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BriefingMedia

At the heart of general practice since 1960

GPs brace for another cut in take-home pay

DH rejects BMA plea for a change in uplift formula used to allow for practice expenses

EXCLUSIVE
By Jaimie Kaffash

Dr Sella Shanmugadasan: another squeeze on practice funding will affect services that GPs provide

GPs have been warned they face yet another cut in take-home pay next year, after the Department of Health rejected a plea from the BMA for a change in the way practice expenses are taken into account.

In its official submission to the Doctors' and Dentists' Remuneration Body for 2013/14, the BMA argued rising practice expenses and new costs around CQC registration and revalidation meant the pay review body should urgently rewrite the current 'uplift formula' it uses to calculate a recommended gross increase in funding.

A spokesperson for the DDRB said that it had not yet decided whether it would make recommendations on GP pay or which uplift formula it would apply.

But the DH, which has already instructed the DDRB not to make new recommendations on pay, said it was determined to calculate the gross uplift required to deliver a 1% net income increase using the current formula – a move GP leaders predicted would mean another pay cut.

In its DDRB submission, the BMA asked for the full pay review process to be reinstated, and claimed if the current uplift formula was applied, even an intended 1% net income increase could actually result in a net decrease in GP take-home pay.

'The formula used by the DDRB for calculating GP pay uplifts needs revising in light of evidence that gross and net GP earnings have failed to keep pace with inflation and rising staff costs,' the BMA said.

'Average GP net income has consistently failed to reach the review body recommendation or indeed the Government's proposed caps.'

The BMA cited new costs such as CQC registration – likely to be between £550 and £850 for most practices in the first year – as a factor, and claimed 'the share of premises in total expenses has continued to rise faster than general inflation'.

It also warned that increases in staff expenses have 'consistently outstripped the Agenda for Change-based coefficient in the formula'.

But the DH said it had no plans to look again at the formula.

A spokesperson said that the DH's position remained that outlined in a letter from former health secretary Andrew Lansley in July, in which he said there was no need for new DDRB recommendations because the current formula 'provided a well-established basis for calculating the gross uplift needed to deliver a 1% increase in net income after allowing for expenses'.

GPC negotiator Dr Peter Holden said: 'Any award that yields us less than inflation inevitably means a pay cut. A pay freeze is an utter luxury. The Government has conveniently forgotten that we have to pay our expenses. The DH is not playing fair.'

Dr Paul Roblin, chief executive of Berkshire, Buckinghamshire and Oxfordshire LMC, said: 'There will be expenses that haven't been taken into account so it will be a pay cut on top of a pay freeze. We need to have a regular, annual DDRB that reflects the expenses and legitimate income consideration of GPs.'

Dr Sella Shanmugadasan, chair of Tower Hamlets LMC, said that expenses for everything from IT to utilities were increasing sharply, with his surgery's gas and electricity bills up by 9% in the past year.

'We are expected to manage with no increase,' he said. 'If expenses are not taken into account proportionately, income will go down. It will have a big financial impact that will obviously affect services that practices provide.'

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▶ Turn to page 2 to read an accountant's analysis

How pay uplifts have fallen short

Year	Gross GP pay uplift (%)	GP net income change (%)*
2010/11	0.8	-1.51
2009/10	2.29	-0.73
2008/09	2.7	0.38

*BMA estimates, DDRB submission 2013/14

MORE ONLINE
Read the BMA's submission
pulsetoday.co.uk/ddrb2013

BIG Question Are blanket 28-day prescription policies a false economy? ▶ pulsetoday.co.uk

Blanket 28-day script policies 'cost more than they save'

Pharmacy study finds cutting average prescription length costs an extra £150m in dispensing fees annually

By Emma Wilkinson

Policies promoting 28-day prescribing by GPs are likely to be a false economy as they cost at least as much as they are projected to save, pharmacy researchers have suggested.

Their study said the Department of Health-endorsed policy to promote shorter prescribing durations costs at least an additional £150m a year due to increased dispensing fees from pharmacies.

It found the policy had been effective in prompting a 'generalised change in prescribing behaviour', with GPs prescribing five fewer doses per prescription compared with a decade ago.

But the analysis led by Professor David Taylor, professor of pharmaceutical and public health policy at University College London School of Pharmacy, concluded the policies had been applied too 'rigidly' in some areas, and said GPs should be allowed to use their discretion in determining prescription duration.

Published in the journal *Primary Care Research and Development* this month, the study looked at trends in prescribing data from 1998-2009 in England for 11 medicines, including simvastatin, aspirin and ramipril.

The medicines represented a fifth of all prescription items supplied and apart from amoxicillin, which was included as an acute comparator, all the medicines showed a significant drop in doses per prescription. This drop in prescription length meant an extra 35 million items were dispensed during 2009 compared with 1998.

The researchers calculated this would equate to an additional £150m a year in dispensing fees and, when taking into account other costs such as patient/GP time, loss of disease control and so on, the benefits were unlikely to outweigh the expense.

They cited a University of York analysis showing that in England policies to reduce the cost of unused medicines in the NHS were likely to only generate savings of up to £150m at best.

'A cost of £150m, the available evidence suggests, is considerably in excess of any possible savings that a blanket rather than selective use of 28-day prescribing periods is likely to generate,' the researchers concluded.

Dr Bill Beeby, chair of the GPC clinical and prescribing subcommittee and a GP in Middlesbrough, said the study showed rigid 28-day policies were based on flawed figures.

He said: 'The problem is most people do take their medicines and so it is inconvenient, insulting and demotivating to have to get their medicines every 28 days.'

Dr Peter Swinyard, chair of the Family Doctor Association, told Pulse that GPs should be allowed to decide prescribing lengths on a case-by-case basis 'depending on the drug and on the patient'.

He said: 'There are some

'Some PCTs have been extremely heavy handed with practices' Dr Peter Swinyard

Changes in average number of doses per prescription

Drug	1999	2009
Ramipril 5mg	54	39
Amlodipine 5mg	43	37
Atenolol 50mg	46	39
Simvastatin 10mg	43	36
Levothyroxine 50µg	74	43

Source: *Prim Health Care Res Dev* 2012, online 3 October

BMA pledge card plan 'divisive'

By Jaimie Kaffash

A proposal for the BMA to issue patients with pledge cards to block referrals to private providers puts 'political prejudice ahead of patients' interests', the alliance representing independent providers has warned.

The angry rebuttal comes after Pulse revealed BMA Council was considering plans for GPs to record patient preferences on NHS treatment from private providers in their notes as part of its opposition to the NHS reforms.

In contrast, the Department of Health declined to explicitly condemn the plan and said although it wanted to give patients the best treatment available, they were 'free to express a preference'.

The cards would allow patients to stipulate a preference to be treated only by NHS providers whenever possible, and will be considered at this month's GPC meeting.

However, David Worskett, director of the NHS Partners Network, said the organisation was 'disappointed and shocked' that the BMA was considering such a 'divisive' scheme.

He said: 'Will any GP really face up to a patient and say: "You could go to an excellent independent hospital, paid for by the NHS, which is more convenient for you and can give you quicker treatment of the highest quality but I'm afraid you've already ruled that option out by signing your political pledge card"?'

A DH spokesperson said: 'We want patients to get the best treatment free on the NHS, whoever it is provided by. Everyone is of course free to express a preference.'

ANALYSIS

Devil in expenses detail

The BMA is making a strong argument that GP pay must increase as practice expenses have risen – but as always the devil is in the detail.

The BMA argues that over the past four years staffing costs have risen by more than inflation, but there are some flaws with this argument. In the early years, practices were giving pay reviews to staff, but practices are also 'employing additional and higher skilled staff', the report says. Some practices have changed the mix

The study suggested blanket 28-day prescription policies could prove a false economy

areas of the country where PCTs have been extremely heavy handed with practices and have performance-managed them to make sure they only prescribe in 28-day cycles.'

But Dr Agnelo Fernades, assistant clinical chair at Croydon CCG, said guidelines for practices in his area had helped to dramatically reduce the quantity of drugs wasted.

He said: 'In south-west London alone, three metric tonnes of wasted drugs were returned last year from patients who didn't take them.

'Yes, 28-day prescribing creates extra work for GPs because they have to generate the prescriptions, but you have to balance the inconvenience with the fact that patients will be more compliant in taking their medication. I think 28-day prescribing is the right thing to do.'

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QIPP chief set for private sector role

The Department of Health's national leader of the QIPP programme, Jim Easton, has been approached for a senior post at private healthcare provider Care UK.

Mr Easton became one of the most senior figures in the NHS when he was made national director for improvement and efficiency in 2009.

The appointment is subject to approval in line with business appointment rules

NHS Commissioning Board

In 2010 he caused uproar when he backed proposals for GP patient appointments to be handled by national or regional call centres rather than by GP receptionists. The plan was later shelved.

Mr Easton's move is likely to prove controversial as Care UK is one of the most prominent independent providers that is vying for NHS contracts.

An NHS Commissioning Board spokesperson said: 'We can confirm that Jim Easton has been approached about a job opportunity by an organisation in the independent health sector.

'Because this would be an outside appointment, it is subject to approval in line with the business appointment rules for senior Department of Health staff moving to new roles in the independent sector,' the spokesperson said.

A Care UK spokesperson confirmed the company had had inital discussions with Mr Easton.

between partners and salaried GPs – a senior partner retires and the younger GP wants to come in as a salaried GP, which is reflected in the payroll bill.

One cannot be totally confident the average actual staff cost increases are purely for non-doctor staff. There is a chance that this is misleading.

But the BMA contends practices are genuinely facing increased staffing costs, either from cost-of-living rises or more likely from extra work, and needing to employ more staff.

Bob Senior is head of medical services at RSM Tenon

The week in general practice

INSIDE

Dr Sam Everington

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Ministers have offered additional money to the regulatory body for nurses in order to offset a sharp proposed hike in fees
▶ pulsetoday.co.uk/practice

Download of the week
Read the full evidence from the BMA to the Doctors' and Dentists' Remuneration Body
▶ pulsetoday.co.uk/DDRB2013

Video of the week
GPC Wales deputy chair Dr Charlotte Jones is this week's Big Interview
▶ pulsetoday.co.uk/the-big-interview

Key questions: erectile dysfunction
▶ page 28

CCG changes 'may take five years'

Senior commissioning leader acknowledges fears over GP engagement and pleads for patience on reforms

By Sofia Lind

Clinical commissioning groups may take up to five years to successfully engage GPs and bring about meaningful changes to their local health service, one of the country's most senior GP commissioning leaders has warned.

Speaking at the Conservative party conference in Birmingham last week, Dr Johnny Marshall, interim partnership development director of NHS Clinical Commissioners (NHSCC), insisted CCGs' engagement with practices was 'improving' but acknowledged that in some areas it was 'not good'.

He said the NHS Commissioning Board should only partially authorise groups that were unable to demonstrate GP engagement, with the renewal of conditions dependent on better local partnerships with GPs and other healthcare professionals.

Pulse recently revealed that some CCGs have struggled to engage member practices, with initial results of practice surveys showing many GPs feel frozen out of the decision-making of the new boards.

Dr Johnny Marshall: clinical leadership will take time

Dr Marshall, a GP in Wendover, Buckinghamshire and an adviser to the NHS Commissioning Board, said: 'Clinical leadership will successfully shape general practice. How long is that going to take? In some places it is happening already because they have been doing practice-based commissioning for five or six years. If you are looking at the next five years, it is going to take that length of time for the majority of people to develop the necessary relationships and partnerships.'

'You can't just come in and stop people from referring, or challenge people. For many of us who have been involved in practice-based commissioning it has taken that long to really get that embedded as the new culture of the organisation.'

Dr Marshall said the process would be slower in some as CCGs were 'starting from a different position' of little or no clinical engagement.

He said: 'You can't put a timetable [on it] and say you must all have a relationship by 1 April 2013. That is an unrealistic vision. The NHS Commissioning Board recognises that in some areas relationships are developing really well and in other areas they are not. It should be recognised if they do not have these relationships and form part of their conditions [of authorisation]'.

