'revalidation is to assure patients and the public, employers, healthcare providers and other healthcare professionals that licensed doctors are up to date and practising to the appropriate professional standards'.

But if revalidation is intended as some kind of public relations exercise, then it is an expensive and time-consuming one. And if it is genuinely intended to raise professional standards and weed out poor practice, it is a peculiarly woolly way of doing so.

As one GP put it this week: 'Revalidation should test whether or not I am safe and up to date. In fact, it does neither. An exam and observed surgery would have.'

Where is the evidence that asking GPs to jump through revalidation's hoops will prevent a new Shipman? The NHS Revalidation Support Team may claim it is not supposed to, but such a denial is disingenuous when the proposals in their current form were triggered directly by Dame Janet Smith's inquiry.

What must be acknowledged is that the undoubted benefits of revalidation inevitably come with a price tag attached. There is a financial cost – a not-insignificant one, given the ever-multiplying array of toolkits, working groups, appraisal systems and so on that has sprung up around the process.

But there is also a less tangible, professional cost. This week we publish the harrowing tale of a GP who faced an unfounded GMC complaint. It is an object lesson in the human cost of over-zealous regulation – increased stress, decreased morale and doctors practising defensive, inefficient medicine as a result. Will this also be the fate of GPs caught up in revalidation?

The great and good of the profession may now be on board, but many grassroots GPs are far from convinced. The who, what, where, when and how of revalidation are almost sorted. There's some work to do yet in explaining the why.

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

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Inactivated Influenza Vaccine (Split Virion) BP
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For a complete list of undesirable effects please refer to the Summary of Product Characteristics. **Package quantities and basic NHS cost:** Single dose prefilled syringes in single packs, basic NHS cost £6.59; packs of 10 single dose prefilled syringes, basic NHS cost £65.90. **Marketing authorisation holder:** Sanofi Pasteur MSD Limited, Mallards Reach, Bridge Avenue, Maidenhead, Berkshire, SL6 1QP. **Marketing authorisation number:** PL 6745/0095
Legal category: POM. Date of last review: April 2012
Reference: 1. Sanofi Pasteur MSD. Data on file 2012 UK15877

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A recipe for QOFtastrophe

ILLUSTRATION: SIMON KELLETT

The punters flock to A&E for reasons beyond GPs' control, says **Copperfield** – but that doesn't somehow stop it being our fault

QP12. No, come back. Look, if we didn't have the misfortune to be GPs, a QP12 could be a recipe album, a World War II shipping convoy or a lead acid battery (cheers, Google). But we are, and it isn't. It's one of the revised quality and productivity hoops – raised higher, doused in petrol, then set on fire – that we're supposed to jump through.

Except that, according to recent reports, many of us aren't. So the plan to slash A&E attendances has gone phut, perhaps because we missed the tight deadline, or the PCT failed to provide the relevant data, or we just couldn't be arsed.

Given the potential domino effect on QP13 and QP14, this could be a complete QOFtastrophe. But that's not the main reason why QP12 has got right up our turbinates.

What's really annoying is that this QP criterion is an implied criticism of our practices. Oh, hang on. No it's not. It's an *explicit* criticism of our practices.

There it is, in finger-wagging black and white: 'The practice will meet internally to review data on A&E attendance ... the review will include consideration of whether access to clinicians in practice is appropriate in the light of the patterns.' Or, as Malcolm Tucker would say: 'You're shite and you know you are.'

Thanks for that. Where the QOF was once a motivational tool, it now reads more like a *Daily Mail* editorial.

Listen, QPeople. My practice has repeatedly looked at A&E 'abusers', and the message is consistent. They roll up to casualty not because we're shut, unapproachable, lacking appointments, inflexible, uninterested, or any other access cliché you care to trot out. No, they go either because they live nearer to A&E than they do to the practice, or because they want antibiotics and they know that, while we won't dish them out, the casualty officer will. Oh, and because they abuse every other service, too.

Logically, our proposals for QP13 and 14 should be to dismantle the health centre and rebuild it next to A&E, and/or put a massive trough of amoxicillin in our waiting room/and or cull frequent attenders. Lack of premises investment and draconian prescribing restrictions means only one of these is realistic.

We can hardly blame the punters, though: they've been force-fed a message of choice in healthcare, so no wonder they choose where and how to have their 'accident' or 'emergency' dealt with. Nor can we blame casualty – after all, it's in their interests to attract custom, even if it does mean erecting a flashing neon 'McDoxycycline' sign.

So that leaves us. Inappropriate A&E attendance is our fault, even though it isn't, and it's up to us to sort it out, even though we can't. And when we've finished banging our head against this particular wall, presumably we can look forward to more cranial trauma – with, say, new QP criteria browbeating us into reducing other politically driven, uncontrollable workload, such as out-of-hours calls or two-week referrals. All of which will be enough to give us subdurals.

Off to A&E? Er, no, it'll spoil our figures. Besides, the way things are going, I'd rather let nature take its course.

Dr Tony Copperfield is a GP in Essex. Read his regular blog online at pulsetoday.co.uk/copperfield

After unfounded GMC complaint, I feel at the mercy of my patients

An anonymous GP describes how a two-line email left her facing a four-month fitness-to-practise investigation

'I don't want to talk to you. I just want to confirm your full name and tell you that you will have to defend your actions in front of your peers.' Her tone was angry and intensely spiteful. The conversation was over before I could speak and it left me shaken. We had never met. She was the relative of a patient who two days earlier had been in my consulting room with symptoms of confusion, malaise and cough, and 30 minutes after leaving had collapsed with a massive stroke, but survived. It was evident the relative was not interested in any explanation or facts. She just wanted my head on a plate.

I hoped the threat of action would not be followed up, and was just a way of the relative coping with shock and grief. I was confident that I had done the right thing, and my partners and doctor friends agreed.

But four weeks later I opened a letter from the GMC informing me I was now the subject of a fitness-to-practise investigation. It left me stunned and fearing deeply for the future of my career. Last year nearly 9,000 of us were the subject of a formal complaint to the GMC, a rise of almost a quarter on the year before. Next year, it might be you, and no matter how sure you are of your actions, the effect on your self-confidence and on your attitude to your patients may shock you.

I consider myself a conscientious, hard-working GP who genuinely cares about patients, so to be accused of being an uncaring and incompetent doctor who may not even be fit to practise felt like a slap in the face. It may sound illogical and self-pitying, but I felt that I had been betrayed by my patients as a whole.

And the fact that two lines sent in anger by email to the GMC could result in a full-scale, four-month investigation of my competence made me feel intensely vulnerable. It just seemed too easy for a patient to complain and cause me such stress.

As old-fashioned as it sounds, I felt strongly that the complainant should have been made to write a formal letter. I understand the GMC wishes to be more accessible, but a brief email seemed to make complaining too easy.

Confidence that the GMC would see things my way evaporated during sleepless nights. Thoughts of 'what if I have to go to court', 'what if I get struck off', and 'I don't know anything but to be a doctor, what else could I do?' ran through my head repeatedly, usually at 3am when things always seem worst.

I had great support from family, friends and partners. My defence union proved invaluable, and the GMC concluded my case with no further action being taken.

I feel no joy or vindication; I'm just grateful I was spared the humiliation of a public hearing. If, however distant in the future, another patient or relative decides in anger that I should be held to account, this earlier investigation could count against me as I will no longer be able to use the lack of any previous investigation as a mitigating factor, even though this one found in my favour. It is a black mark against my name that can never be erased and I find this immensely unfair.

I am aware that patients are more demanding, and more likely to complain, so I feel like I am now at their mercy. My medical practice is more defensive as a result and if we all start to act this way, health costs will rise. My notes are the length of short novels because I now wish to document immensely detailed follow-up plans and all my thoughts relating to a consultation.

My interactions with patients are now tainted by a faint mistrust, which saddens me.

At the same time as putting GPs under immense pressure to ensure patient satisfaction, we are also expected to reduce or maintain the cost of the care we provide. But the Government cannot have it both ways.

In a climate where patients are more likely to complain and it is harder for us to provide the care they expect, more and more of us will go through what I just experienced. I ask myself whether it's worth it.

'Cottage industry'? Bigger is not always better in general practice

Primary care requires organic growth rather than wholesale redesign, argues **Dr Michelle Drage**

Much in the King's Fund report published earlier this month, *Transforming the delivery of health and social care*, resonates with what GPs have been saying for two decades. Clinical and non-clinical complexity, along with rising expectations, have squeezed general practice to the point where the pips have not simply squeaked, but have been ground down to molecular level.

But the report makes the fundamental error of viewing the UK healthcare system through the narrow-angle lens of hospital institutions, and concludes that the model of delivery of primary care, which it described as 'the cottage industry of general practice', must be radically transformed to manage pressure and demand.

GPs sigh wearily when we hear this, just as we balk at the suggestion that if only others could look after the simple cases, we could be freed up for a lifetime of managing multiple long-term conditions in growing numbers of older patients.

With the overwhelming majority of patient care already taking place in primary care and 85% of resources embedded in our hospitals, could we work smarter in general practice? Could we employ more nurses, liaise better with other members of the primary care team, integrate our services with others such as community, social and hospital services?

Yes, we could, and we should, because integration has been the glue of general practice since the term was coined by the profession itself in the 1950s. Two generations of GPs have been trained to identify the need for integration and, through primary care teams, practise it.

Yet since the early 1990s, the system has failed to value it, leading to workforce crises and patchwork solutions based on the bigger-is-better philosophy of Darzi centres, polyclinics and others.

All of these models mistakenly focus on redesigning models of care rather than supporting the organic growth of what we already have. The danger inherent in this report is that it will be interpreted as another panacea, providing a platform for yet another round of political ribbon-cutting and drainage of our scarce resources to global firms of management consultants whose understanding centres far more on self-perpetuation than general practice.

Well, as the old bus adage goes, just when you've been waiting for ages two come along at once. In its new paper, *Patients, Doctors and the NHS in 2022*, the RCGP offers a more rational approach, recognising general practice has its own set of values, centred around the whole patient's needs, be they medical, socio-economic or psychological.