Dr Michael Dixon, interim president of NHSCC, and a GP in Cullompton, Devon, agreed: 'It will take three to four years until we see total visible change in the organisational system. It takes time to turn a tanker around.' 'I think there will be some low hanging fruit with some new commissioners that will be hitting the ground running while for others it will take longer.'

@sofialind_pulsetoday

Melanoma limit 'should be raised'

The sensitivity of melanoma diagnosis in primary care could be improved by raising the threshold for intervention needed under NICE's recommended score, say researchers.

The study – the first to evaluate the score in primary care – showed the accuracy of melanoma diagnosis could be improved by raising the cut-off score for referral under the seven-point checklist from three to four.

The research, presented at the Society for Academic Primary Care's conference in Glasgow last week, showed that revising the cut-off could increase the ability of GPs to reassure patients with benign lesions and correctly refer those with suspicious lesions.

The study examined 1,436 melanoma lesions in 1,182 participants from 15 practices, and calculated scores blinded to whether they were malignant or benign.

They found the seven-point checklist, which takes into account characteristics such as change in size, an irregular border and inflammation, performed moderately well in the identification of clinically significant lesions. But diagnostic accuracy improved when the cut-off score was revised from three to four.

Lead author Dr Fiona Walter, a GP in Royston, Hertfordshire, and clinical lecturer in general practice at the University of Cambridge, said raising the cut-off would improve diagnosis and reduce costs: 'This would result in a diagnostic aid that maintains a very high sensitivity for melanoma while improving the positive predictive value.'

GPs hit out at plan to cut sexual health services

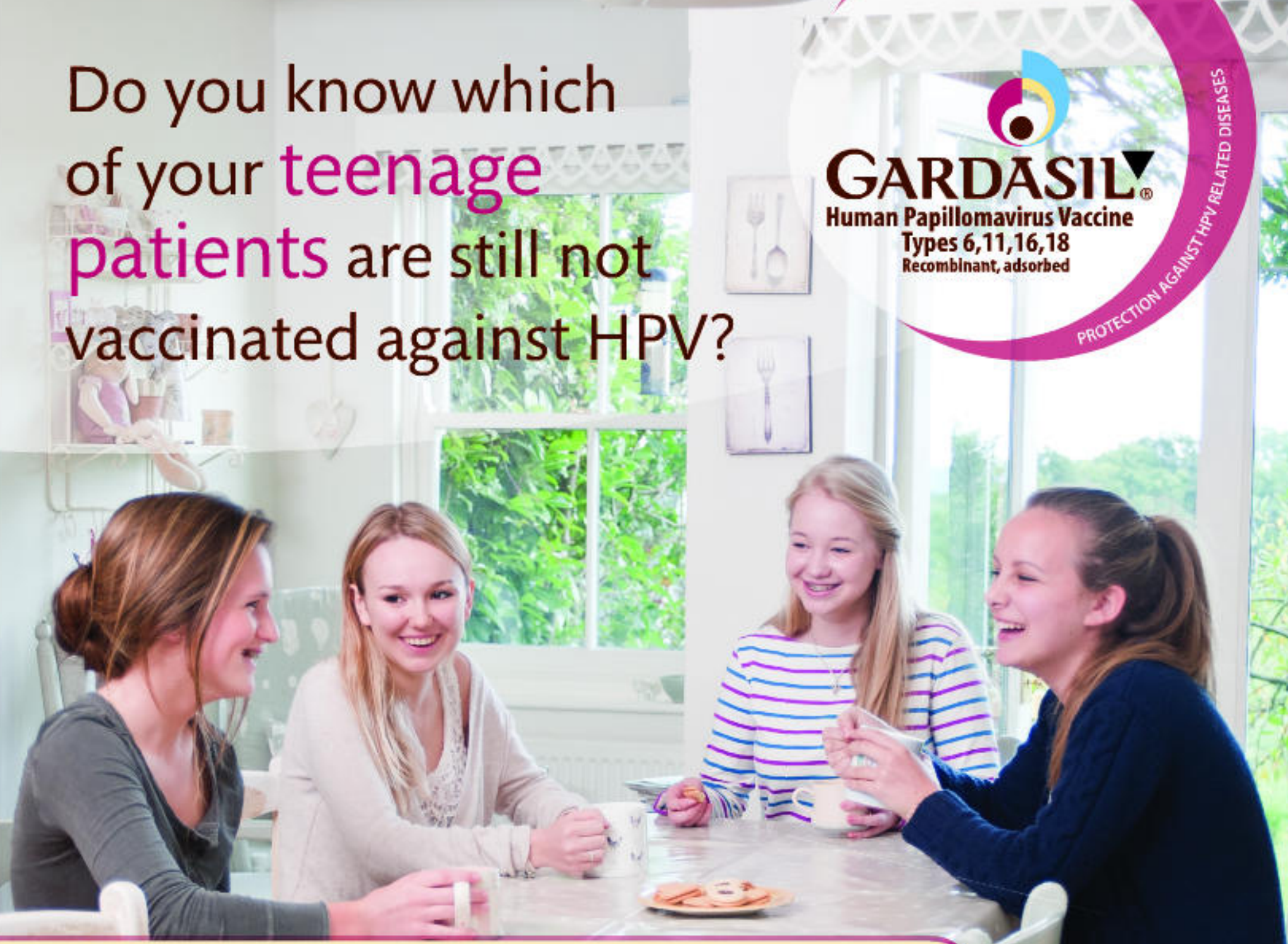
LMC leaders have criticised a PCT's plans to cap practice funding for providing sexual health services to the under-25s, claiming the restrictions are clinically and financially inappropriate.

NHS Manchester plans to limit the number of patients practices will be reimbursed for treating after claiming some exceeded budgets this year.

But Manchester LMC said the services were 'completely appropriate', as practices exceeding budgets were catering for huge student populations, and providing a valuable service. Dr John Hughes, honorary secretary, told Pulse one affected practice, which had been shortlisted for an award for its sexual health service, had a 'one-in-five pick up rate... at least double what [sexual health] clinics are picking up'. He said: 'We are extremely unhappy that they are potentially putting patients at risk, and potentially affecting their own public health targets.'

NHS Manchester said: 'There is a need to review the element relating to under-25s, given the other sexual health services aimed at this age group.'

Do you know which of your teenage patients are still not vaccinated against HPV?



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

PROTECTION AGAINST HPV RELATED DISEASES

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

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

Identify them, then help protect them.

For further information, contact your local Sanofi Pasteur MSD representative or visit www.123againstHPV.co.uk

ABRIDGED PRESCRIBING INFORMATION

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

Refer to Summary of Product Characteristics for full product information.

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

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

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

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UK15592 a 08/12

Guideline update: preventing diabetes
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Practices face 'pedantic' claims over QOF points

PCOs are becoming increasingly inflexible about approving QOF payments, LMCs warn

By Julia Robinson

LMCs are warning practices are facing unprecedented scrutiny on their achievement under QOF and enhanced services, as 'officious' managers battle to balance the books.

GPC leaders have met the NHS Commissioning Board to raise concern over primary care organisations' increasingly inflexible approaches to handling payments, amid concerns that the loss of PCT staff has exacerbated the problem in England.

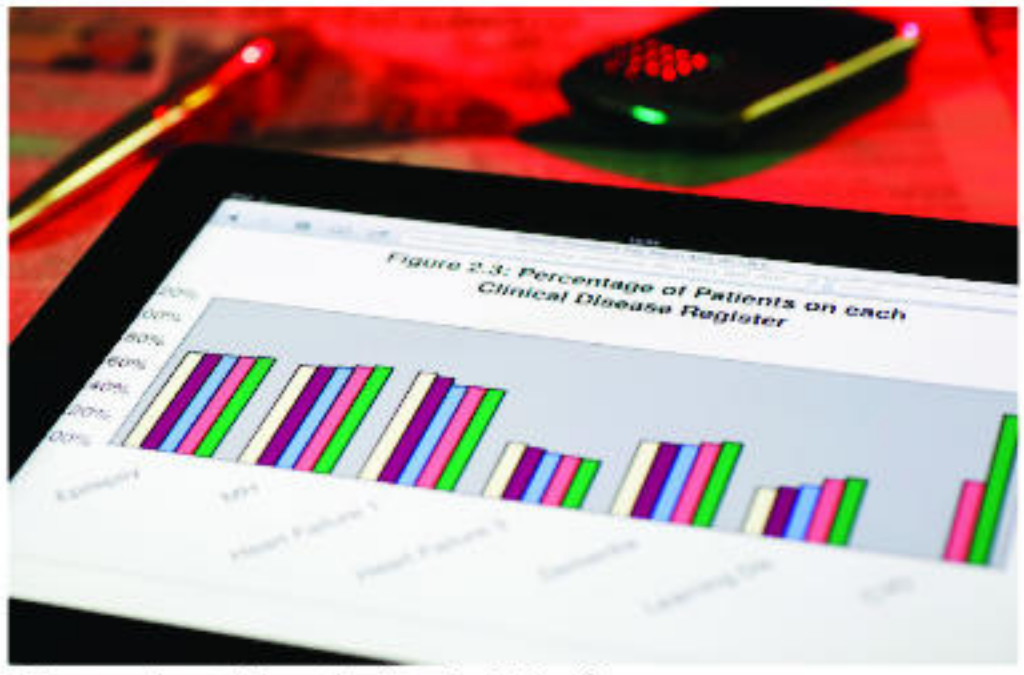
LMCs across the country told Pulse that processes had become noticeably more arduous, with payments for quality and productivity (QP) indicators and the patient participation DES among those causing difficulty.

Cambridgeshire LMC said seven practices had appealed against NHS Peterborough's decision not to award points for QP indicators this year, with three appeals rejected, three awarded some of the points, and just one decision fully upheld.

South Staffordshire LMC said it had also had 'issues' with QP indicators.

Dr John Allingham, medical director of Kent LMC, said the process of QOF appeals in the county was 'stricter and more pedantic than ever before'.

Writing in the LMC newsletter, he advised members: 'If there is a hoop it is better to jump through it rather than try and argue that in going around it the same objective was achieved.'



PCTs are ramping up their scrutiny of practices' QOF performance

Where practices are facing scrutiny

QP indicators Indicators requiring practices to formulate plans to reduce prescribing costs, referrals and emergency admissions have proved troublesome

Patient participation DES Introduced in 2011, the DES requires practices to demonstrate patient engagement

Dr Tony Grewal, medical director of Londonwide LMCs, said: 'This mirrors our experience of onerous and pedantic assessments of claims for QOF points carried out by PCTs and their successors. This has completely overturned the spirit of the new GMS contract of "high trust, low bureaucracy".'

Dr Richard Vautrey, GPC deputy chair and a GP in Leeds, said the issue was being exacerbated by support staff being more remote, which had caused a more 'officious' approach.

He said: 'There are fewer staff with experience of local practices, so PCTs are resorting much more to sticking to the letter of the law. It's one of the things we've talked to the national commissioning board about. The way local area teams operate is very much on our agenda.'

A Pulse survey published last month found one in eight practices was owed DES funding, with nine taking legal action to recapture the money.

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ANALYSIS

Managers turning the screw

In the past, managers used discretion when assessing the performance of practices under the QOF, but those days have gone.

To some extent this is because money is increasingly tight. PCOs are less inclined to give practices the benefit of the doubt, and do everything possible to save money. In some parts of the country PCOs have become more pernickety about awarding QOF points, although which indicators cause the most problems can vary from place to place.

There are national QOF guidelines published by NHS Employers and the GPC. They give a rundown of what is needed to achieve each point and how to exception-report patients. That's what practices and managers should follow, and then you should get the points, no argument.

But if you don't, issue a formal appeal. You have nothing to lose if you have been following this guidance, and your LMC can help support you through this dispute.

Dr David Bailey, chair of GPC Wales

Records plan 'insulting'

By Julia Robinson

GPs may be forced to copy patients in on all correspondence made on their behalf under radical plans being considered by the Welsh Government to improve patient safety.

The proposals follow an investigation into the death of Welsh schoolboy Robbie Powell, which found a breakdown in communication had contributed to his death.

The review of the handling of patient records was launched on 9 October and will consider 12 recommendations made by the Powell investigation earlier this year, including copying in patients, and the parents of children, to all correspondence about their care.

Pulse understands the review will also consider controversial plans to store GP records in such a way that they cannot be altered, moved or lost after a patient has died. Ministers said the review was designed to improve communication with patients and the integration and safety of care, but GP leaders in Wales branded the plans 'insulting' and unworkable.

Robbie Powell died 22 years ago, aged 10, after a series of errors meant Addison's syndrome was not detected or treated.

The Welsh Government said the results of the review would be implemented in 2013/14, but in the meantime, all local health boards were 'expected to ensure that processes are in place to handle any issues regarding the retrieval and handling of medical records following a patient's death'.

It isn't possible for every piece of correspondence to be copied
Dr David Bailey

But Dr David Bailey, GPC Wales chair, described the plans to lock down records after a death as 'utterly insulting' and added: 'Copying patients into every piece of correspondence would result in a huge administrative burden and require a huge amount of funding. I have nothing against patients being involved with discussions but it isn't possible for every piece of correspondence to be copied.'

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MP withdraws call for GP premises investigation

A Conservative MP has withdrawn his call for a 'comprehensive investigation' into the way GP practices are reimbursed for premises costs, after he found the system was working well.

James Wharton, a Conservative member of the House of Commons Public Accounts Committee (PAC), had accused GPs of 'fiddling the system' and said he would ask his committee and the National Audit Office (NAO) to open a 'full and comprehensive investigation' into the way notional rent was calculated.

His call came after a newspaper investigation by the *Daily Telegraph* in July 2011 claimed GPs were 'pocketing millions' from the taxpayer, by 'renting' surgeries back to the Department of Health for more than the mortgage repayments and then selling the surgeries for profit on retirement.

But Mr Wharton told Pulse this month that he had withdrawn his call and the PAC was also now satisfied the arrangements were fair. He said: 'We looked into it and found that though of course there may well be examples of bad value, on the whole the scheme looked like it was working OK.'

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

Pfizer

 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

Letters: NICE admission on guidelines is welcome
▶ page 26

CCGs struggling with recruitment forced to share consultant and nurse board members

AUTHORISATION

CCGs share board members

By Gareth Iacobucci

CCGs have announced plans to share consultant and nurse representatives across boards to mitigate recruitment difficulties and smooth the passage to authorisation.

As site visits from the NHS Commissioning Board to prepare for authorisation get under way, NHS London revealed CCGs in the capital have made slow progress in finalising their boards, with some likely to share members to ensure they are authorised.

Leading GP commissioners also told Pulse recruiting consultants from outside their area to sit on boards had been challenging, with one CCG appointing a retired local consultant to avoid conflicts of interest.

The health act stipulates all CCGs must have at least one secondary care doctor and nurse on their governing body to ensure adequate representation, but these must be appointed from outside the local area to avoid conflicts of interest.

But after a Pulse investigation in June found only 7% of CCGs across England had managed to appoint a secondary care doctor to their board, NHS chief executive Sir David Nicholson announced a potential rethink, saying he was 'very open' to relaxing the legal stipulation that they must come from outside the area.

Board papers from NHS London said the status of its 32 CCGs, as of last month, was: 'Six CCGs have appointed secondary care doctors. Some CCGs plan to share secondary care doctors and three out of 26 vacancies across London have been appointed. Eight CCGs have appointed nurse members. Some plan to share nurse members and five out of 26 vacancies across London have been appointed.'

A spokesperson for NHS London said: 'It is for the CCG to decide how it will discharge its responsibilities within the legislative framework, which will be subject to the NHS Commissioning Board's CCG authorisation process.'

Dr Sam Everington, chair of Tower Hamlets CCG and a GP in Bromley-by-Bow, east London, said: 'We're not planning to share, but I know others have struggled to appoint somebody, and it's mainly because of the issue around having to find somebody external to your local area.

'What you really want is a consultant with local expertise and knowledge, and that makes it very difficult to recruit somebody.'

He added: 'What we've gone out to do is look at people who have recently retired from the local trust, and a number of other CCGs have done that too, to get the best of both worlds. You've dealt with the conflict of interest but you've got somebody who absolutely understands the people you have got local contracts with.'

Dr Johnny Marshall, interim partnership development director of NHS Clinical Commissioners and an adviser to the NHS Commissioning Board, said: 'I know that some CCGs even outside London have been inviting the same nurses to sit on more than one governing body. It is not just in London that people have been looking at that.'

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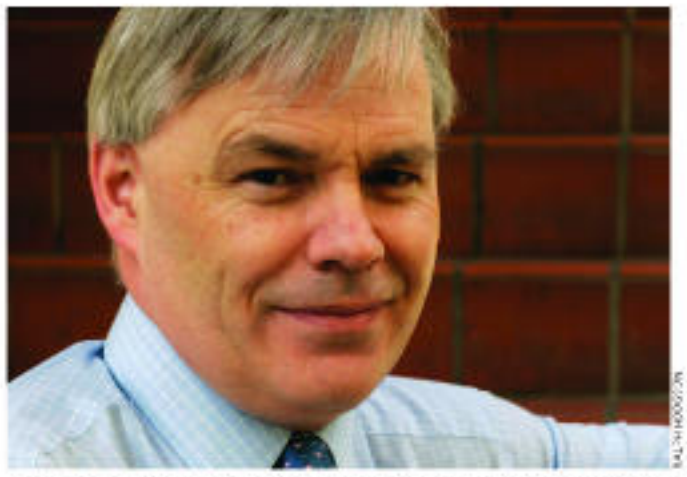

Dr Sam Everington: retired consultants offer 'best of both worlds'

Who must CCG boards recruit?

- Someone with a professional qualification or expertise in accountancy
- A registered nurse (but not an employee of any service contracted by the CCG)
- A secondary care specialist (but not an employee of any service contracted by the CCG)
- Two lay people

Source: NHS (CCG) Regulations 2012

GP ENGAGEMENT

Warning over 'disconnected' CCGs

The BMA chair has warned the NHS could be heading towards a worst-case scenario where CCGs are 'disconnected' from most GPs and operating without grassroots support.

Speaking at the Conservative Party Conference in Birmingham last week, Dr Mark Porter warned that CCGs were drawing up 'irresponsible' constitutions that made GPs disillusioned with clinical commissioning.

He said: 'The worst-case scenario is that by 2017 we see a series of groups that are operated by an enthusiastic minority, rather than by all GPs and are disconnected from and unaccountable to the majority of the working profession.'

But Dr Johnny Marshall, interim partnership development director of NHS Clinical Commissioners and a GP in Wendover, Buckinghamshire, said the level of engagement was on an upward trajectory.

He said: 'There are some areas where engagement isn't happening. But most of what we hear is an improving position in terms of engagement with commissioning groups.'

NURSING

District nursing service may be axed

GP commissioners are considering decommissioning a district nursing service because of concerns over its performance, in plans deemed necessary to demonstrate their CCG is fit to be authorised.

The service in Harrow, north west London, has been issued with a formal contract query following claims of reduced satisfaction, decline in activity levels and poor communication.

Board papers from Harrow CCG said 'serious consideration' would be given to serving a decommissioning notice.

A spokesperson for NHS North West London said: 'Commissioners recognised early signs of the service failing and a need to take action. It was decided that the first stage of the process was to issue a formal contract query that would result in the [service] delivering an improvement plan with measurable outcomes. This query was issued in late September.'

But a spokesperson for Ealing Hospital NHS Trust, which runs the service, rejected the criticisms: 'We are aware of the GP feedback but we are yet to receive robust information to indicate if there are any governance issues in relation to patient care that would signal a requirement to decommission services.'

Dr Chaand Nagpaul, GPC negotiator and a GP in Harrow, said: 'It's the sort of thing CCGs really have to get to grips with.'

JANUVIA: More prescriptions than any other DPP-4 inhibitor[1]

TOTAL PRESCRIPTIONS DISPENSED WORLDWIDE[2]

SITAGLIPTIN FAMILY: **46.6 MILLION** (JANUVIA & JANUMET)

JANUVIA: More licence indications than any other DPP-4 inhibitor[3]

- ✔ As monotherapy when metformin is not appropriate
- ✔ As add-on to metformin
- ✔ As add-on to sulphonylurea (SU)
- ✔ As add-on to metformin and SU
- ✔ As add-on to thiazolidinedione (TZD)
- ✔ As add-on to metformin and TZD
- ✔ Added on to insulin +/- metformin

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

MSD

Prescribing Information can be found overleaf

Once-daily Januvia® (sitagliptin)

DH 'should plan for flu vaccine shortage'

DH admits it has no contingency as practices are left struggling following the recall of flu vaccines

By Jaimie Kaffash

GPs have criticised the Department of Health for failing to stockpile emergency flu vaccinations, as practices cope with shortages after a major manufacturer withdrew supplies.

The DH has told Pulse that it does not have any flu vaccine reserves, and will only develop them towards the end of the flu season. But GPs warned this would be too late for some practices if there is a sudden rise in demand.

The manufacturer Crucell has had to recall its Viroflu and Inflexal vaccines following unexpected test results on some of its batches, leading to major shortages as the flu vaccination programme begins.

The DH traditionally holds a reserve of 400,000 vaccines in case supplies run out; however, Pulse understands that it has not yet built up this reserve this year. In addition, the DH concluded last year that a bigger central reserve stockpile was needed.

Flu campaign in numbers

11%
proportion of flu vaccine affected by delays

9.6%
current flu uptake in at-risk groups under 65 years

400,000
reserve of vaccine doses DH expects by end of campaign

GPs say a vaccine reserve is needed at the start of season

A DH spokesperson told Pulse: 'As in previous years, once delivery of vaccine to general practice is under way the department builds a strategic reserve of around 400,000 doses of flu vaccine. This reserve is to use near the end of the seasonal vaccination programme if all other supplies have been exhausted.'

But Dr George Kassianos, RCGP immunisation lead and a GP in Bracknell, Berkshire, said this could be too late: 'The right time for having the central emergency reserves is at the start of the season. This will help practices that have difficulties obtaining their ordered supplies, as they will with Crucell now, but also ensure enough flu vaccine is around to cope with a sudden rise in demand that may be dictated by the unpredictable behaviour of the influenza viruses.'

Dr John Allingham, medical secretary of Kent LMC, agreed: 'The DH should have had reserves. The targets have changed this year – they have added in pregnant women and increased targets for over-65s – and NHS staff have been criticised for a low uptake. All that is putting pressure on the system. They need more vaccine. The DH should have a contingency plan for something going wrong.'

Pulse reported last week that practices across the country had been affected by the Crucell recall, with Derbyshire LMC reporting 15 practices were short of supplies and several flu clinics had been cancelled.

However, GPC negotiator Dr Peter Holden said he had been in discussions with the DH and they had estimated that the current shortages represented only 11% of the nation's total annual flu vaccine supply.