The report offers a less radical, potentially more successful solution. It highlights the need for more GPs with longer training as central to the development of general practice in the next 10 years – something that cannot be denied. The RCGP brings together elements that are prominent in the King's Fund report and ties them to a rationale that makes sense to GPs.

Integration of services is key, but it should be flexible and defined by factors such as 'patient need, geographical factors and organisational characteristics'. In terms of flexibility, the RCGP concept of federated practices needs to be tailored to local GP cultures and infrastructure constraints. A single partnership or company may suit some, but neighbourhood networks of practices, linked by good management and telecommunications support, could offer just as much if not more.

The RCGP paper also addresses clinical complexity and the need for longer consultations, which would lead to more effective interventions and better outcomes. But it does so through the wide-angle lens of general practice, where the presenting problem is just the ticket to explore what really are the underlying causes of concern and where the whole patient picture is valued.

Can these reports lead to a new valuing of the clinical generalist and a whole-patient approach? With former RCGP chair Professor Steve Field now deputy medical director of the National Commissioning Board, there is potential to finally turn the system's thinking towards making this a reality.

Dr Michelle Drage is the chief executive of Londonwide LMCs

MORE ONLINE
Professor Chris Ham expands on the King's Fund report. Read both sides of the debate at pulsetoday.co.uk/debates

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Where were the women in Pulse's top 50 influential GPs?

LETTER OF THE WEEK

From Dr Fiona Cornish
President, Medical Women's Federation (MWF) and GP in Cambridge
Dr Beryl de Souza
Honorary secretary, MWF and registrar in plastic surgery
Dr Fay Wilson
GPC and BMA Council member, MWF member and GP in Birmingham

The Medical Women's Federation (MWF), the largest body of women doctors, echoes the words of RCGP chair Dr Clare Gerada, deploring the lack of women in Pulse's list of the top 50 most influential GPs.

We also congratulate Clare on being No 1 for the second year running.

Clare is a superb role model for women GPs and we are proud to have nominated her last year for a Women in the City Woman of Achievement Award. She won not only the Healthcare category but went on to win the overall Woman of Achievement Award.

One of the criteria for this award is to support and encourage other women in the profession, which is evident from her many activities.

We call upon all women GPs to gather together and support each other to get involved in leadership positions in the NHS, including CCGs, and medical organisations, such as the royal colleges and the BMA.

We offer mentorship and support and we ask each one of you to get involved in the issues affecting our medical profession. Yes, we also have family commitments to juggle, but then we have an inherent multi-tasking attitude.

At our MWF autumn meeting we will seek to address why women should join networks in a discussion forum that includes the current BMA president Baroness Sheila Hollins and the medical director of the Medical Protection Society Dr Priya Singh.

MORE ONLINE
Pulse's top 50 TPs
pulsetoday.co.uk/top50

Dr Clare Gerada: a role model for many female GPs

The BMA must show its teeth

From Dr Atul Kothare
Coventry
via pulsetoday

The 'industrial action' on pensions was completely unworkable ('Pensions bill will "entrench" unfairness for doctors, says BMA', pulsetoday.co.uk/news).

What was the point of saying patients for emergency appointments would be seen but routine ones wouldn't?

How can you triage a patient's needs? By seeing the patient. And then you will tell the patient that you will not treat them as they are not an emergency?

The best thing the BMA can do now is to stop all support for commissioning.

● **From Dr Andrew Field**
York
via pulsetoday

The way the NHS is going, there will be the loss of doctors abroad, difficulty in recruitment in many areas (especially primary care), and a further lowering of morale – creating less effective doctors, less chance of the reforms working (if they had a chance in the first place) and huge additional cost to the NHS in the long run.

I plead for some effective strategic industrial action with teeth, one that will not hurt patients or make my day job harder.

Surely this can only come from refusal to engage with some or all aspects of Government bureaucracy?

We should boycott CCGs en masse

● **From Dr Louise Irvine**
BMA Council member
Lewisham, south London
via pulsetoday

Your story on internal BMA discussions about the NHS reforms has provoked an interesting discussion ('Leaked emails reveal pressure within BMA for GP commissioning boycott', pulsetoday.co.uk/news).

We have six months left until we are contractually obliged to be members of CCGs, and while many GPs are talking about boycotting CCGs, they fear that by refusing to sign up to CCGs they could lose their contracts.

As a strategy, a boycott would only be successful if it was supported by the great mass of GPs.

If enough refused to join CCGs it would be unlikely that all the contracts could be removed as that would be too destabilising for patient care.

A mass GP boycott of CCGs (including resignations from board positions) could have a huge public and press impact, adding to everything else that is making this health act unworkable, stalling things until the next election when there is a chance of a change in governing party.

It would put pressure on the Labour party to clarify its position on repealing the act. So I think it's worth opening up a discussion about this idea within the profession.

● **From Dr Ron Singer**
President, The Medical Practitioners' Union
via pulsetoday

As the true effects and controlling nature of the NHS act become apparent to all, 'I told you so' has become an inadequate response.

But for the BMA, having refused a public campaign against the bill stage even though BMA Council and an annual representatives meeting requested (or demanded) it, a campaign now where a clear majority or large minority of GPs refuses to co-operate with the further development of CCGs is feasible and timely. I urge the GPC in this direction.

There is ample evidence that CCGs will be the decommissioning organs of the new NHS, forced to rush through cut after cut. Involving the public will amount to CCG leaders appearing as apologists at public meetings for CCG decisions to close this service or cut that one – just like PCT managers have had to do in the past.

The public have been misled and GPs duped – the NHS is being privatised and fragmented before our eyes. As the public feel the effects of a shrinking NHS, now is the time to launch a campaign for GPs to say: 'Up with this we will not put'.

● **From Dr Clare Gerada**
RCGP chair and leader of the Practitioner Health Programme

I am seeing increasing numbers of GPs on CCGs who are worried about their conflict between being patient advocates and chief practitioners – we are certainly seeing an increase in GPs presenting to us as part of the Practitioner Health Programme. Many are citing stress as a result of the new commissioning roles and financial issues, as well as problems with workload pressures.

Should the BMA lead a boycott of commissioning?

Make medical students want to be GPs

From Dr Krishna Kasaraneni
Chair of the GPC trainees subcommittee and GP in Sheffield

I agree with Dr Sarah Wollaston's view that medical students should be encouraged to opt for a career in general practice ('Recruiting more GPs is the key to future-proofing the NHS', pulsetoday.co.uk/opinion).

But a 'carrot' for GPs rather than a 'stick' for hospital specialties should be the way forward.

Dr Wollaston's suggestion of disinvestment in hospital training posts to encourage GP recruitment would be the wrong approach. It will encourage doctors to pursue a career in general practice because there is nothing else out there.

Do we really want that kind of GP or would we prefer the ones with a genuine interest in primary care?

I know which one I'd rather see if I was a patient. The focus should be on the positives of a career in general practice and promoting the specialty.

Peverley struck a chord

From Dr Selwyn Goldthorpe
Retired GP, Liverpool
via pulsetoday

It is sad that the senior members of our profession, who have so much wisdom to offer younger colleagues, are leaving the profession like rats from a sinking ship ('The tale of a spurned lover', pulsetoday.co.uk/peverley).

But I am one of those senior GPs. I retired five months ago from singlehanded general practice as a trainer of F2 doctors, medical students, and a finals examiner, at the age of 58.

The various governments over the years have eroded job satisfaction and have made personal care to individuals and families (if you remember the old Royal College definition) impossible to achieve.

We were taught that the personal care of patients, centred on a primary healthcare team, was paramount – not the achieving of financial goals (though you could hope that good care is financially rewarding).

I have put all my thank-you letters from patients in a large ring-binder file. I look upon my 30 years of practice as a privilege, but life moves on. We will be the last generation of doctors to have practised patient-centred medicine.

The public will never know what they have lost; neither, perhaps, will the profession.

Yes, we should charge DNAs

From Dr Siddapa Gada
Ipswich, Suffolk
via pulsetoday

I was interested in your survey on fees for patients who repeatedly miss GP appointments ('GPs support charging for no-shows', pulsetoday.co.uk/news).

I do feel a minimal charge for a DNA – say, £1 per time – is not unreasonable. But that money should be used for improving patient access and communication, or for funding a mobile phone that can be used to send appointment reminders to the patients.

'Choice' agenda is pure fantasy

From Dr Diana Lowry
Epping, Essex
via pulsetoday

Obviously I am pleased that HM Government is trying to deal with my boredom by giving me more to do ('RCGP rejects Government plans to force GPs to refer patients through Choose and Book', pulsetoday.co.uk/news).

However, I do have two comments about the system.

First, I thought that computers were good at sorting information. Perhaps Choose and Book could be set up to tell us the shortest wait in the easily accessible hospitals?

Second, and more important, it is a fantasy that patients want to shop around.

Most of them want to go to the local hospital, and they are more concerned that it is 'fit for purpose' than whether there are alternatives.

If it is, that is where they want to go.

For the record

In Dr Paul Lovell's commissioning feature last week, 'How we set up virtual wards', we should have stated that the Southern locality in Devon reduced admissions by 22%, and the Northern locality reduced admissions by 14%. The amended article is available now online at pulsetoday.co.uk/commissioning with a corrected table and outcomes. Pulse's priority is accuracy. However, in the busy process of preparing a weekly publication, mistakes can occur. To draw our attention to an error, email letters@pulsetoday.co.uk

Pulse Plus

Our monthly CPD section provides an in-depth update on a clinical area, allowing you to earn credits for appraisal by answering questions online

In this issue

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The information: carpal tunnel syndrome 0.5 CPD hours
Confirming diagnosis and the management options

PulseToday
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After reading this month's Pulse Plus, go to pulsetoday.co.uk/tools-and-resources to download a copy of the Resuscitation Council UK guidelines for advice on emergency life support

Primary care emergencies

Key questions

Emergencies in primary care

GPs with an interest in emergency care **Dr Mark Folman** and **Dr Peter Holden** tackle GP **Dr Mandy Fry**'s questions on epistaxis, a non-blanching rash and the hypoglycaemic patient

Administration of parenteral benzylpenicillin while waiting for an ambulance is vital in any patient who is unwell with a blanching rash

1 Sometimes patients present with prolonged epistaxis. What should we do if applying direct pressure doesn't help? Should GPs learn how to 'pack' noses?