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MORE ONLINE
Follow the latest updates on this year's flu campaign
pulsetoday.co.uk/flu

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]

ZOSTAVAX®▼

Shingles (herpes zoster) vaccine (live)

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

ABRIDGED PRESCRIBING INFORMATION

ZOSTAVAX® powder and solvent for suspension for injection (shingles (herpes zoster) vaccine (live)) *Refer to Summary of Product Characteristics for full product information.*

Presentation: Vial containing a lyophilised preparation of live attenuated varicella-zoster virus (Oka/Merck strain) and a pre-filled syringe containing water for injections. After reconstitution, one dose contains no less than 19400 PFU (Plaque-forming units) varicella-zoster virus (Oka/Merck strain). **Indications:** Active immunisation for the prevention of herpes zoster ("zoster" or shingles) and herpes zoster-related post-herpetic neuralgia (PHN) in individuals 50 years of age and older. **Dosage and administration:** A single dose should be administered by subcutaneous injection, preferably in the deltoid region. **Contraindications:** Hypersensitivity to the vaccine or any of its components (including neomycin). Individuals receiving immunosuppressive therapy (including high-dose corticosteroids) or who have a primary or acquired immunodeficiency. Individuals with active untreated tuberculosis. Pregnancy. **Warnings and precautions:** Appropriate facilities and medication should be available in the rare event of anaphylaxis. Deferral of vaccination should be considered in the presence of fever. In clinical trials with Zostavax, transmission of the vaccine virus has not been reported. However, post-marketing experience with varicella vaccines suggest that transmission of vaccine virus may occur rarely between vaccinees who develop a varicella-like rash and susceptible contacts (for example, VZV-susceptible infant grandchildren). Transmission of vaccine virus from varicella vaccine recipients without a varicella-zoster virus (VZV)-like rash has been reported but has not been confirmed. This is a theoretical risk for vaccination with Zostavax. The risk of transmitting the attenuated vaccine virus from a vaccinee to a susceptible contact should be weighed against the risk of developing natural zoster and potentially transmitting wild-type VZV to a susceptible contact. As with any vaccine, vaccination with Zostavax may not result in protection in all vaccine recipients. **Pregnancy and lactation:** Zostavax is not intended to be administered to pregnant women. Pregnancy should be avoided for three months following vaccination. Caution should be exercised if ZOSTAVAX is administered to a breast-feeding woman. **Undesirable effects:** Very common side effects include: pain/tenderness, erythema, swelling and pruritus at the injection site. Common side effects include warmth, haematoma and induration at the injection site, pain in extremity, and headache. Post marketing use has shown hypersensitivity reactions including anaphylactic reactions, joint and muscle pain, fever, swollen glands, rash, also hives and rash at the injection site. For a complete list of undesirable effects please refer to the Summary of Product Characteristics. **Package quantities and basic cost:** Vial and pre-filled syringe with two separate needles. The cost of this vaccine is £99.96. **Marketing authorisation holder:** Sanofi Pasteur MSD SNC, 8 Rue Jonas Salk, F-69007 Lyon, France **Marketing authorisation number:** EU/1/06/341/011 **Legal category:** POM * Registered trademark **Date of last review:** June 2012

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

References: 1. 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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Writing a business plan for new premises
▶ page 37

Chronic kidney disease patients over 75 years old should be referred at same stage as younger patients

CKD

Elderly CKD referrals 'justified'

By David Swan

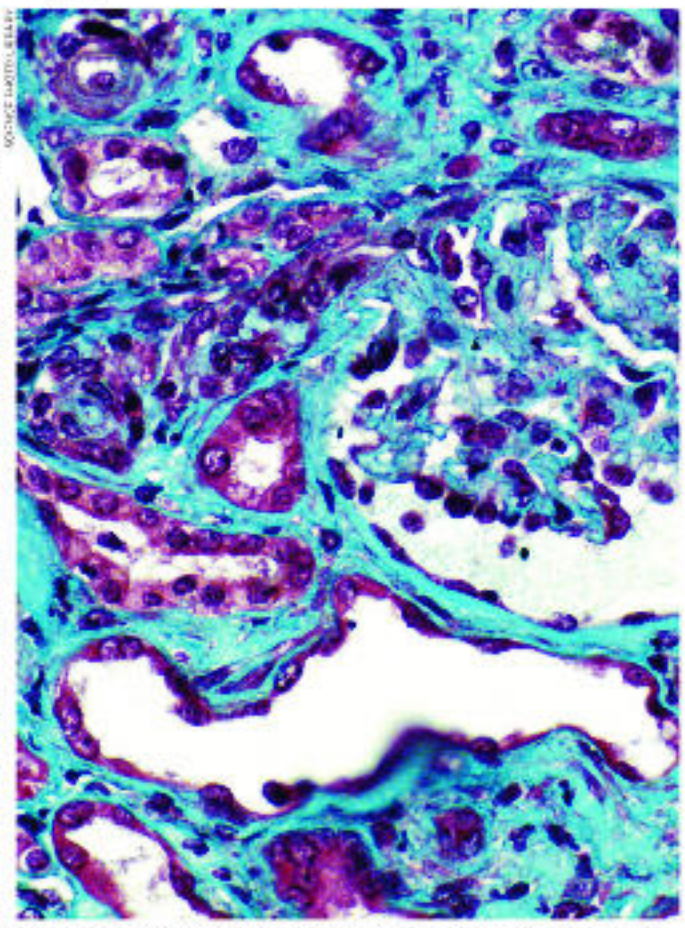
Criticism of GP referrals for CKD in elderly patients is unjustified as this group is just as likely to require specialist care, a UK analysis has concluded.

The study of patients at 25 hospital outpatient clinics in Wales found that, despite large numbers of elderly patients being referred to secondary care since the introduction of eGFR, there was no difference in intervention rates between those aged under 75 years and those over 75.

The researchers said the findings showed that the ongoing debate over the referral of elderly patients with stage three CKD was unfounded, and that age should not be a barrier to referral for specialist care.

The researchers, from University Hospital Wales in Cardiff, retrospectively followed nearly 550 patients presenting at outpatient clinics over 19 weeks within a single NHS trust that covered 20% of the Welsh population.

Clinical parameters, including eGFR, were recorded at the time of the clinic appointment, and recordings from the previous six and 12 months were also analysed to measure stability over a one-year period.



Hypertensive kidney: age should not be a barrier to treatment

Impact of age on CKD referrals

	Over-75s (%)	Under-75s (%)
Intervention rates	30.7	32.5
Unstable eGFR over 12 months	17.9	24.3

Eur J Intern Med 2012, available online 28 September

There were large numbers of elderly patients presenting at the clinics, with 43% of those seen in outpatient clinics aged over 75 years.

But the researchers found no significant difference between the over-75s and under-75s in terms of intervention rates, defined as a change to medication or further referral, with figures of 31% and 33% of patients respectively. Medication changes included any alteration, initiation or discontinuation of drugs, while referrals covered those to a renal anaemia team, surgical team and dialysis units.

There was also no significant difference in eGFR stability between the over-75s and under-75s over a 12-month period, with 24% of under-75s and 18% of over-75s exhibiting an unstable eGFR.

But the older cohort did have a greater degree of renal anaemia requiring erythropoietin than the younger group.

The authors concluded that elderly CKD patients in nephrology outpatient clinics were managed no differently from a younger cohort, apart from their higher rates of renal anaemia.

They concluded: 'Despite an increase in the mean age of nephrology outpatients in the era of automated eGFR reporting, we can provide no evidence that the over-75 age group has a lesser need for specialist nephrology intervention than the under-75 group.'

Professor Mike Kirby, a GP in Radlett, Hertfordshire, and editor of the *Primary Care Cardiovascular Journal*, said this supported GPs referring and managing elderly patients the same as younger patients with CKD.

He said: 'I'm against ageism for CKD and I don't support the idea of using age, in this case 75 years, as a cut-off. Treatment decisions should be taken on a case-by-case basis.'

He added that it was important elderly patients were managed well to prevent further complications from CKD.

He said: 'If we manage patients well in stage three, with good blood pressure control and proteinuria management, then it reduces the likelihood of them reaching stage four, where renal anaemia occurs.

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Pic quiz: can you identify these infestations?
▶ page 35

INSOMNIA

Self-help CBT scheme 'can improve insomnia'

A self-help advice programme based on cognitive behavioural therapy techniques can reduce the symptoms of insomnia, say UK researchers.

The trial comprised 193 primary care patients aged 55 to 87 and with chronic diseases such as osteoarthritis, heart disease and cancer. Each had moderate-to-severe insomnia according to the Pittsburgh Sleep Quality Index (PSQI) and were randomised to either self-help or a control group that received usual care.

The self-help group received six consecutive self-help booklets and a telephone helpline providing advice such as developing good sleep hygiene and improving thinking about sleep.

This group had significantly improved sleep quality compared with the control group, with mean PSQI scores of 3.9 and 1.3 respectively. The self-help group also had improved sleep efficiency scores, with a mean score of 14.6 compared with 2.1 in the control group.

***J Am Geriatr Soc* 2012, online 5 October**

CPD TIP OF THE WEEK

Metformin can be used in patients with prediabetes

NICE has effectively given the go-ahead to prescribe metformin for patients with impaired glucose tolerance before they develop type 2 diabetes, according to a new case-based learning module.

The module – a guide to the recent NICE guideline on preventing diabetes – gives details on identifying which patients could benefit and prescribing advice.

Although this is an unlicensed indication – and informed consent will have to be obtained – metformin was used safely by people with impaired glucose tolerance in the US Diabetes Prevention Program Outcomes Study and produced durable weight loss.

CASE-BASED LEARNING
Guideline debrief: preventing diabetes
pulse-learning.co.uk

INCONTINENCE

Botox offers relief from incontinence

Botox injections are as effective as anticholinergic therapy for the treatment of urge incontinence, say US researchers.

Their trial found no significant difference in the mean reduction in episodes of urgency urinary incontinence per day, with 3.4 fewer episodes for patients on anticholinergics and 3.3 in the botulinum toxin group.

The study investigated 241 women with moderate-to-severe urgency urinary incontinence assigned to receive solifenacin starting at 5mg daily or a single botulinum toxin A injection.

Long-term follow-up showed no significant difference between the groups in terms of number who had adequate control of symptoms 12 months after discontinuation.

The researchers concluded: 'The choice between these therapies should take into account the differing regimens and routes of administration and the side-effect profiles.'

***NEJM*, available online 4 October**

CONFERENCE ROUND-UP

Combine CBT with antidepressants

A combination of CBT and pharmacotherapy doubles the chance of symptom reduction in patients who have not responded to antidepressants alone. Of 441 patients, 46 experienced a 50% reduction in symptoms with combined therapy after six months, compared to 22% of controls using antidepressants.

SAPC conference, abstract 1E.2

Mirena benefits

Mirena produces greater improvements in menorrhagia than oral contraceptive care, say researchers. Women receiving the levonorgestrel intrauterine system averaged 13.4 points more on the Menorrhagia Multi-attribute Scale than usual treatment.

SAPC conference, abstract 3G.5

Five TIA indicators

Confusion, memory loss, reduced consciousness, unilateral sensory disturbance and nausea are all predictors of a TIA in primary care, say researchers. They found a prediction model had good discrimination, with an area under the curve of 0.81.

SAPC conference, abstract 1A.3

CVD

Dabigatran coronary risk 'higher than alternatives'

BMJ open

Dabigatran is associated with a higher risk of coronary events than newer anticoagulants, a new meta-analysis concludes.

The analysis studied 28 randomised controlled trials involving 138,948 patients using four recent alternatives to warfarin: dabigatran, rivaroxaban, apixaban and ximelagatran.

Trial selection was based on whether they mentioned the occurrence of acute coronary events or all-cause mortality and if they comprised at least 1,000 subjects.

The study found that, compared with the control group, the risk of acute coronary events, such as myocardial infarction and acute coronary syndrome, rose significantly by 30% in the groups using dabigatran.

In contrast, the risk associated with rivaroxaban and apixaban decreased by 22% and 6% respectively, compared with controls.

The difference in risk associated with ximelagatran, which has since been withdrawn from the market, was not found to be statistically significant.

The authors, from The Mak Heart Clinic in Singapore, concluded: 'These findings were instructive in providing insight [into] the relative occurrence of adverse cardiovascular events impacting on the choice of these agents in specific patient subsets requiring anticoagulation.'

A spokesperson from the manufacturer of dabigatran, Boehringer Ingelheim, said the analysis was only from a 'restricted data set'.

***BMJ Open*, online 6 October**

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1. Barnett AH, *et al.* Poster No. 823-P and abstract. The European Association for the Study of Diabetes 46th Annual Meeting, 20–24 September 2010, Stockholm, Sweden. **2.** Taskinen MR, *et al. Diabetes Obes Metab* 2011;13:65–71. **3.** Owens DR, *et al. Diabet Med* 2011;28:1352–61. **4.** Trajenta® Summary of Product Characteristics, August 2011. **5.** Boehringer Ingelheim, data on file LIN11-06a. **6.** Vincent SH, *et al. Drug Metab Dispos* 2007;35:533–8. **7.** Januvia (sitagliptin) Summary of Product Characteristics. Available at: http://www.medicines.org.uk/EMC/medicine/19609/SPC/JANUVIA+25mg%2c+50mg%2c+100mg+film-coated+tablets/ (accessed August 2012). **8.** Galvus (vildagliptin) Summary of Product Characteristics. Available at: http://www.medicines.org.uk/EMC/medicine/20734/SPC/Galvus+50+mg+Tablets/ (accessed August 2012). **9.** Onglyza (saxagliptin) Summary of Product Characteristics. Available at: http://www.medicines.org.uk/EMC/medicine/22315/SPC/Onglyza+2.5mg+%26+5mg+film-coated+tablets/ (accessed August 2012). **10.** Deacon CF. *Diabetes Obes Metab* 2011;13:7–18. **11.** Blech S, *et al. Drug Metab Dispos* 2010;38:667–78. **12.** Haak T, *et al. Diabetes Obes Metab* 2012;14:565–74. **13.** Jentadueto® Summary of Product Characteristics, August 2012.

Ten tips for commissioning COPD care
▶ page 39

GMC backtracks on 'back to work'

Controversial amendment to new version of *Good Medical Practice* rewritten after fierce BMA criticism

By Sofia Lind

GPs will have a new duty to encourage patients to take part in 'fulfilling activity' under draft guidance approved by GMC Council - but will not be asked to urge them to go back to work as previously proposed.

The watering-down of proposed amendments to *Good Medical Practice* comes after claims that the regulator had been pressurised by the Government to force doctors into supporting its 'back to work' drive.

Pulse reported a year ago that the GMC was proposing to include a duty on doctors 'to encourage patients with long-term conditions to stay in, or return to, employment'.

But the proposal - drafted with input from the Department for Work and Pensions and based on evidence that work can be 'life enhancing' - was met with heavy criticism from GPs and the BMA.

The BMA warned the duty was a 'possible political capture of *Good Medical Practice*' and said it undermined the duty on doctors to put patient care first.

What the new draft says

'You must support patients in caring for themselves to empower them to improve and maintain their health. 'This may include… supporting patients to make lifestyle changes including doing voluntary or paid work or other fulfilling activities.'

Source: GMC, *Good Medical Practice* guidance

In response, GMC Council has reworded the new guidance to remove the reference to 'employment' and will instead ask GPs to encourage 'fulfilling activities'. The final guidance will be published in November, subject to approval by the GMC chair, and will come into force next year.

The final draft says: 'You must support patients in caring for themselves to empower them to improve and maintain their health.

'This may, for example, include… supporting patients to make lifestyle changes, where appropriate, including changes to diet, exercise, smoking and alcohol consumption, doing voluntary or paid work or other fulfilling activities.'

In minutes from a meeting held last month the GMC said 'some amplification of the principle was valuable' but added 'the emphasis should be on doctors empowering patients to improve their health, rather than specifying ways in which the patient may do this'.

Dr Kambiz Boomla, a GP in Tower Hamlets, east London, said: 'The real issue is not the wording in the guidance, it is that the Government is not putting the infrastructure in place to help people back into work.'

'We have people in tears over being told they have to work and their benefits are being cut off, although it is clear they are not capable of doing what they are asked, or jobs aren't available.'

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MORE ONLINE
Read the draft guidance
pulsetoday.co.uk/backtowork

Paediatric clinic: cystic fibrosis
▶ page 30

Dr Kambiz Boomla: unemployed patients 'in tears'

Do not provide information on suicide, GPs told

The GMC has published draft guidance for fitness-to-practise panels on how to treat complaints about doctors alleged to have helped patients commit suicide.

The final guidance, to be released later this year, is due to say that when considering an allegation of a doctor 'encouraging or assisting suicide', assessors should consider whether there is a 'realistic prospect of establishing a doctor's fitness to practise is impaired to a degree justifying action on their registration'.

Assessors are advised to consider the 'intensity of the encouragement or assistance', whether it was persistent, active and instrumental, or minor and peripheral.

The guidance also says doctors should limit the information they give patients to an explanation that it is a criminal offence for them to encourage or assist a person to commit or attempt suicide.

The guidance was developed in response to the case of a disabled man, 'AM', who last year brought a case against the GMC, the director of public prosecutions, and the Solicitors Regulation Authority. Following discussions with AM's solicitors the GMC agreed to develop guidance on suicide.

IN BRIEF

New party recruits

National Health Action, a new political party set up by doctors to 'stop the destruction of the NHS', has opened its doors to members.

Full story ▶ pulsetoday.co.uk/politics

Managing Crohn's

People with Crohn's disease should be given the choice of how they want to manage their disease when in remission, says NICE.

Full story ▶ pulsetoday.co.uk/clinical

Procedures restricted

Older people are being denied potentially life-saving treatment because of restrictions on GP referrals for certain procedures, says a study by the Royal College of Surgeons and Age UK.

Full story ▶ pulsetoday.co.uk/practice

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Date of preparation: August 2012 UK/SPI-121330

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Margaret McCartney: why every GP should consider tweeting ▶ page 23

KEYNOTE SPEECH

Hunt vows to change NHS culture

Health secretary aims to make dementia care the best in Europe and make hospital managers accountable

By Sofia Lind

Jeremy Hunt has pledged to use the reforms started by his predecessor to 'change the culture' in the NHS and improve the outcomes of patients with major diseases, in his first major speech as health secretary.

Addressing the Conservative Party conference in Birmingham last week, Mr Hunt said he wanted to make dementia care in the NHS the 'best in Europe' by the next election and escalate the use of technology within GP surgeries to enable online booking of appointments.

He also warned managers he had ordered the Care Quality Commission to look into how to make them more accountable for the care that is provided in hospital.

Mr Hunt replaced Andrew Lansley as health secretary last month, and has maintained a low profile since – drawing jibes from the Opposition that he has been 'invisible'. But in his first major speech since his appointment, Mr Hunt attacked the Labour party and vowed that he would see through Mr Lansley's reforms.

He said: '[Andrew] Lansley's reforms are brave, they are right and they will make the NHS stronger.

'If Andrew was the health minister who set the structure, I want to be the health secretary to help change the culture and the system to make it the best healthcare system to look after people in the world.'

Jeremy Hunt: plans to see Mr Lansley's reforms through

He said he wanted the UK to have the best survival rates in Europe for major diseases. 'I want to see a big change in the way we look after people with dementia,' he said.

'I want us to raise our game further – and say by the next election we will be among the best in Europe at dealing with this most challenging of conditions.'

He added that access to technology needed to be improved, including giving patients access to their records and online appointment booking.

He said: 'The final challenge I will mention is the technology revolution which has barely touched the NHS... Why can you book a hotel online but not make a GP appointment?

BMA chair Dr Mark Porter said: 'We agree with him on the massive importance of meeting the challenges posed to the NHS by the ageing population, but elderly care in particular requires a joined-up, collaborative approach. The changes currently being implemented in the NHS in England will generate more competition and more fragmentation.'

@sofialind_pulsetoday

Jeremy Hunt on...

The NHS reforms
'They are brave, they are right and they will make our NHS stronger'

Andy Burnham
'Criticise what the new lot do, not what you did yourself'

Dementia care
'By the next election we will be among the best in Europe'

GP IT
'Why can you order your groceries at home but not your prescription?'

MORE ONLINE
Read the full speech
pulsetoday.co.uk/huntspeech

COMMISSIONING

'More GPs needed for commissioning' says MP

An impending shortage of GPs in the workforce is the 'biggest threat' to the success of clinical commissioning, a leading GP-turned-MP has warned.

Dr Sarah Wollaston, Conservative MP for Totnes, Devon, and a member of the House of Commons Health Committee, said the system had been training too many hospital specialists and not enough GPs, and called for a campaign to inform medical students about the benefits of going into general practice.

Speaking to Pulse at the Conservative Party conference, Dr Wollaston said half of all medical students would need to go into general practice to address the shortage.

'The real issue is GP numbers,' she said. 'If we look at the crisis coming up in the workforce, the biggest threat to commissioning is going to be high-quality commissioners having the time to spare from clinical commitments, because their first priority is their patients. If they can't find locums or have the support from their partners to get involved in commissioning, that is going to be a problem. For years now we have trained too many hospital specialists, for whom there are no jobs.'

The Department of Health plans to increase the proportion of specialty training places taken up by GP registrars to 50% by 2015.

IN BRIEF

Conference diary

More box-ticking

One Conservative MP shared his opposition to revalidation with Pulse. Dr Phillip Lee, Conservative MP for Bracknell, Berkshire, and a part-time GP locum, warned it was likely to be more 'box-ticking' regulation. He said: 'I am sceptical of unnecessary bureaucracy masquerading as protecting the patient.'

Get on with it, GPs told

The chair of Conservative Health gave the following advice to CCG leaders at the conference: 'Get on with it and stop worrying about being told exactly what to do.' Dr Paul Charlson said GPs should be focused on shaping services in the way that worked best for their patients.

Out with the new

RCGP chair Clare Gerada told Conservatives to stop looking for whizz-bang solutions to improve the NHS. She said: 'People go looking for new partnerships and innovations in healthcare, [but] never look in their own backyard. They never look at what we know works – and what is working already.'

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

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NHS Price: £3.60
MA Number: 17871 / 0151

MA Holder: Jenson Pharmaceutical Services Ltd, Carradine House, 237 Regents Park Road, London N3 3LF, UK.
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internis.

Building a new NHS will take time

How long does it take to achieve a revolution? Amid the rush to authorisation, and the ever-mounting workload from the day job, it's easy for GPs to forget just how far and how fast the NHS has come over the past two years.

In the early days of the white paper and pathfinder consortia, it seemed inconceivable the unprecedented reforms could proceed at anything like the breakneck pace Andrew Lansley had mandated. But while there remain huge questions over the implementation of GP commissioning – and nagging doubts among many over its rationale – there are now just five and a half months until the big handover. Across the length and breadth of England, CCGs are making do, learning as they go and trying to get to grips with the hideously complex business of taking over from PCTs.

Steve Nowottny
Editor

It might seem surprising, then, that the most prominent cheerleaders of GP commissioning are choosing this moment to pour cold water on expectations. Last week Dr Johnny Marshall, former chair of the NAPC and now an adviser to the NHS Commissioning Board, warned it could take five years for most CCGs 'to develop the necessary relationships and partnerships'. The NHS Alliance's Dr Michael Dixon largely concurred. 'It takes time to turn a tanker around,' he said.

Many of the GPs who have volunteered to help steer that tanker would no doubt agree. Between managing shrunken budgets, jumping through the NHS Commissioning Board's hoops and simply setting up their own infrastructure, CCGs are facing a formidable challenge.

Many are struggling even to meet the requirements for board membership, with some being forced to 'share' willing consultants and nurses. Some, as Dr Sam Barrell writes in our opinion section this week, are wrestling with how to effect whole-system change while being given only limited power. And then there's the small matter of trying to 'engage' sceptical member practices while simultaneously making real efficiency savings by cutting referrals and prescribing.

Achieving all that even in five years might seem optimistic – but the chances are, CCGs won't get five years. Patience is a rare virtue in any part of Government, and in the NHS, perpetual upheaval has become a way of life.

Part of Mr Lansley's determination to enshrine his reforms in legislation was to ensure they would survive a change in health secretary or even Government – but even he could not have foreseen that he would lose his post before they began. And when his successor took the stage at the Conservative Party conference last week his theme was, almost inevitably, more change, with a vow to 'transform the culture of the system'.

GPs who are excited about the possibilities of clinical commissioning will fervently hope for some patience from politicians. But even those who harbour grave doubts will be wary of any further wholesale reorganisation. For better or worse, CCGs are poised to start running the NHS. They must be given time to prove they can do so.

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

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Suffer the little children

When a harassed mother leaves her four-year-old in the consultation room, **Phil** suddenly finds himself in a very uncomfortable position

I could hear them coming down the corridor, long before they arrived at my consulting room; two small children in conflict. Each was accusing the other of something or other, and recriminations were flying.

Both of them were shamelessly informing on each other, base pleading filled the air, and if the little boy's opinion was to be credited, the little girl was stinky.

Twins, aged about four. The mother, who actually had the appointment, was the very model of the terminally harassed. She'd gone past the stage of trying to impose authority, and was basically begging for some sort of temporary order. 'Please Tyler, please Minty, (Minty?) stop fighting or the doctor will be very cross.'