Direct pressure is the mainstay of treatment of epistaxis – try this initially for 10 minutes, holding the anterior (soft) part of the nose as tightly as possible and leaning the patient forward to prevent them inhaling or swallowing blood.

If there is no slowing of the flow at this point, arrange for the patient to be transferred to A&E. If the blood flow is slowing, a further 10 minutes of direct pressure may be appropriate. It is useful to actually time 10 minutes rather than guess how long direct pressure has been applied for.

Advise them to avoid blowing or picking their nose for the next 48 hours, and to avoid hot drinks or alcohol, as these can cause vasodilatation within the nose.

Patients on anticoagulation require special consideration. GPs are, of course, aware of the potential medicolegal consequences of dismissing such a patient without a carefully documented decision.

Increasingly, anticoagulation is monitored in general practice – do INR testing if this is available, or consider referring the patient to the emergency assessment unit for an INR according to local protocol.

It is more appropriate for noses to be packed at hospital than in the practice. But appropriately trained GPs can consider nasal cautery, using silver nitrate sticks cautiously.

2 Should we administer antibiotics for a non-blanching rash while awaiting transfer to hospital? What are the recommendations about the choice of antibiotic? What about individuals who are allergic to penicillin?

If an unwell patient presents with a non-blanching rash, administration of parenteral benzylpenicillin while waiting for an ambulance is vital. The earlier this is given, the better the outcome.

The typical purpuric rash is a late sign of meningococcal septicaemia, so consider administering penicillin in any child who is unwell, with neck stiffness or photophobia. See the tables on the following page for benzylpenicillin doses.[1]

Administration of penicillin should not delay transfer to hospital. Ideally, penicillin should be given prior to the arrival of the ambulance, but if not, the ambulance paramedic will be able to give it.

Genuine penicillin allergy occurs in around 1% of the population. Only withhold penicillin if there is a solid history of anaphylaxis – consider giving benzylpenicillin if the reaction sounds less severe, such as a rash or diarrhoea.

Penicillin is the first-line treatment for meningococcal septicaemia in the UK for both GPs and the ambulance service. Ambulance service paramedics do not carry an alternative, and we would suggest there is little need for GPs to do so – although those working in out-of-hours services may wish to also consider carrying cefotaxime.

3 Are there situations where we can be more relaxed about a non-blanching rash?

Patients presenting with a purpuric rash, who are clinically well – normal temperature, pulse, respiratory rate

22

21 and capillary refill time – and have no signs of meningism, are unlikely to have meningococcal septicaemia. In this instance, emergency transfer to hospital is not indicated. But it would be wise to seek secondary care review and investigation – unless the cause of the rash is known, for example, the patient has already received a diagnosis of idiopathic thrombocytopenic purpura. Make a same-day ambulatory clinic referral or arrange admission to the local assessment unit. We would advise against waiting overnight.

Also note that if the rash is confined to the head and neck area, it may have been caused by raised venous and capillary pressure brought on by coughing, vomiting or crying.

4 How would you manage a patient who collapses in the surgery? Apart from baseline observations, how else can we determine the potential aetiology?

If a patient collapses in the surgery, the first priority is to summon help – all members of practice staff should know how to raise the alarm and procedures should be regularly tested.

You should assess whether it is safe to approach, then check for responsiveness – shout and shake the patient to see if they wake up.

If they do not, follow standard basic life support algorithms. Go to pulsetoday.co.uk/tools-and-resources to download the Resuscitation Council UK guidelines.

Assuming the patient is unconscious but breathing and has a pulse, place them in the recovery position.

If a patient is unconscious, call an ambulance. While waiting for the ambulance:

- check blood sugar
- check blood pressure and pulse, and do an ECG if possible
- do pulse oximetry to guide oxygen administration
- ask someone to retrieve the patient's notes and document relevant history. Take particular note of whether any new medication has been started.

+IV DOSE OF BENZYLPENICILLIN

Age	Dose	Volume
<1 year	300mg	5.0ml
1 to <9 years	600mg	10.0ml
9 years to adult	1.2g (two vials)	20.0ml

Concentration – 600mg dissolved in 9.6ml water for injections

+IM DOSE OF BENZYLPENICILLIN

Age	Dose	Volume
<1 year	300mg	1.0ml
1 to <9 years	600mg	2.0ml
9 years to adult	1.2g (2 vials)	4.0ml

Concentration – 600mg dissolved in 1.6ml water for injections

5 What is the preferred treatment for status epilepticus? How long should we wait before intervening? How does rectal diazepam compare to buccal midazolam?

Initial treatment for a patient having an epileptic fit is to prevent them hurting themselves – for example, ensure they are on the floor and are away from any dangers.

Do not try to hold the patient down or attempt to insert anything into their airway while they fit.

If the fit lasts for longer than 10 minutes, you can attempt to pharmacologically arrest the fit. Current guidance is still to use rectal diazepam, but some patients now have buccal midazolam for the termination of fits.

Midazolam has a faster onset than diazepam, but it requires oral administration – this can be risky for the rescuer and challenging if the patient is unable to open their mouth. Despite the longer duration of action and sometimes challenging method of administration, rectal diazepam remains the most common and safest agent to arrest fitting and it can also be given by ambulance paramedics.

6 What are the recommendations on emergency treatment of the hypoglycaemic patient? Is it true that oral glucose gels are no longer appropriate in semiconscious patients? Should we give IM glucagon or aim for IV access?

A patient with diabetes having a hypoglycaemic attack is one of the most common emergencies a GP will experience.

Prevention is the best option and some practices have phlebotomy arrangements that ensure patients with diabetes are not kept waiting for fasting blood tests.

If a patient with diabetes collapses, check the scene is safe and then start basic medical emergency management – check for airway patency, effective breathing and a strong pulse. If the history suggests hypoglycaemia and you have a confirmatory blood glucose stick measurement, fully conscious patients should receive oral glucose – either glucose gel, a sugary drink or chocolate. Repeat the blood sugar test afterward to ensure a rise.

If the patient is semiconscious or unconscious, call an ambulance – if it is a simple hypoglycaemic attack there is often no need to transfer the patient, but occasionally there is an additional cause for unconsciousness. Glucose gel can then still be used cautiously. Ensure the patient is on their side – ideally in the recovery position – and smear small amounts of the gel onto the mucous membranes in their mouth, taking care not to obstruct the airway or get your fingers in the way of the teeth.

You can give 1mg glucagon IM – this will mobilise glycogen stores and provide a transient rise in blood glucose. This will need to be followed up with both oral glucose supplementation and carbohydrates – biscuits or a slice of toast.

IV glucose is the preferred treatment for unconscious patients. Ambulance services currently advocate 10% glucose solution instead of the 50% glucose solution, which is an irritant to veins. Give 100mls of 10% glucose aliquots, ideally through a flushed large bore cannula into a large vein, waiting five minutes between boluses to check for clinical response.[2]

Remember to review the patient's diabetes control to establish why the episode occurred.

7 Is there still a role for nebulised salbutamol in practice or is it as effective to use repeated doses of a metered-dose inhaler through a spacer in patients with asthma who are acutely short of breath? What dose of prednisolone would you give in these patients?

There is little benefit from air-driven nebulised salbutamol compared with 10 puffs of MDI salbutamol through a spacer. All patients who present having an asthma attack should have basic observations taken, including oximetry. If a patient has lowered oxygen saturations, oxygen-driven nebulised salbutamol (or salbutamol and ipratropium) should be given while awaiting the ambulance. Lowered oxygen saturations are particularly concerning in children, who should be treated with extreme caution.

According to the BTS/SIGN guidelines,[3] steroids reduce mortality and relapses and should be given as early as possible in an acute attack for both adults and children.

The dosing schedule for children is 20mg per day prednisolone in those between two and five years of age, and 30-40mg for children older than five years. The dose can be repeated if the patient vomits. Intravenous steroids should be reserved for patients who continually vomit or can't swallow.

Dr Mark Folman is a GP in Nottinghamshire and Dr Peter Holden is a GP in Derbyshire, and both are members of the Magpas-Helimedix team

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References

1 Joint Royal Colleges ambulance liaison committee. *Clinical practice guidelines on benzylpenicillin (penicillin G)*. 2006. tinyurl.com/aq5dxq (accessed 4 September 2012)

2 Joint Royal Colleges ambulance liaison committee. *Clinical practice guidelines on glucose 10%*. 2006. tinyurl.com/4ufl7q (accessed 4 September 2012)

3 BTS/SIGN. *British guideline on the management of asthma* (revised January 2012). Guideline 101

1 in 4

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

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

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

* The need for a second dose is currently unknown

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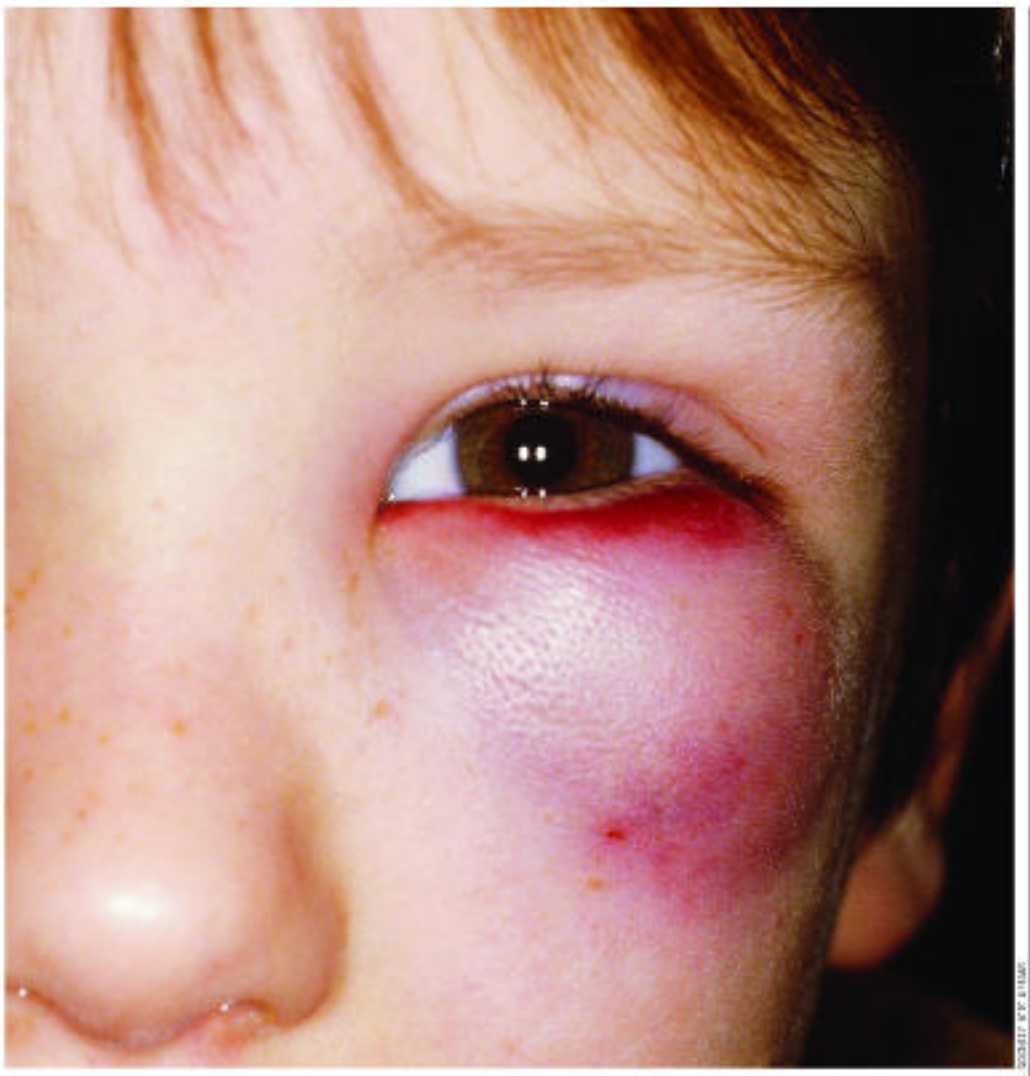
Urgent dilemmas

Our panel of experts offer their tips to help you make the right diagnosis when you're faced with an urgent dilemma



Faint or anaphylaxis?

One of the first dilemmas you will face when attending a patient who appears to be developing an anaphylactic reaction after vaccination is determining whether or not it is a fainting episode (vasovagal syncope). The table below will help you to make the diagnosis.

Also remember that patients occasionally experience a panic attack before or after vaccination. Look for hyperventilation, and numbness and tingling in the upper and lower extremities. There is often a red rash associated with anxiety during a panic attack.

Dr George Kassianos is a GP in Berkshire, RCGP immunisation lead and president of the British Global and Travel Health Association

IS THE PATIENT FAINTING OR IS IT AN ANAPHYLACTIC REACTION?

	Fainting	Anaphylaxis
Age	• Usually adults and adolescents • Infants and children under five years of age rarely faint	• Any age • Sudden loss of consciousness in a child is more likely to be an anaphylactic reaction
Exposure	• Past history of vasovagal episodes	• There may be a known allergen
Onset	• Before, during, or after a vaccine is administered • Patient becomes lightheaded, nauseous or weak, with blurred or faded vision and muffled hearing	• Usually occurs within five minutes of vaccination, but rarely it can occur one to four hours after exposure and very rarely within 24 hours • Symptoms progress rapidly – the more rapid the onset, the more severe the course
Skin	• Pale, clammy, can feel cold and no skin rash • Tingling sensation in the body	• Itchy, flushed or pale skin • Skin redness or urticaria • Swelling of the deeper layers of skin or subcutaneous tissues (angioedema) • Swelling of the mouth
Gastrointestinal	• May have nausea and vomiting	• May have diarrhoea and vomiting
Neurological	• Patient becomes lightheaded, feels faint and has a transient loss of consciousness that improves on lying down • Transient jerking of limbs • Eyes rolling	• No improvement once lying down • Loss of consciousness • Sense of anxiety and distress
Respiratory	• Normal breathing • May be shallow or deep but not laboured	• Dyspnoea, tachypnoea, rib recession or cyanosis • Life-threatening airways compromise • Coughing, sneezing or runny nose • Wheeze, hoarse voice or stridor
Cardiovascular	• Strong central pulse • Bradycardia • Transient hypotension that improves on lying down	• Weak or absent central pulse • Tachycardia • Hypotension that does not improve on lying down • Arrhythmias are possible • Peripheral cramps
Recovery	• Rapid recovery within minutes	• The symptoms and signs improve, particularly with treatment • After initial improvement, symptoms may recur within four to 12 hours • Occasionally, the reaction may be persistent and more severe

Innocent or non-accidental injury in a child?

Distinguishing non-accidental injury – where there has been maltreatment, even from another child – from innocent or accidental injury is a difficult judgment.

You might only notice bruises or unexpected tenderness when being consulted for something else. The risks to the child are high, as you might not see them again and further injuries could be fatal – or at least very damaging to the child's development and wellbeing.

The CORE-info reviews resource is very helpful in describing differences between accidental and non-accidental bruising – go to pulsetoday.co.uk/tools-and-resources.

Injuries to the pinna, head and soft areas of the body are more likely to be non-accidental than injuries to other areas.

Delay in seeking advice is another classic sign of possible non-accidental injury,[1] but surprisingly the colour of a bruise is not always a guide to its age. Bruises in non-mobile babies or disabled children are particularly suspicious.

Ask the child or young person what happened – questioning any unexplained or unaccountable injury are key skills. The GMC advises recording any concerns about the context or character of an injury, seeking advice,[3] and, where appropriate, prompt referral.[4]

Dr Janice Allister is a GP in Peterborough and RCGP clinical champion in child health 2011/12

Indigestion or infarct?

When a patient presents with a potential infarct, or indigestion, listen and watch carefully as they tell you about their symptoms.

Upper abdominal pain, nausea, belching or bloating are far more likely to originate from the stomach than from the heart. If the pain occurs in the chest ask the patient to describe it – heaviness, pressure, aching or squeezing are suggestive of acute coronary syndrome (ACS).

Other symptoms of ACS include shortness of breath, palpitations, weakness, dizziness or sweating.

Symptoms of ACS typically last 30 minutes or longer and may start with mild discomfort that increases in intensity. Ask specifically about exertional chest pain or any previous discomfort – patients with ACS often have a history of exertional discomfort before presenting acutely.

It is the combination of symptoms that is important in determining whether a person is having an infarct and not the severity of chest pain. Women often describe their symptoms as pressure, tightness or an ache – rather than as severe pain – during an infarct. Shortness of breath is more common in women, whereas sweating is more common in men during an infarct.

Pain from infarct and indigestion – especially GORD – may be felt in the shoulders, arms, throat, jaw or back. These features are not helpful in separating the two conditions.

Consider the patient's cardiovascular risk profile – if high, ACS becomes more likely.

Dr Adam Harris is chair of the British Society of Gastroenterology's (bsg.org.uk) clinical services and standards committee and a consultant physician and gastroenterologist at the Tunbridge Wells Hospital, Kent

Migraine or stroke?

GPs will be familiar with the patient who presents with a headache and neurological symptoms.

There are a number of factors that can make this presentation tricky:

- Headache is a feature of up to 30% of all types of stroke.
- Migraine can be associated with an aura – a reversible positive or negative, motor or sensory transient phenomenon. Aura can occur in the absence of headache.
- Migraineurs who have aura have a twofold increase in stroke risk.
- Migraine can precipitate stroke – a migrainous infarct.
- Triptans are potent vasoconstrictors and so could induce stroke in a patient with a vulnerable circulation.
- Rare neurological syndromes can produce both stroke and migraine.

The history is key to making the right diagnosis. Aura is caused by a wave of depolarisation that traverses the cortex at 3mm per minute, so auras will progress with time, while ischaemic events will occur suddenly and there is unlikely to be any progression.

The type of aura will depend on the area of cortex involved. In migraine, auras will typically last between 30 and 60 minutes and precede the headache, which will have migrainous features – pulsating and the associated nausea, phonophobia, photophobia or movement sensitivity.

Formally, migraine is not diagnosed until there is a history of five attacks – although in practice, this is often relaxed. A past history or family history of migraine are reassuring features.

But if there is no history of migraine and the neurological presentation does not fit the pattern of a typical aura, a phone call to the stroke clinic would be indicated.

Dr David Kernick is a headache GPSI in Exeter and RCGP headache champion

Sprain or fracture?

The management of subtle fractures and sprains can cause real anxiety in primary care, because misdiagnosed injuries can cause long-term problems.

Both conditions are painful, and may be difficult to distinguish, so here are some tips:

- The first thing to do is compare the injured limb with the normal side. Fractures may be obvious and present with extreme pain and a deformity, or they may be more subtle.
- Sprains tend to occur at the sites of ligament attachments, close to the joint, while fractures may occur anywhere along the length of a bone.
- Pain and crepitation on moving the bone may suggest a mobile fracture.
- A reduced range of movement in an injured limb should always be taken seriously and investigated further.
- Complete ligament ruptures are usually less painful than partial tear, and cause joint laxity when compared with the normal side.
- Always ask for help if in doubt – refer to A&E or a fracture clinic.

The Ottawa rules can be useful, and can be viewed at pulsetoday.co.uk/tools-and-resources. But they should be used with caution.

As a junior A&E doctor, armed with the Ottawa rules, I recall explaining to a Lancashire farmer he did not need an X-ray as he could walk on his ankle.

But he wanted one, and in the end I agreed to arrange it. He turned out to have a complex comminuted fracture.

So the important point is to trust your instinct and take into account the patient's concerns and expectations.