I was quick to leap in. 'Can I just stop you there for a moment? I'm not going to be very cross. Sorry, but that's your job, okay? Hello Tyler and Minty, by the way.'

I hate it when patients try to do that. I'm not the bogeyman. If ever a patient tries to use me as a scary authority figure and pretend to their children that I'm going to do the parenting that they are so manifestly failing to do, I am quick to stop them in their tracks.

I tell them that if they try that again, a big nasty policeman will come and take them away to prison.

Mrs Harassed sat down, while her children fought over the other chair, and started to tell me about her problem (tension headaches I think it was - can't imagine why she was suffering those). Half-way into her first whinge Tyler clocked Minty, who had possession of the chair, with a haymaker that jerked her head back and banged it off the wall.

There was a shocked silence. Mrs Harassed leapt to her feet. 'Right young man! You are going back to the waiting room right now to sit with grandma.'

And with that she grabbed Tyler by the wrist, and with a rapidly diminishing squeal of protest, they were gone. Minty and I were left staring at each other, nonplussed.

And here, ladies and gentlemen, is the rub. I suddenly found myself in a very uncomfortable position indeed. I was sitting on my own in my consulting room, with a shocked and upset four-year-old girl, arms locked round her drawn-up knees, tear-filling eyes fixed on me, lower lip trembling and protruding further by the second, and very obviously about to burst into floods.

And I was with her, alone.

It wouldn't have been a big deal 20, 15, maybe even 10 years ago. I could have done the talking rabbit hand puppetry schtick that always entertained my sons, or given her a tickle or even a cuddle to calm her down until her mum came back.

I made it to the door, opened it, and stood half in and half out

But now, and especially recently thanks to the allegations against that 'Now-then-now-then' track-suited tit-end which are polluting the corridors of the NHS, I can't go anywhere near her. In fact, I had to get out of there immediately! I was almost panicking.

Circling round her, keeping at least 10 feet away, I made it to the door, opened it, and stood half in and half out. 'It's okay, Minty, mum will be back soon!' I blathered, willing the bloody woman to come back from the waiting room.

The little girl was starting to cry, but what could I do? 'Come on, come on, come on,' I urged through gritted teeth. Seconds passed like years. Then the mother reappeared.

Once Mrs Harassed sat down again, I couldn't let the incident pass unmentioned. 'Look, why did you do that? You shouldn't leave your daughter alone with me like that.'

She'd relaxed somewhat, now the fighting had stopped. 'Why on earth not, doctor? After all, if I can't trust you, who can I trust?'

Dr Phil Peverley **is a GP in Sunderland**

More online

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

Why every GP should consider tweeting

Don't listen to the critics – social media sites can get the profession talking again, says **Margaret**

ILLUSTRATION: JAMES WILLIAMS

Baroness Susan Greenfield, the leading brain physiologist, writer and broadcaster, spoke to the RCGP annual conference in Glasgow earlier this month about the perils of living in a cyberworld.

She believes social networking is a kind of Wild West. She is on record as warning that there is little accountability online, where relationships are not face to face, there is no eye contact and there is a lack of 'real' or 'proper' human relationships – and she has argued those who use social media are missing out on real life. This is the kind of thing she told the assorted doctors at the conference.

A couple of days later I sat alongside RCGP chair Professor Clare Gerada and Dr Ben Riley, RCGP medical director for e-learning. Behind us was a massive screen filled with tweets from people in the audience, from people elsewhere in the UK and people on the other side of the world – all talking about social media and medicine.

I'm not very good at large meetings; big groups are difficult for me to navigate and it's unpleasant to be faced with hundreds of people who all seem to know each other really well and are all having a fabulous time.

But, thanks to Twitter, I did know lots of people, and I found them, and they were just as interesting and kind as their interactions online had suggested. And, unlike Baroness Greenfield's vision, which suggests social media isolates and dehumanises us, Twitter had made introductions and enabled me to meet people in a way that was quite wonderful.

The real dehumanising force

Back in our surgeries, we are harried by the pressure to fill in PHQ-9s – even though there is no evidence for us to use them in the way we are pushed to – and asked by secretaries to fill in new referral forms – even though we may just have written a very long and detailed referral on an ordinary piece of paper that has somehow been judged not acceptable. Then we find our partners have been pressed into house calls and prescription signing, and we are back in surgery again.

It is in the NHS that human interaction is being squeezed out. There has not been much time – any time – to discuss the latest in whooping cough vaccines for pregnant women, or the headline that tomatoes can prevent dementia, or the advert in the *Guardian* for a director of intelligence and a director of insight for commisssioning.

The NHS is being slowly dissolved and we are wasting time ticking boxes for contract points, many of which we know are pointless.

On Twitter there are GPs who are passionate about the NHS, about being GPs, about stopping doing things that don't work and doing things that do.

The RCGP conference allowed me to meet some of these doctors, who I knew in many ways already.

Social media allows us to interact with leaders, to influence and direct them; it makes politicians and journalists more accountable.

It also allows GPs to talk quickly and easily; doctors on Twitter are able to inspire, educate and support each other. We – us GPs – are our own enormous resouce.

As for what Baroness Greenfield had to say? I couldn't disagree more; social media has the power to create a morality and humanness in healthcare that the health act now threatens to dissolve.

So, if you want something for your PDP next year that involves learning from your peers, I'd make a suggestion. Go on, let out a tweet.

Dr Margaret McCartney is a GP in Glasgow. You can follow her on Twitter @mgtmccartney

Investing in primary care is the key to commissioning success

CCGs can redesign care pathways, but they are powerless to tackle the area most critical to a joined-up health service, writes **Dr Sam Barrell**

During a recent visit to South Devon and Torbay the now-former health secretary, Andrew Lansley, was clear. 'GPs have been asking for this for many years,' he said. 'It's now over to you.'

Mr Lansley was right. Both GP fundholding and practice-based commissioning were early – and somewhat clumsy – attempts at trying to achieve greater clinical involvement.

We have tinkered before, but we have never had this level of responsibility.

Things are different now and, 10 years on from practice-based commissioning, GPs are in the ascendant.

Whatever your view on the reforms (and the pragmatist in me says you usually have to take the rough with the smooth to achieve change), I welcome the opportunities Messrs Lansley and Hunt are giving to GPs like me. It is, I think, undeniable that we will have real influence over how services are delivered in our acute and community hospitals and clinics, making changes that really affect patient outcomes.

But there remains, for me, a lingering question. We may control the vast majority of the NHS budget, but do we have all the levers to achieve the change we want to see locally?

For me, patient experience is the key. To make this a reality we need to see the system as a whole and reduce the gaps between organisations. There is a gap that we cannot bridge at present, though, and that new 'no man's land' is in primary care.

We know that primary care provision has always had a softer focus in the NHS. Only a few weeks ago, in the pages of Pulse, we saw speculation that LES funding could be about to fall further.

While it may not be LES funding that is the answer, there needs to be some system of investment to encourage GP providers to initiate or improve services. Personal influence may not be enough and, just as we use CQUIN payments for acute providers, other levers are needed.

Back in the days of practice-based commissioning, many GPs were genuinely enthused about innovation, backing schemes that even today we have failed to roll out across the NHS.

But, many failed business cases later, enthusiasm turned to gloom as colleagues speculated that the underlying problem was that it was safer, politically, to give money to NHS-run hospitals rather than use it, in tabloid parlance, 'to line GPs' pockets'.

A whole-system approach

It is not popular to invest public money in primary care and this has resulted in the system evolving 'organically' – or, if you listen to the critics, with no real planning to speak of. It may meet patients' immediate needs, but such an approach will never allow the preventive or self-care agenda to be truly explored. Neither will it allow us to deal adequately with complex elderly patients so that they avoid trips to A&E and unplanned admissions. Add to this the need for more generalists in the NHS and it seems the pressure on GPs is likely to increase – not fall away.

If we don't take a whole-system approach, primary care is in danger of being left behind in the race to join up services. There has been little work on mapping capacity in primary care, for instance, and over the years there has been a patchy but significant shift of work from secondary care. During this time there has been no overall primary care service redesign and no new contracting arrangements.

If primary care is to work well, there needs to be capacity for training, time to reflect to allow innovation and a culture of sharing learning. Of course, all this takes time; but it also takes will and authority.

While we in the CCG have the will and the time (although at times I wonder if I should move into the office), we don't have the authority. Primary care commissioning rests with the NHS Commissioning Board local area team (LAT). This is where the role of the LAT director is key.

I understand the arguments around the need to separate primary care commissioning from the other forms of commissioning. But I really hope that our LAT director is someone who understands the dynamic I have spoken of above.

My great fear, and one that I know is shared by many colleagues up and down the country, is the great 'what if?'. What if the LAT director doesn't get the relationship between primary care and the rest of the system? What if they see their task as only to monitor performance? What then?

Unless LATs grasp the opportunity to look at the whole system, including primary care, we may have to accept that our vision of seamless care will not be truly achieved.

We can make real changes to care pathways, community hospitals and work closely with our social care colleagues to join up services.

But, unless CCGs and LATs are as one in their approach, we may be missing a trick. Are we really all in this together?

Dr Sam Barrell is clinical accountable officer for South Devon and Torbay CCG and a GP in Brixham

Why I quit my partnership to become a locum

Having been a partner in a busy town practice for eight years, Dr Libby Hodges opted to become a locum four years ago – and hasn't looked back since

The constant pressure of a demanding patient population combined with office politics and problems with staff tipped me into the stress stratosphere early on in my career. Added to this, I had a desire for more variety in my career. I wanted to teach and train, and also have time for a life outside medicine, but the rigidity of the system I worked in made it difficult to pursue these interests...

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NICE admission on guidelines is overdue

LETTER OF THE WEEK

From Dr Ted Willis
Brigg, Lincolnshire

NICE chair Sir Michael Rawlins writes that the institute's guidelines are only 'advisory recommendations' after all ('NICE guidelines are crucial – but they are not compulsory', pulsetoday.co.uk/comment).

Having been browbeaten and threatened by our PCT, and having had to submit pleading letters to funding panels in the usually vain hope that patients might have basic simple surgery for their facial blemishes and varicose veins, that is truly welcome news.

But what next? PCTs have built up a whole structure of policies based on the foundation that what NICE says is law. But Sir Michael says the guidelines are not suitable for that purpose.

Is this article going to be sent to all the PCT bosses (sorry, chief executive officers and chief operating officers)? Are they going to take any notice? Will the funding panels be abolished – saving lots of money for patient care? Probably not, unless turkeys start voting for Christmas.

It's a start, so thanks – but what a pity NICE did not make this clearer before.

Sir Michael Rawlins: NICE guidelines are 'advisory' rather than mandatory

BMA campaign plan fraught with pitfalls

From Dr Janette Lockhart
Retired GP, Ashton-under-Lyne, Greater Manchester

The BMA is 'considering' launching a campaign to enable patients to opt out from the private sector – I suspect that is as far as it will go ('BMA debates plan to lead mass patient opt-out from privately provided NHS care', pulsetoday.co.uk/news). As many have pointed out, it would be fraught with complications: legal, moral and practical.

I doubt there would be enough patients willing to reduce their options. Patients are understandably inclined to think of their own situation rather than take a political stance. After all, they are seeking medical help because they have a problem that needs sorting – and that is rightly what will guide their thinking when it comes to the crunch. I also think it would be unfair if patients felt, however slightly, that they were letting the doctor or the BMA down by choosing a private provider.

Dr Coral Jones has had 20 opt-out cards returned by patients – out of how many in her practice? It doesn't sound like a lot and, furthermore, will they stick to it when they actually need a referral?

● **From Dr Josef Kurlacose**
Moneymore, Northern Ireland
via pulsetoday.co.uk

We have to be careful. The NHS is wonderful most of the time and you won't go bankrupt if you fall terribly ill, as you can in the US. However, the Department of Health can and will reduce pay and pensions. At what point will doctors say enough is enough and leave?

We don't need to fear private medical care. We will do better than the current £45 per patient profit per year. And if we don't – at least we will get what we deserve in the private market. I think patients and the DH get good value for money, but maybe I am wrong and it would be better for all to go private.

It's a democracy – let the people decide what is cheaper for them.

● **From Dr Paul Joshi**
Tamworth, Staffordshire
via pulsetoday.co.uk

The campaign sounds good in theory, but if you read the *Daily Mail* people want MORE private sector input and choice, not less. The *Daily Mail* will see it as BMA members trying to protect their turf.

Many – if not most – out-of-hours providers are private companies. Does that mean a BMA representative will see patients out of hours if they fall ill? Just because you and I think publicly funded healthcare is best doesn't mean it actually is.

To all the well-meaning BMA members: this will be seen as a far worse plug for ourselves than the fizzled-out strike on pensions.

But the NHS is already fragmented

From Dr Paul Charlson
Brough, East Yorkshire

The BMA and other professional bodies are against privatisation of the NHS. And yet GPs are themselves private businesses.

If a group of physiotherapists band together to provide an NHS musculoskeletal service, is that privatisation? What about a charity providing a patient service funded by a PCT to provide alcohol misuse services?

I suspect these would not be considered 'privatisation' by most people, yet there is little difference between them and a large plc employing GPs, physiotherapists or counsellors to provide the same services.

I also wonder whether plcs will really feature as providers in the future. Many are already pulling out or handing back services because they are unviable. The profit margins are too small.

I also hear of 'fear of fragmentation of the NHS' – as if the NHS is not already fragmented. When GPs understandably opted out of providing 24-hour cover and hospital doctors were forced to at least nearly adhere to the Working Time Directive, the NHS became truly fragmented.

Different services working together to create a seamless patient pathway is achievable without a single employer. What it needs is good commissioning, good communication and someone to help the patient navigate.

Patients deserve choice and this choice can actually make people raise their game. We should ensure that our CCGs commission joined-up services using competition where it is needed and stop worrying about who provides the service as long as it is good.

Then again, we should never let a good idea get in the way of ideological dogma.

A chance to send a real message

From Dr Marie-Louise Irvine
BMA Council member
Lewisham, south London

The BMA has taken up this issue because the annual representative meeting voted for a campaign against the Health and Social Care Act. BMA members have made it clear that they want the BMA to act to help limit the damaging effects of the act. This includes the accelerating takeover of NHS services by private corporations.

Many patients are concerned about the degree to which health services are being outsourced to private companies, which cherry-pick the profitable services and undermine the local NHS. Patients have a right to know what is going on and express a view about where they are referred, in a way that helps to keep local NHS services, such as our local hospitals, secure.

Of course, if there is no alternative except a private provider, or the patient wishes a private referral, or if it is in their best interests to go to a private provider, that

would still happen. But where possible, and where it would not be detrimental to care, the patient pledge card would allow patients to express a preference for NHS-provided services. This card is to facilitate dialogue and to empower patients, as well as send a message up the line to CCGs about what patients think about this issue.

Why the presumption of GP guilt?

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

It is sad that the tone of official comment from National Clinical Assessment Service on the drop in issues in general practice is again presumptive of guilt and may be summarised as 'they are happening but we are not finding them' ('NCAS reports sharp drop in GP suspensions', pulsetoday.co.uk/news).

I am aware of a difference between NHS Sefton, which has had 100% GP appraisal uptake for many years, and an adjacent PCT that has never attained 100% uptake, in terms of number of performers under investigation.

It seems there are fewer reports where more comprehensive appraisal coverage has occurred.

I hope the trend shows us the profession has 'worked through the backlog' and that the time and effort expended on appraisal and revalidation is being rewarded with higher professional standards of practice.

Suspending fewer GPs saves PCTs cash

From Dr Julius Parker
Slough, Berkshire
via pulsetoday.co.uk

Sadly there may be another reason for the fall in GP suspensions reported by NCAS. If GPs are suspended by the GMC, PCTs have perhaps started to realise that there is a major financial disincentive to also suspend them, since they then become eligible for financial support from the PCT. Suspension by the GMC does not confer that eligibility, but from the PCT point of view the GP is just as unable to practise and the PCT may decide to take no further action.

Revalidation resources better spent on CME

From Dr Edoardo Cervoni
Southport, Merseyside

I question the opinion expressed by the RCGP's Professor Nigel Sparrow that revalidation should be a process that GPs 'enjoy' ('GPs should enjoy revalidation, says RCGP leader', pulsetoday.co.uk/news).

Perhaps it was thought revalidation should be introduced to rebuild the public's trust in doctors, rather than because it was truly felt our profession really needed revalidation.

I suspect, given the political climate, it was much easier jumping on the revalidation bus than objecting to it on the basis of its questionable benefits. Revalidation is a costly exercise not able to bring, per se, any improvement to our professionalism. If anything, it will give us negative feedback and outcomes.

I would welcome the money and time that is being invested in revalidation being redirected towards CME instead. Revalidation is the fruit of negativity rather than an attempt to respond to our educational and professional development needs.

Screening for hearing loss worth a try

From Professor Adrian Davis
Director, NHS Newborn Hearing Screening Programme
via pulsetoday.co.uk

There are a lot of people who would benefit from support and advice for their hearing loss and many who want to know how to communicate with someone who has hearing loss ('Screening all older adults for hearing loss more cost-effective than GP referral scheme' pulsetoday.co.uk/news).

So screening or targeted screening seems to be a good idea. If hearing aids are part of that support then compliance is better than for most long-term conditions.

The earlier advice is sought, the less the burden of hearing loss in terms of isolation and depression. So it seems sensible to try.

GPs need to pull a rabbit out of the hat

From Dr Jan Yazici
Stockport, Greater Manchester

It has been fascinating reading your letters pages, and I have noticed a few key themes from GP grassroots. Those interested in training have voiced their opinion on longer training periods and longer consultation times. I do believe these are a nice idea but are they evidence based? What is the driver for change?

How should we deal with an ever-increasing demand for consultations? Can we provide longer consultations to our patients, and who will be the lucky few to get them? Will it be fair? Will we see a year-on-year increase in complaints at the GMC?

Sure, our patients are expecting more from us as hospitals shift more work into primary care and our helpful Government wants GPs to manage the NHS.

Does our workload ease elsewhere to allow for this? No, we are now told that appraisal isn't enough, that, as Dr David Church tells us, we shouldn't 'run away from revalidation'.

Is there some hope on the horizon of more GPs entering the system?

Unfortunately not. Only another looming shortage of GPs because our training needs are outweighed by the predicted loss through retirement.

If ever there was a time to pull the rabbit out of the hat, it would be now.

Have your say

PulseToday has been upgraded, and as part of that we've improved our comment threads and our forum. As well as sporting a new style, the forum now allows you to set up your own profile and add your photo. You can also save stories and threads you're following as part of your account. Log on to the website to try it out.

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Pulse Clinical

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Resource of the week After reading the first in our new Tricky Ten Minutes series, go to pulsetoday.co.uk/tools-and-resources to download a patient information leaflet from NICE on diet in IBS

KEY QUESTIONS

Erectile dysfunction

Sexual medicine consultant Dr Geoff Hackett answers GP Dr Mandy Fry's questions on possible causes, investigations and who to treat

Patients with cardiovascular and neurological co-morbidities are likely to require drug therapy

1 How common is erectile dysfunction? Is there an age at which you would no longer consider treatment appropriate, or does it simply depend on how much it is affecting the individual?

Prevalence rates vary depending on whether ED is volunteered by the patient or whether validated questionnaires are used, which is why increasing prevalence rates have been quoted in recent years. ED is age related, and occurs in 40% of men over 40, increasing to 70% of men over 70. ED is strongly related to cardiovascular disease; there is 75% prevalence in men with type 2 diabetes, 66% in hypertension, 60% in dyslipidaemia and 70% in men treated for depression.[1]

ED – even if it is mild – can cause relationship and family break-up and diminished quality of life. Age is not a contraindication for treatment. Studies show that couples expect to remain sexually active into their 80s and many widowed men in their 70s see normal erections as being essential to a new relationship.

2 Which drugs most commonly cause ED? How quickly should ED improve upon stopping the suspected drug?

Many commonly-used drugs cause ED, most notably antihypertensives[2] – particularly thiazides and ß-blockers – usually by increasing angiotensin levels, causing vasoconstriction and diminishing nitric oxide release in the vascular endothelium. ARBs (but not ACE inhibitors) improve ED. ARBs can be particularly useful – and cost-effective as they are now off patent – in men with cardiovascular disease who also have ED of recent onset, or those who do not have advanced and irreversible atherosclerosis.

SSRIs affect desire, erection, orgasm and ejaculation, and these sexual side-effects are a major cause of cessation of therapy. The 5-alpha reductase inhibitors, finasteride and dutasteride, are associated with low desire, reduced ejaculation and ED in men with benign prostatic hyperplasia or lower urinary tract symptoms – and these men are already at high risk of ED.[1]

Men taking long-term opiate analgesics and those taking anticonvulsants, are at high risk of hypogonadism and ED.

Symptoms often continue for many months after the offending drug is stopped.[1] But stopping the associated medication can result in resolution if there is a clear temporal relationship and short duration of symptoms.

3 Is there still a role for non-drug treatments for ED? In what circumstances would you consider using them?

Patients with cardiovascular and neurological co-morbidities are likely to require drug therapy,[1] but there is still a role for non-drug treatments in other groups. Men without significant co-morbidities – especially if they still have morning erections and erections with masturbation – are candidates for sex therapy. Sex therapists often prefer to combine traditional approaches with oral therapy, particularly in single men.

Vacuum devices are also classified as first-line therapy[1] and may appeal to some men who are willing to persevere with this method and want to avoid medication. Recently studies have reported that multiple sessions of extracorporeal shock-wave therapy are effective in mild to moderately severe ED[3], but equipment is only available in a few centres and is expensive so is unlikely to be available at NHS cost.

4 NICE recommends that we should ask men with type 2 diabetes about ED at their annual review. Are there any other groups of patients we should consider screening?

Patients with cardiovascular disease should be targeted for questions about ED.[4] You should evaluate risk factors and address lifestyle issues. Under proposed changes to the QOF for 2013–14, you should also ask about ED in diabetes. Patients with depression, BPH, LUTS, and those taking long-term analgesics and anticoagulants

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should also be considered.[1]

Asking about ED is part of routine health screening of men in the US and most European healthcare systems. The average UK patient has had ED for at least three years before seeking medical help and currently only 10-15% of patients who express a wish to be treated are actually receiving treatment.[1] The longer the duration of ED, the lower the response rate to treatment.

Reluctance by healthcare professionals to include ED in over-40s patient medicals is probably due to a combination of embarrassment and a fear of potentially expensive medication being required, but studies suggest that men welcome the opportunity to discuss ED with their doctor.[2]

5 How close is the relationship between ED and vascular disease? Does this depend on age, and how should this association affect our assessment of the patient?

ED is an early marker of future cardiac events[3] - it represents endothelial dysfunction in the smaller penile arteries (6mm diameter) occurring three to five years before involvement of coronary arteries (10mm). The relationship is most marked in younger men (35-45) where the risk of a coronary event is nearly 50 times greater in men with ED than those who do not have ED.[4] Younger men with ED often have lipid-rich unstable plaques that may be missed by exercise testing and calcium score. Cardiologists are well aware of the importance of assessing such high-risk men, and will welcome early referral after appropriate baseline assessment.

ED in older men is still a predictor of cardiac events, but the relationship is weaker with advancing age.[4] In men with type 2 diabetes and no coronary heart disease, ED predicts cardiac events more reliably than microalbuminuria, hypertension, HbA$_1$c and lipids.[4]

A recent study recommended that ED detection was an excellent opportunity for early intervention and CHD prevention.[5] And some publications have suggested that the development of ED is equivalent to a 50% increase in QRisk score, requiring aggressive cardiovascular risk reduction.[4] Lifestyle modification has been shown to produce modest improvement in ED.[4]

6 What investigations should we do in men presenting with ED? Should these be done in everyone or can we exclude an organic cause in men who still have spontaneous early morning erections?