Mr Mike Hayton is a consultant orthopaedic surgeon at Wrightington, Wigan and Leigh NHS Foundation Trust

Hyperventilation or pulmonary embolism?

GPs will all have been faced with the urgent appointment who presents with breathlessness – but is it potential hyperventilation, or pulmonary embolism?

- Take a history – how old is the patient, do they have any other illness or family history of venothrombosis?

A young patient with no other illnesses or family history of venothrombosis is reassuring. An older patient who doesn't have any history of hyperventilation is much more likely to have a cardiac or respiratory cause for their symptoms – but you should still do the same initial history and examination.

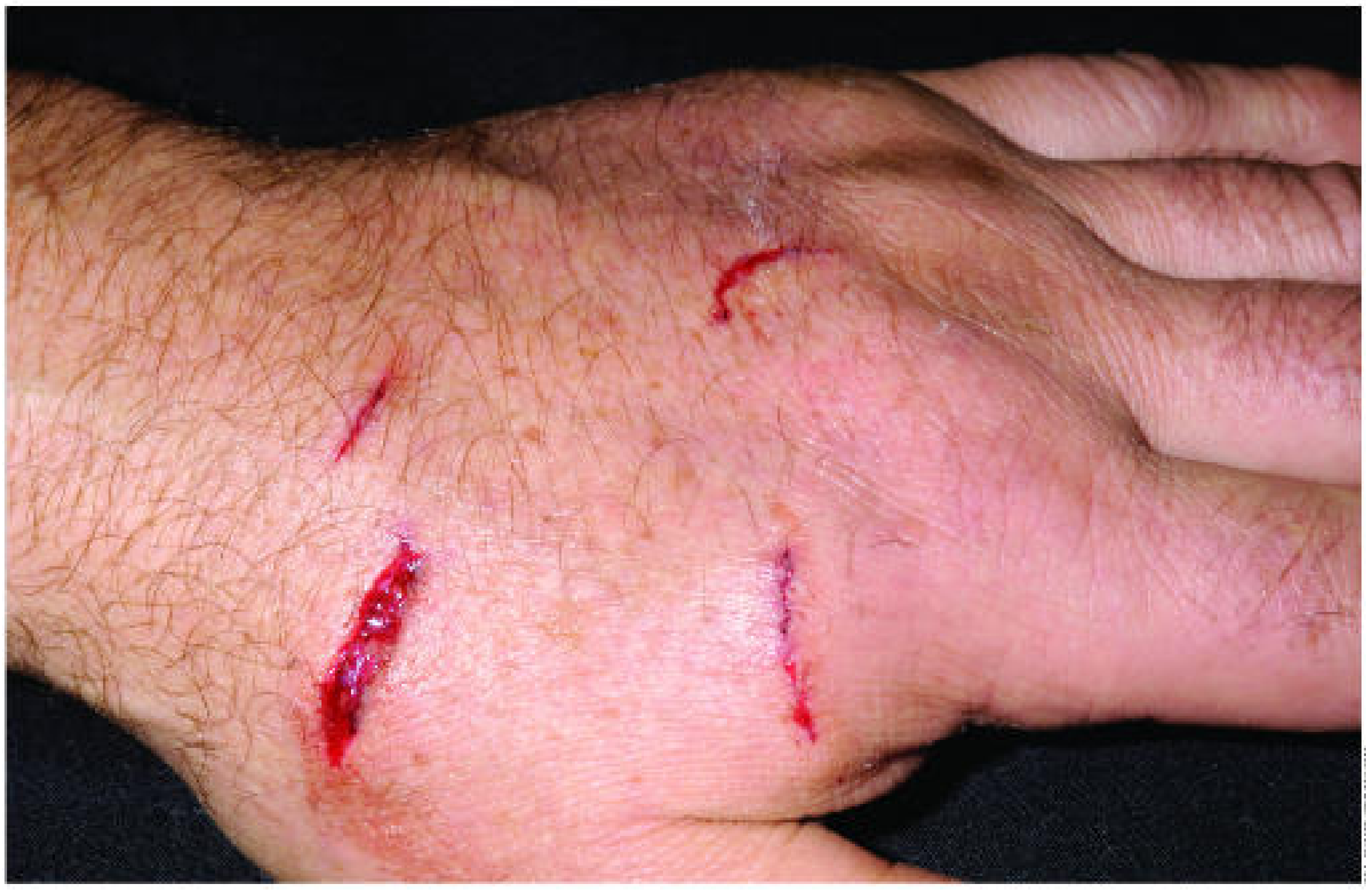
- Ask what brought on the symptoms, and if they came on suddenly – had the patient been in a stressful situation which may have brought on hyperventilation?
- Ask about chest pain – patients with hyperventilation may report that their chest feels tight, but not usually painful.
- Check for haemoptysis and cyanosis.
- Do a chest examination and pulse oximetry.
- If there is sudden chest pain, haemoptysis, abnormal chest examination or low oxygen saturation, the patient should be referred into hospital.

Dr Ivan Benett is a cardiology GPSI in Manchester

References

1 NICE. *When to suspect child maltreatment*. 2009;CG89
2 RCGP. Safeguarding children and young people: a toolkit for general practice. 2011. tinyurl.com/8ackqdm (accessed 6 September 2012)
3 GMC. *Protecting children and young people – the responsibilities of doctors*. July 2012. gmc-uk.org/static/documents/content/Child_protection_-_English_0712.pdf (accessed 6 September 2012)

Emergency medicine consultant **Dr Clifford Mann** advises on common emergencies in primary care



Dog bite wounds – prompt irrigation is important

Potential pitfalls in emergency cases

This article offers some advice on how to manage four of the most common emergencies you may be faced with in primary care.

Intraocular foreign bodies

Intraocular foreign bodies can present in a remarkably benign manner. The patient will usually recount a specific incident associated with the onset of pain in the eye, but the pain may have diminished and the patient may minimise the injuring event. So the initial impression of the eye may not alert you to the seriousness of the injury.

There are two key actions to take:

- Find out the mechanism of injury. Ask the patient if they have been doing high-risk activities that may have resulted in an intraocular foreign body. For example, chiselling or hammering – especially metal on stone, metal on metal or similar – where fragments may strike the eye. Goggles do afford good protection, but patients often wear them incorrectly or not at all.
- Record the visual acuity using a Snellen chart or similar tool. Any significant difference in the visual acuity that didn't exist before should prompt referral for an X-ray and further assessment.

Intraocular foreign bodies have a guarded prognosis, even with prompt treatment. It is not sufficient to assume that flourescein staining will highlight the injury. History and examination will often exclude foreign body, without the need for an X-ray. But if you do suspect an intraocular foreign body, particularly glass or metal, it is prudent to refer to A&E for an X-ray.

Human or animal bites

Both human and animal bites are common and may be associated with secondary infection. Animal bites are generally no more dangerous than human bites.

The most important aspect of care is prompt wound irrigation, and tap water is fine for this purpose. There is no evidence that closure of these wounds requires sterile gloves. You need to assess the site, size and depth of the bite, and any comorbidities. In an animal bite, it may also be important to try to find out the species.

Site

Any bite on the face is obviously of key cosmetic importance – and relatively small bites may lead to unsightly scars if not managed carefully. Wounds requiring closure should be managed by clinicians experienced in the relevant techniques.

Size and depth

The size of the bite is important because traditional teaching advises that wounds from bites should not undergo primary closure. But while this is true of hand lacerations, there is good evidence that wounds elsewhere on the body may be safely treated by primary closure after thorough cleaning.[1] There is some evidence that prophylactic antibiotics are of benefit.[2] In some patient groups they reduce the risk of infection by 50%. Bites deeper than the epidermal layer and bites to the hands, feet and skin overlying joints or cartilaginous structures are high risk, though they don't necessarily require A&E referral. Closure of the wound can be attempted in primary care if you are confident to do so.

Comorbidities

Patients with peripheral vascular disease, or diabetes, or those who are taking steroids or other immunosupressants are at particular risk of wound infection. In these patients antibiotics are often prescribed by the GP. Co-amoxiclav 375mg tds is the usual antibiotic, and dose, of choice.

Species

Human bites are just as prone to infection as animal bites.[3] Some rarer animal bites, such as squirrels, llamas or seals, require a different antimicrobial spectrum and advice should be sought from a microbiologist. Bites are not particularly tetanus prone and immunoglobulin is only recommended for actual cases of tetanus. Anyone who has had five doses of the vaccine (three as an infant, one pre-school and one as a teenager) is regarded as having lifelong immunity.

Needle-stick injury

When a patient first presents with a needle-stick injury, let the puncture site bleed and then clean it thoroughly with soap and water.

There are two types of needle-stick injury – where the identity of the 'source' person whose blood was in contact with the needle before the unintended inoculation is known, and conversely where their identity is unknown.

If the source can be identified, the best course of action is to request that a further sample of blood is taken from them and tested urgently for blood-borne viruses. The result of this urgent assay will allow specific advice to be given to the exposed patient, and if necessary, treatment.

Post-exposure prophylaxis (PEP) advice is best sought from local microbiology or sexual health services.

If the source patient is already known to have HIV or the risk is very high, then PEP for the patient with the needle-stick injury should be started as soon as possible. If PEP is started within one hour of the needle-stick injury, the transmission risk is reduced by 80%. Sometimes it is sensible to administer the first dose while seeking expert advice or review. Referral to A&E may well take longer than dispensing on FP10 but if the indication is clear but there is a problem obtaining PEP, telephone ahead to A&E to make sure there are no added delays with registration, triage and history taking.

Where the source patient is unknown or if they decline consent for a blood sample, the epidemiological likelihood of HIV in the source needs to be considered. In areas of low HIV prevalence, PEP will usually not be appropriate. Hepatitis B immunoglobulin should be given within 72 hours if the source is known to be hepatitis B positive or if their status is unknown and the exposed person has negative serology.

All patients with needle-stick injuries should have blood taken for serology and LFTs, and urine for ß-human chorionic gonadotropin (in women, to check for pregnancy, as PEP is likely to be teratogenic). These tests should be repeated at three and six months.

Burns

The key determinants of outcomes for a burn are site, size and depth. It is important to appreciate that – in terms of the consequences of a burn – simple erythema can be ignored because healing will occur without complication. Burn sizes are often overestimated because simple erythema is included in the assessment.

A useful guide to assessing burn size is to compare the area of the burn with the palm of the patient's hand. The patient's palm roughly equates to 1% of their body surface area. Burns that are greater than 5% of the body surface area should be referred for specialist assessment. Prophylactic antibiotics are not indicated because they increase rates of infection with resistant organisms.

Full thickness burns appear black or pale and are insensate. All full thickness burns – however small – should be referred for specialist assessment. For small burns – less than 1% of the body surface area – referral can be delayed for 24 hours. For larger burns, same-day referral is recommended.

Chemical burns are often mistakenly thought to be less serious than thermal burns. But alkalis in particular are very caustic. The classic presentation of a chemical burn is a circumferential burn above the level of the boot in someone working with cement. The GP management should be identical to that described above for thermal burns, with the exception that initial irrigation is aimed at decontamination rather than cooling.

Dr Clifford Mann is a consultant in emergency medicine at Musgrove Park Hospital, Somerset, and registrar of the College of Emergency Medicine

The College of Emergency Medicine was founded by Royal Charter in 2007 and exists to improve emergency care and to provide advice on relevant policy decisions. It works closely with other royal colleges and the Department of Health to ensure patients with acute illness or injury can gain prompt access to appropriate services. The College hosts educational meetings, and publishes the *EMJ* and online learning resources that are relevant to all practitioners dealing with acute illness or injury. Membership of the College is open to all registered medical practitioners.

References

1 Maimaris C and Quinton D. Dog-bite lacerations: a controlled trial of primary wound closure. *Arch Emerg Med* 1988;5:156-61
2 Cummings P. Antibiotics to prevent infection in patients with dog-bite wounds: a meta-analysis of randomized trials. *Ann Emerg Med* 1994;23:535-40
3 Broder J, Jerrard D, Olshaker J and Witting M. Low-risk infection in selected human bites treated without antibiotics. *Am J Emerg Med* 2004;22:10-13

Drugs for the doctor's bag

Dr Phil Brown, GPSI in emergency and unscheduled care, on what to keep in your doctor's bag

When you have to deal with a very sick patient – either at the surgery or in their home – having the right medication to hand may make the difference between life and death.

All surgeries should have a defibrillator and both clinical and reception staff should know how to use it and have regular retraining. All surgeries should also have access to oxygen capable of supplying greater than 85% inspired oxygen to the patient, and ideally a portable set that can be taken out – with the defibrillator – on a home visit.

Below are the drugs I consider a GP should have available. It may be impractical for all GPs in your practice to hold all of these in their bag, but having an 'on-call' bag available – with the oxygen, the defibrillator and pocket mask – means you will never be left wanting in an emergency.

Adrenaline (1:1000, 1mg/ml) can be used IM for anaphylaxis. Patients rarely die from being given IM adrenaline, but they may die because it is given too late.

Dose

Adult 500µg (0.5 ml) repeated every five minutes as necessary.

Child
- 12 to 18 years – as per adult, unless the child is very small, then as per six to 12 years
- Six to 12 years – 300µg (0.3ml) repeated every five minutes as necessary
- Under six years – 150µg (0.15ml) repeated every five minutes as necessary.

Chlorpheniramine (10mg/ml) can be used IV for anaphylaxis – given once only.

Dose

Adult 10mg

Child
- Over 12 years – 10mg
- Six to 12 years – 5mg
- Six months to six years – 2.5mg
- Under six months – 250µg/kg.

Hydrocortisone (as sodium succinate) 100mg/ml can be used IV for anaphylaxis or acute asthma – given once only.

If you don't have IV access, you can give oral prednisolone at a dose of 2mg/kg.

Dose

Adult 200mg

Child 4mg/kg.

Aspirin (dispersible) 75mg can be used orally for acute MI or unstable angina (acute coronary syndrome), unless there is a real allergy to aspirin.

Dose

Adult 300mg (dispersed or chewed).

Glyceryl trinitrate spray 400µg/metered dose can be used sublingually for unstable angina, acute coronary syndrome and acute MI.

Dose

Adult One to two metered doses, repeat as required.

Atropine sulphate 600µg/ml ampoule can be used for symptomatic bradycardia – usually less than 40 beats per minute with a low blood pressure. Note that atropine is no longer used for cardiac arrest.

Dose

Adult 500µg, repeated if required after five minutes up to a maximum of 3g.

Diamorphine 5mg amp – powder for reconstitution – can be used IV for acute MI or acute severe pain. Give this with metoclopramide 10mg IV to reduce nausea and vomiting.

Dose

Adult 5mg followed by 2.5mg doses as required, but halve the dose for the frail or elderly.

Salbutamol nebuliser solution 1mg/ml or 2mg/ml can be used for acute exacerbation of asthma or COPD. You should also give IV hydrocortisone as above – see anaphylaxis.

Dose

Adult 5mg as required, but repeated nebulisation requires admission.

Child
- Five to 12 years – 2.5-5mg
- Under five years – 2.5mg.

Salbutamol aerosol inhalation at a dose of 100µg/inhalation via a large volume spacer with or without a mask works just as well, using two to 10 puffs inhaled separately.

Ipratropium nebuliser solution 250µg/ml can be added if a patient with acute asthma or COPD exacerbation is not improving with salbutamol as above. All nebulisers should be driven by oxygen, not room air, unless oxygen is unavailable.

Dose

Adult/child Over 12 years – 500µg

Child Under 12 years – 250µg.

Midazolam 10mg/ml is my preferred drug for convulsions, including febrile convulsions. It can be given intranasally, using a mucosal atomisation device. Rectal diazepam is an option if you prefer it.

Dose

Adult 10mg

Child
- Over 10 years – 10mg, as per adult
- Five to 10 years – 7.5mg
- One to five years – 5mg
- Six to 12 months – 2.5mg
- One to six months – 300µg/kg.

Dexamethasone oral solution 2mg/5ml can be given orally for croup as a single dose.

Dose

Child 150µg/kg.

Benzylpenicillin 600mg, or 1.2g for reconstitution, should be given straight away if you have any suspicion of meningococcal disease – IM if you cannot obtain IV access. Do not wait for admission or for blood cultures to be taken.

Dose

Adult 1.2g

Child
- 10 to 18 years: – as per adult
- One to nine years – 600µg
- Birth to one year – 300µg.

If the patient has a true allergy to penicillin, you could consider giving chloramphenicol injection, 1g amp, 12.5-25mg/kg.

Glucagon 1mg/ml is needed for patients with diabetic hypoglycaemia and can be given SC, IM or IV. Dose is by weight.

Dose

Under 25kg 500µg

Over 25kg 1mg.

If the patient has a swallow reflex and is conscious, give glucose gel or a drink containing glucose rather than the glucagon injection.

Diclofenac suppositories 100mg can be used for renal colic or severe musculoskeletal pain. A single dose per rectum is much better than the IM injection as it avoids the possibility of sterile abscess formation.

Dose

Adult Single 100mg dose per rectum.

Hyoscine butylbromide 20mg/ml amp can be used for gastrointestinal or genitourinary smooth muscle spasm.

Dose

Adult 20mg IM.

Furosemide 10mg/ml 5ml amp can be used for acute breathlessness due to acute left ventricular failure. Also consider using glyceryl trinitrate spray and morphine to reduce cardiac pre-load and after-load. But keep an eye on the patient's blood pressure.

Dose

Adult 50mg stat dose IV.

Prochlorperazine 12.5mg/ml amp can be used for acute vertigo, nausea and vomiting.

Dose

Adult 12.5mg stat deep IM injection.

You could also consider buccal prochlorperazine tablets 3mg, which are particularly good for nausea and vomiting associated with migraine.

Lorazepam 1mg tab can be used for acute agitation – oral medication is the preferred option where the patient will accept it.

Dose

Adult 1-2mg orally.

If the patient is agitated or violent and won't accept oral medication, use lorazepam 4mg/ml 1ml ampoule at a dose of 1-2mg IM. The onset of action is 30-45 minutes, with the peak effect after one to three hours. Always consider your personal safety in these cases. Note the maximum dose of lorazepam in a 24-hour period is 4mg.

In addition to these drugs, you will need some ampoules of water for injection and normal saline for reconstitution or flushing post-IV drugs.

It's also a good idea to have some reference material, including the BNF (adult and paediatric), peak flow charts, a pregnancy wheel and a copy of the *Oxford Handbook of General Practice*.

I would also suggest an aide-memoire of emergency drug doses. You will need something to write a referral letter on, and a pen.

Unless you are trained and regularly get a chance to practise, I would avoid getting involved with advanced airway management.

I wouldn't advise carrying endotracheal tubes – stick with the pocket mask and oropharyngeal or nasopharyngeal airways.

Emergencies don't occur often in general practice, but when they do it can be very stressful for all involved.

It is important to remain up to date with basic life support, basic airway management and the use of a defibrillator.

I would also suggest an annual update of your emergency skills – it will be time well spent.

Dr Phil Brown is a GPSI in emergency and unscheduled care and associate specialist in emergency medicine in Tiptree, Essex

OTHER ESSENTIALS

Other equipment kept in your practice's 'on-call' bag will be largely dependent on the skill mix in the practice and how far your patients are from definitive care. As a minimum I would suggest:

- **stethoscope**
- **manual sphygmomanometer**
- **pulse oximeter**
- **glucose meter with test strips and needles**
- **thermometer**
- **urine test strips and specimen bottles**
- **pregnancy tests**
- **a selection of syringes and needles**
- **peak flow meter (adult and paediatric)**
- **ophthalmoscope/otoscope**
- **tongue depressors**
- **examination gloves**
- **pocket mask and tourniquet.**

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Ten tips for maximising your non-NHS income

Medical accountant **Luke Bennett** advises practices on how to generate a better stream of income from non-NHS services

As the funds available for GMS and PMS work are squeezed ever tighter, practices should ensure they are running non-NHS services as efficiently as possible in order to maximise profits.

The following tips will help you check how your practice is performing when providing services such as the preparation of private medical reports:

1 Agree on who gets what

Decide whether non-NHS income is to be kept by the partner carrying out the work, or pooled as part of partnership income. If it is to be treated as personal income, how is the partnership compensated for the use of practice resources (space, staff time, postage and stationery)? Perhaps 10% of the fee should be retained by the practice to cover these costs.

2 Publish fees clearly

Having set the rates, publish a list of charges in a prominent place in reception so there is no doubt what the charges are. If you are a VAT-registered practice, remember to charge 20% VAT on top of the fee where appropriate. See HMRC Notice 701/57 for more information on when it is appropriate to charge VAT.

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Non-NHS services

Examples of non-NHS services GPs can charge for include:

- **Work linked to adoption and fostering, such as paternity tests (£37.90)**
- **Filling in certificates or extracts from records, such as character references (negotiable)**
- **Court and legal work, such as attending events as an expert witness (£65 to £82.25, depending on the location)**
- **Providing certificates for drivers, such as Series II proforma (£39)**
- **Providing childminder health forms (£87.50)**
- **Filling in insurance forms, such as reports for insurance applicants (£100)**

All fees are based on BMA-suggested figures

▶ A full and up-to-date list of non-NHS fees is available on PulseToday. Go to http://tinyurl.com/c8us3mu

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3 Update your fees each year
Review your charges on an annual basis. It is usually easier to increase the rates by a small percentage each year than to impose a large increase less frequently. Use the annual review to remind the doctors of the rates and to ensure charges are being applied consistently.

4 Don't leave doctors to chase payment
As far as possible, remove the need to ask for payment in the consulting room. Patients should know how much they are going to be charged for a report before they attend, and the reception staff should deal with the collection of the fee. If it is left to the GPs, some may be reluctant to charge patients. Consequently the follow-up of debts will be haphazard and there will be inconsistency between partners.

5 Charge a fair fee for reports
Set realistic rates for the preparation of reports. If it is going to take 30 minutes to see the patient and complete the report, think how much you would have to pay a locum for 30 minutes' work and then charge accordingly. Remember to add on an allowance for administrative time and resources.

6 Swap letters for forms
Make sure patients bring the relevant form to be completed to prevent wasting time chasing up for this afterwards. If a patient asks the practice to write to a third party such as a travel insurance company or solicitor, do not agree to this. There is always a form to be completed which will clarify exactly what the report should cover, and which will help the doctor to avoid the danger of disclosing too much, or irrelevant information.

7 Don't be undercut by insurance companies
Do not feel pressurised by insurance companies to accept a fee if this is inadequate for the work involved. Either decline the work or agree in advance a more realistic fee. Trying to agree an increased fee after the event is a fruitless exercise, so you need to assess the time likely to be involved at the outset.

The provision of electronic notes may seem straightforward, but it still takes time to ensure they are up to date and that any confidential information is edited out.

8 Charge for private prescriptions
Non-dispensing practices will need to make a charge for private prescriptions, although dispensing practices may decide to offer this free of charge if they can make a profit on the drugs supplied.

If it will take 30 minutes to see the patient and write the report, charge for it

9 Use the skills you already have
Make use of partner specialties since these can generate useful income as well as ensuring professionally rewarding work. If you have an occupational health specialist, can you establish a relationship with local larger employers to provide occupational health services?

10 Say no to (some) private work
Do not automatically carry out all private work. For example, countersignature of passport application forms may not be work worth doing. It is difficult to charge an appropriate rate since no specialist medical knowledge is required. The forms are often bounced for minor infringements such as signatures not being kept within the pre-printed box, and the disclosure of the GP's own passport number on the form may create a risk of identity fraud.

Finally, as with any additional source of income, consider whether what you keep after tax is worth the time and effort. If your total taxable income is between £100,000 and £116,210, your personal allowance will be reduced by £1 for each additional £2 you earn, which means you retain only 38% of what you earn after income tax and national insurance have been deducted.

Luke Bennett is a partner at Francis Clark LLP, a member of the Association of Independent Specialist Medical Accountants (AISMA)

More online Four ways to cut your tax bill

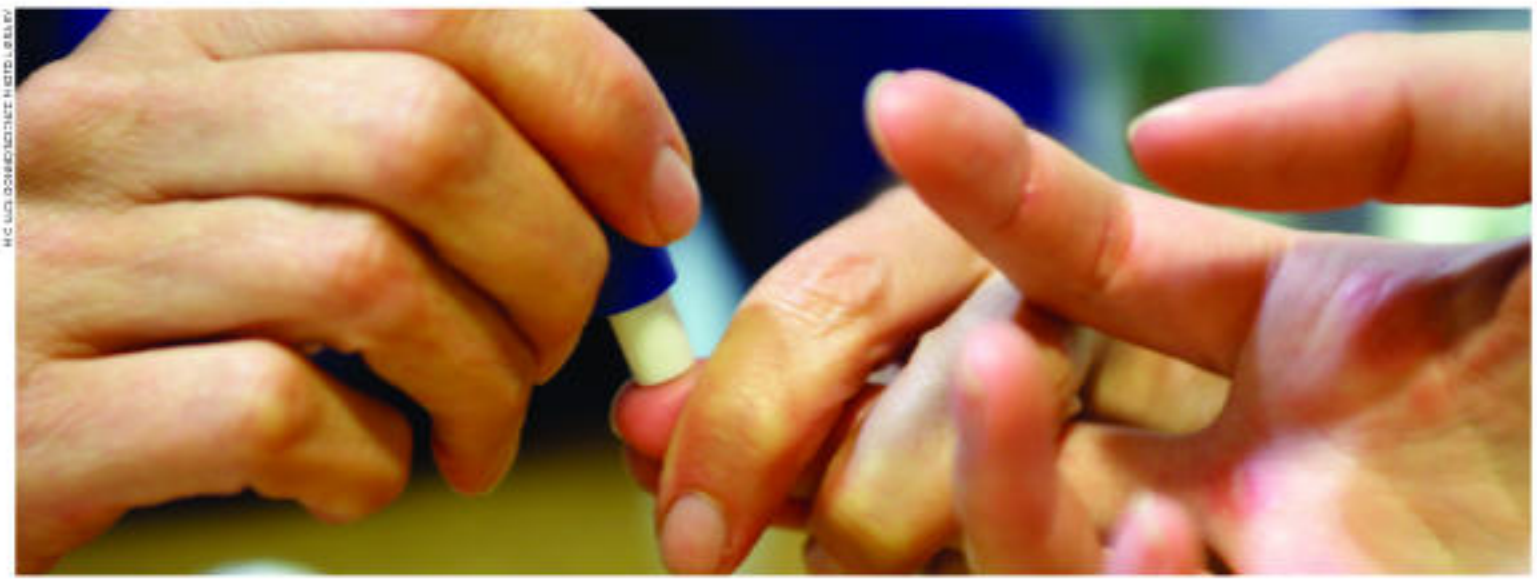
AISMA accountant Nick Holmes offers advice to GPs who regularly pay too much tax

GPs are working longer and harder than ever before, but for less income. Tax allowances have been cut and tax and superannuation rates have increased. Without careful management your take-home pay could be on a downward spiral.

Whether improving your record keeping, changing your business structure or just asking your spouse to drive you to appointments, some simple changes can make a big difference to your tax position. Most GPs could save at least £1,200 tax each year, which can only make things better during a time when everyone is feeling the pinch.

Four common ways that GPs lose out are:
- **Underclaiming expenses**
- **Losing tax relief on pensions contributions**
- **Paying 60% tax instead of 40%**
- **Overpaying national insurance contributions.**

Go online to pulsetoday.co.uk/practice-business to find out how much each pitfall can cost, and read the full article.



Five steps to commissioning with a pharmaceutical company

Dr Neil Fraser offers a simple guide to setting up a partnership to improve services without compromising on independence

In recent years we have worked with a number of pharmaceutical companies to deliver services to the people of south Nottinghamshire. Such projects included commissioning specialist nurses in diabetes and COPD and procuring software to aid case-finding heart failure patients. Such relationships have allowed us to find additional funding at a time when finances have been very tight in our health community.

The relationship between our CCG and pharma companies has been very successful and productive. They have provided financial support, expertise in project management and the evidence base for a number of projects on long-term conditions.[1]

Our interests are often aligned. Identification of undiagnosed patients and optimising care reduces morbidity and mortality for patients, cuts unplanned hospital admissions and cost to the NHS, and may increase the appropriate prescription of medicines in line with best practice. We have been able to commission quality services for patients that may not have been possible without the involvement of the pharmaceutical industry.

When discussing partnership working with pharma, the initial response of many GPs is quiet cynicism – 'what are they trying to sell?' However, the Association of the British Pharmaceutical Industry code of practice strictly governs the way pharma can interact with patients and health professionals. The use of such projects to promote specific products is strictly prohibited.[2]

Below I have broken down the process into five steps based on our own experience, with tips for best practice in each one.

Step 1 Find common ground and propose a project

Such opportunities can arise from casual conversations at meetings or more formal approaches. Pharma companies who are releasing a new product may have a budget to work with commissioning organisations, but, as is often the case, ideas often come about by chance or by building on existing relationships.

Our CCG started working with AstraZeneca on a project to case-find patients with heart failure three or four years ago. This was initially very successful, but the company's priorities changed and it withdrew after the pilot phase.

We were approached by Takeda some time later about the same clinical area.

Initial planning usually takes two or three meetings with clinicians, patient representatives, NHS managers and pharma representatives.

The importance of having meetings with people who can make decisions on funding and budgets cannot be underestimated, otherwise things move very slowly. Likewise clinician engagement is vital, to provide both appropriate direction and legitimacy when communicating with GPs and nurses at a later stage.

We have found this step relatively easy in most cases. Most ideas centre on implementing well-established evidence-based interventions.

Examples include case-management of high-risk COPD patients by community-based COPD nurses, and optimising pharmacological management and self-care for patients with heart failure.

Step 2 Put together a business plan

At this stage, having a good CCG manager is really important. Awareness of governance, finance, employment and contracts is obviously vital, and certainly not one of my strengths as a clinician. Clinical input is still needed to help define the desired outcomes.

Our heart failure case-finding project involved software analysis of GP computer systems to identify patients with heart failure, who were then contacted by the practice and offered referral to a clinic run by the specialist nurse.

At this and subsequent appointments they were educated on the condition, and their medicines management was optimised. The detail of each step of this pathway, including likely numbers of patients, the individuals responsible and timings, was specified at an early stage. Patients attending the clinic had each intervention recorded using a template, which enabled analysis at a later stage.

Our management team worked closely with the pharma representative to produce a business plan containing detail that satisfied both the objectives of the CCG and the pharmaceutical company. The pharmaceutical company's involvement was really limited to providing financial support and impetus, thus enabling service redesign and pathway development, rather than in any way influencing clinical decisions or care.

Step 3 Run a pilot

The idea here is to check your project works, to log any problems and to provide as frank and objective an assessment as possible. The last point is key, as it's tempting to run the pilot in the GP lead's practice alone. This can bias impartial assessment, as that practice will have an interest in making things go smoothly, and have a much more detailed knowledge of the situation than the average GP. Including at least one other sympathetic but uninformed practice is very useful as it will often reveal issues that would otherwise only become apparent when rolling out the project for a large number of patients.

The financial advantages to practices of more complex pathway redesign can be harder to identify, but in the end if patients are getting more clinical input, and their ability to self-manage is increased, everyone benefits.

The integrated COPD project we initiated when still a PBC cluster is such an example.[3] Patients were given comprehensive COPD management along a pathway that included diagnosis through to case management by a pharma-sponsored specialist nurse. The clinical contact required with GPs was reduced, and the specialist nurses add Read codes marking any interventions such as pulmonary rehabilitation to the GP clinical record, thus scoring QOF points for the practice.

Step 4 Analyse the pilot and roll out across the CCG

It is more likely you will be able to iron out any problems identified in the pilot than produce an idea of outcomes at this stage. Information on initial numbers and activity data will be available, which can be used to provide proof of concept.

Reconvening the original project group to go through the data is obviously an important step. The pharma company representatives will want to make sure things are on track, and will be reporting back to their senior management team.

The CCG managerial, patient and clinical engagement achieved earlier on now comes into its own as communication with the wider healthcare community becomes paramount.

We outline the nature of our involvement with the pharmaceutical industry at this stage. We have never had any negative feedback or comments from clinical or managerial professionals or patients. The clinical reasons and evidence base for the projects we have and are running has always been strong. These changes are about implementing well-established care rather than new or controversial therapies.

When commissioning an external organisation to provide services to patients and practices, you relinquish a degree of control while retaining most of the responsibility for any changes taking place. We have found this to be particularly relevant around IT.

Practices are rightly very protective of data on behalf of their patients. The importance of water-tight governance arrangements should not be underestimated, and your job as a commissioner is to ensure these are followed. A swift and firm response is required should there be any problems, especially if confidential patient information is involved.

Any problems with your project must be reported to the pharma company as well as practices and patients as they can be strict with deadlines and budgets.

Step 5 Decide on whether to recommission the service

The decision on whether to recommission is normally governed by a number of factors including outcomes, both financial and clinical, value for money, patient and practice feedback and the financial position of the CCG.

Obviously this is true for all services, not just those commissioned with pharma. In my experience, however, such projects are much more closely scrutinised and so the information on which you base the decision is often of higher quality.

Dr Neil Fraser is head of long-term conditions at NHS Rushcliffe CCG and a GP in East Leake, Nottinghamshire

References

1 The Department of Health. *Long Term Conditions Compendium of Information* (3rd edition). 2012. tinyurl.com/3979b4x
2 The Association of the British Pharmaceutical Industry *Code of Practice for the Pharmaceutical Industry* (2nd edition). 2012. tinyurl.com/8mdjtab
3 NHS Clinical Commissioners. *Clinical Commissioning in Action*. 2012. tinyurl.com/cteooff

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

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

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

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

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

FULL – TIME SALARIED G.P.

with a view to partnership

Croston, Lancashire

Starting Date: 1st January 2013

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

EMIS LV system - High QOF achiever

The existing partners are contemplating retirement.

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

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

SALARIED GP with a view to PARTNERSHIP

5 - 6 SESSIONS PER WEEK

SOUTHWATER/HORSHAM, WEST SUSSEX

An opportunity has arisen in this modern, forward thinking GMS practice.

We currently have 3 Partners, 7500 patients, superb modern premises and high QOF achievement. Our location is in a pleasant, semi-rural area, adjacent to the market town of Horsham.

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

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

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

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

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

The Castle Hedingham Surgery

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

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

Please apply in writing with a CV to

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

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

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 and covering letter to;
Miss A Norfolk or Mrs Frances Rance,
Amwell Street Surgery,
19 Amwell Street, Hoddesdon, Herts, EN11 8TS
or email: amwell.surgery@nhs.net

DOCTORS/GPS REQUIRED

Downlands Medical Centre, Polegate, East Sussex

Full-time Partner wanted from 1st May 2013.

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

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

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

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

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

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

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

Newark Road Surgery, Lincoln, Lincolnshire, LN6 8RT

University and Cathedral city with excellent local schools

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

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

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

NEWPORT, SOUTH WALES

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

Doctors required UK-Wide for Insurance medicals.

dc life

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

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

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

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

HARLEY STREET DOCTORS LTD.

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

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

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

Salaried GP
Blessing Medical Centre
London W9

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

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

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

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

Closing Date: 5th October Interviews 15th October

NHS Partners4Health

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

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

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

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

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

Closing date for applications 28 September 2012

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

Ballards Walk Surgery Basildon, Essex.

Salaried GP required.

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

List size 7100
High QOF Achiever
System One User - Paper light
Purpose built premises

Salary negotiable depending on experience.
6 weeks holiday and one week study leave.

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

Stratford Village Surgery, London E15

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

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

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

GP PARTNERSHIP VACANCY

Claygate, Surrey

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

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

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

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

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

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

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

For further information contact
Sharon Thompson on 0191 4897183

Salary negotiable depending on experience.

Closing date: 28th September 2012

SALARIED GP

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

Dr. Bevan and Partners, Spinney Brook Medical Centre
Northamptonshire

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

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

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

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

Tel: 01933 650595 – Email: alison.fenncoles@gp-k81028.nhs.uk

LOCUM AGENCIES

PREMISES

COURSES/CONFERENCES

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

EDITOR'S CHOICE

A 'thank you' goes a long way

Having been in my new ST3 practice for nearly six weeks, I have had some unexpected encounters with patients – the occasional 'thank you' and, more surprisingly, a 'thank you' with a handshake, even from teenagers.

I hope this is a sign that I have managed a patient well. My preparations for the CSA next year have highlighted the need for a patient-centred approach and the need to develop a shared care plan to make patients feel part of the decision-making process.

So it is disappointing that a GMC report earlier this month revealed the number of complaints about GPs has gone up 23% in a year. Reasons for these complaints include inadequate management plans, poor communication and frustration that patients can't see their own doctor.

I suspect it is because I am an ST3, with longer consultation times and a lower workload, that I have a greater opportunity to address ideas, concerns and expectations. I wonder how many of the complaints were against GP trainees?

Dr Avradeep Chakrabarti: longer slots mean happy patients

The GP landscape will change markedly in the next few years, what with commissioning, retirements and an increased female workforce.

It will be interesting to see whether complaints continue to increase...

Dr Avradeep Chakrabarti is a GP registrar in Swindon

MORE ONLINE
Read more from Dr Chakrabarti and the other 'GPs to be' at pulsetoday.co.uk/gpstobe

VACCINE CHARTS

Stay up to date with the latest travel vaccination and malaria prophylaxis advice using Pulse's indispensable vaccination charts.

▶ pulsetoday.co.uk/vaccination-charts

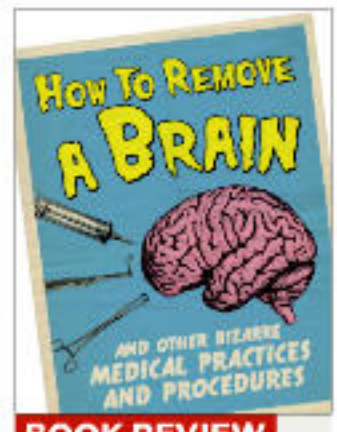
WHAT YOU'VE BEEN SAYING

▶ pulsetoday.co.uk/forum

> **If GPs are to know the costs of everything we do via the CCGs, then patients should do too**
>
> .... on charging patients who DNA

> **MPs, whether they be blue or red, need some shock treatment**
>
> .... on leaked emails revealing pressure within the BMA for a GP commissioning boycott

> **The 360-degree element is the most irritatingly useless aspect of the whole revalidation fiasco**
>
> ... on GPs having to pay for assessment of colleague questionnaires



BOOK REVIEW

Brains, strains and yarns

Our reviewer says: 'Just to be clear: this is not a textbook that actually instructs medics on how to carry out lobotomies. It is a collection of tales about unusual medical practices and historical accounts – what Baron Dupuytren removed from corpses and whether the tongue is the strongest muscle. A GP Christmas stocking must.'

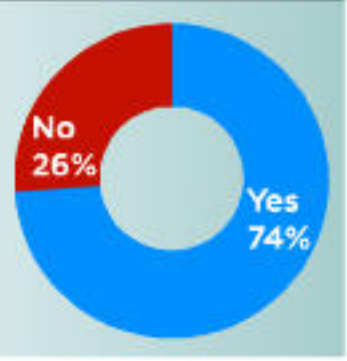
MORE ONLINE
Read the full review at: pulsetoday.co.uk/book-reviews

THIS WEEK'S POLL

Should revalidation begin in December?

Vote at ▶ pulsetoday.co.uk/polls

Last week's poll
Should the BMA boycott commissioning?



Turn inside for this week's shot of the world according to Copperfield ▶ page 18