Guidelines from the British Society for Sexual Medicine[1] and European Association of Urology[6] recommend measuring fasting glucose, HbA$_1$c, lipid profile and morning total testosterone in all patients presenting with ED.

It is usually not helpful to try to divide cases into 'organic' and 'psychogenic' as overlap is almost inevitable. But loss of morning erections, especially with loss of libido, strongly suggests low testosterone and organic pathology. The management of associated cardiovascular risk factors is as important as managing the symptoms of ED[7] so these risk factors must be identified.

Current guidelines recognise the importance of diagnosing and treating low testosterone in men with ED, and in men without established cardiovascular disease, treating low testosterone may be all that's required.[1,6,8] In men with co-morbid cardiovascular disease, phosphodiesterase-5 inhibitors (PDE5Is) are likely to be significantly more effective once low testosterone is corrected. The Endocrine Society guideline[8] recommends that men with multiple total testosterone of 8nmol/l are candidates for testosterone replacement and those with levels of 8-12nmol/l should be considered for therapeutic trials of testosterone for six months or more on the basis of severe symptoms. The guidelines also say that there is no evidence that testosterone therapy causes or exacerbates prostate cancer.[8,9]

7 What is the role of sublingual apomorphine in the treatment of ED? How does it work?

Sublingual apomorphine is no longer available for treating ED in the UK. Trials had shown a modest improvement in men with mild ED but clinical use proved disappointing in men with moderate and severe ED. The mode of action was by dopamine (mainly D2 agonism) central stimulation in the erectile centre of brain stem.[1]

Professor Geoff Hackett is a consultant in sexual medicine at Good Hope Hospital, Birmingham

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

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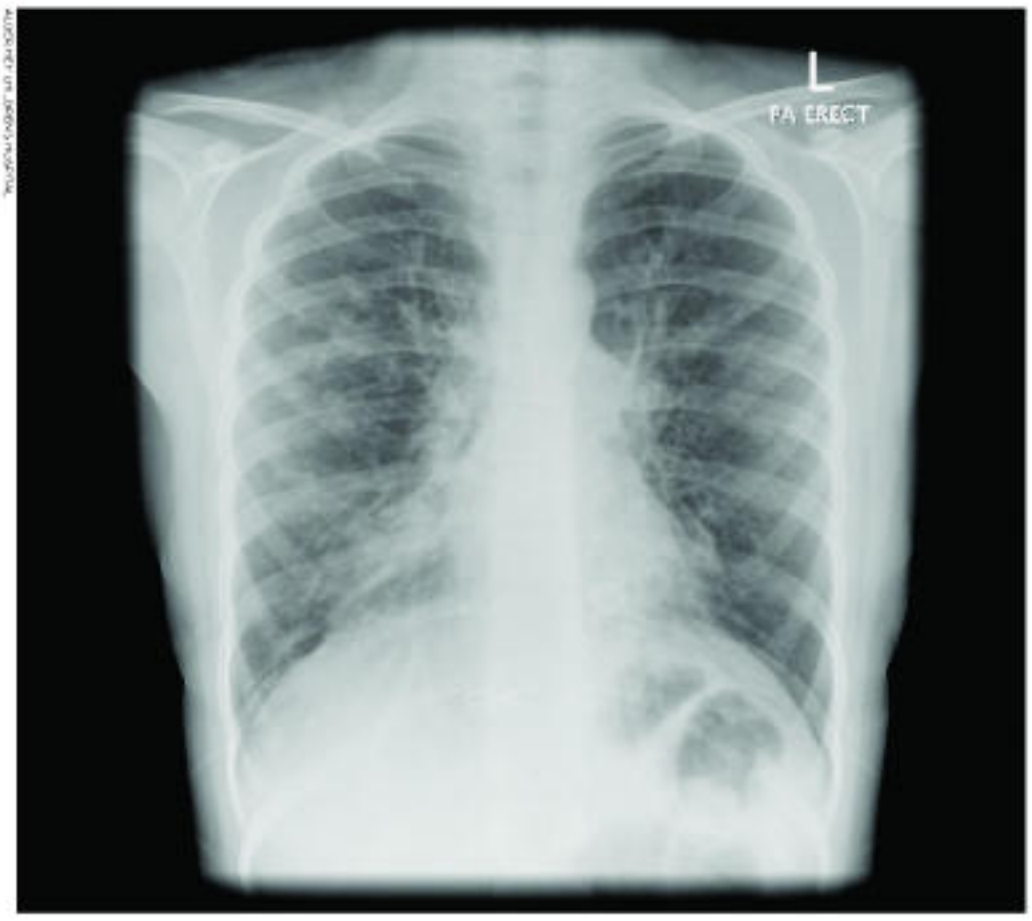
View the online version of this article for answers to four extra questions:
- How should GPs manage patients with depression and ED?
- What are the differences between PDE5Is?
- How can we avoid drug interactions?
- Can ginseng improve erectile function?



PAEDIATRIC CLINIC

Cystic fibrosis

Dr Sarah Mayell, consultant in paediatric respiratory medicine, continues our series on uncommon but serious presentations with a case of cystic fibrosis

CASE

An 11-year-old girl presents to her GP with a long history of cough, which is productive of green sputum. She is breathless on exertion. On questioning, her parents report that the cough has been present since early infancy. When she was five years old, she was diagnosed with asthma but had a poor response to treatment. She has received several courses of antibiotics in primary care but these only give temporary improvement. She also has a poor appetite and frequent abdominal pain.

She is referred to the respiratory paediatric clinic. Her height and weight are both on the 25th centile. She has early clubbing, a wet cough and scattered bilateral crackles. Pulmonary function testing shows FEV_1 40% and FVC 54% of predicted values. Systemic examination is otherwise unremarkable. Chest radiograph shows bilateral bronchial wall thickening and dilatation with multiple areas of atelectasis. A sweat test confirms cystic fibrosis. She is pancreatic sufficient with no fat on faecal microscopy and normal faecal elastase.

She has four siblings, and one is subsequently diagnosed with cystic fibrosis. Her other siblings have normal sweat tests and are offered genetic counselling on their potential carrier status.

The problem

Cystic fibrosis is one of the most common inherited diseases in the UK, and one in 25 of the UK population is a carrier.

Decreased chloride secretion results in increased viscosity of mucus and sticky secretions in the respiratory tract, gastrointestinal tract and pancreas. The spectrum of disease severity varies widely – median predicted survival is currently about 41 years.[1]

Newborn screening for cystic fibrosis in the UK has been available since 2007. But this will not detect all cases because:

- older children and adults may not have been screened
- screening only detects 96% of cases
- screening may be declined.

Features

Meconium ileus is a presenting feature in 10–15% of newborns with cystic fibrosis.

Without newborn screening, presenting features include faltering growth, recurrent respiratory tract infections, rectal prolapse, nasal polyps and infertility.

Diagnosis

Screening protocols use measurement of immunoreactive trypsinogen and DNA analysis. Diagnosis is confirmed by a sweat test, measuring sweat chloride or conductance, in conjunction with genetic testing. The median age of diagnosis without screening is four months, but the range is from birth to over 60 years.[2] Antenatal diagnosis is possible.

Management

- Regular review by a multidisciplinary cystic fibrosis team, including a physiotherapist, dietician, physician, nurse specialist, psychologist and social worker.
- Prevention of cross-infection between patients.
- Management of pancreatic insufficiency with pancreatic enzyme and fat-soluble vitamin supplementation, managing the high energy demands of chronic infection and inflammation, and sodium chloride supplementation.
- Physiotherapy, including airway clearance and exercise.
- Antibiotics – prophylactic and in response to pulmonary exacerbations (nebulised, oral and intravenous).
- Seasonal influenza vaccination in addition to the routine immunisation schedule.
- Mucolytics – nebulised DNase and hypertonic saline.
- Management of complications, such as allergic bronchopulmonary aspergillosis, cystic fibrosis-related diabetes, cystic fibrosis-related liver disease, bone disease and infertility.
- Management of advanced disease with long-term oxygen therapy, non-invasive ventilation and possibly lung transplantation.

Dr Sarah Mayell is a consultant in paediatric respiratory medicine at Alder Hey Children's Hospital, Liverpool

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Further reading

- Cystic Fibrosis Trust. cftrust.org.uk
- UK Newborn Screening Programme Centre newbornbloodspot.screening.nhs.uk

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

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Still to come in this series:
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- Juvenile arthritis

NEW SERIES TRICKY TEN MINUTES

What diet should I follow for my IBS?

Our new series offers advice on handling tricky patient questions – backed up with a leaflet to take away. Dr Peter Irving starts with IBS

Functional gut disorders – of which irritable bowel syndrome (IBS) is the best known – affect 10-20% of the population and are a common presentation in primary care. Diagnosis is usually made on the basis of the history – long-standing symptoms including change in bowel habit associated with abdominal pain, in the absence of alarm symptoms. The term IBS is often also used to describe other functional gut disorders, such as functional bloating, functional diarrhoea or functional abdominal pain, and while some argue that this use is incorrect, it is generally accepted within the medical community.

Reviewing the diagnosis

Patients with IBS often seek advice on diet and it's important to give evidence-based advice. But it's also an opportunity to review the diagnosis and wider management.

- **Is the original diagnosis of IBS correct?** A brief consideration of who made the diagnosis, and how, is useful. It is important that other chronic gastrointestinal diagnoses such as inflammatory bowel disease or coeliac disease have been excluded. Coeliac serology – while the patient is eating gluten – should have been performed and blood tests to look for inflammation (such as FBC and CRP) should have been checked. Where available, faecal calprotectin assessment is a very useful marker of organic diarrhoea.
- **Is the diagnosis still IBS?** Infections or the development of new conditions should always be considered. Ask about alarm symptoms such as weight loss and rectal bleeding.
- **Why has the patient presented now?** With chronic conditions there is often a trigger for presentation (or re-presentation) and it is important to identify this to address the patient's concerns. Any suggestion of new pathology should prompt referral to secondary care.

Tackling the question

Diagnosing functional gut disorders is often straightforward, but management can be challenging.

It is important to make a positive diagnosis and to explain this in a way that fits with the patient's beliefs of what is wrong with them. This is often time consuming, but is worthwhile in terms of successful management and in minimising future visits. Sometimes reassurance is all that is required, but many patients need some form of intervention. A variety of treatments are available for functional gut disorders. Again, choosing one that fits in with the patient's beliefs is a good predictor of success.

Diet is important in the management of functional gut disorders and given its safety, acceptability, tolerability and success it should be regarded as the first-line intervention in most patients with IBS. Indeed, most identify dietary triggers for their symptoms and will, quite sensibly, have tried cutting out or reducing specific foods – such as wheat and dairy.

NICE has produced a guideline for patients on dietary treatment for IBS, including easy-to-follow advice that is worth considering in all patients. Simple measures such as cutting down on meal size, and decreasing caffeine and alcohol intake can be very helpful. Similarly, avoiding lactose-containing foods can be highly effective in people with lactase deficiency. Go to pulsetoday.co.uk/tools-and-resources to download this leaflet.

A recent dietary intervention, the low-FODMAP diet (fermentable oligo-, di, monosaccharides and polyols) is even more effective than NICE guidance in patients with IBS.[1,2] This involves decreasing the intake of foods containing high levels of FODMAPs, for example, honey (fructose), wheat and artichokes (fructans) and stone fruit (sorbitol). Unlike many dietary interventions, it is supported by high-quality clinical trials, and response rates of up to 75% are consistently seen. Patients with bloating and diarrhoea respond particularly well to a low-FODMAP diet.

Although the low-FODMAP diet is relatively easy to follow, it is best administered by a dietician experienced in its use, because they will need to tailor it to the patient and develop a plan for reintroduction of excluded foods. This is time consuming, but evidence is emerging that group sessions can be used effectively to train patients in how to follow the diet. More than 100 dieticians in the UK are trained in administering the low-FODMAP diet.[3]

Patients often also request food allergy testing, but most dietary triggers in IBS are caused by intolerance rather than allergy.

If you suspect the patient has a true allergy, refer to an allergy specialist. Unfortunately, because of the confusion surrounding dietary triggers, a thriving market in over-the-counter testing for food allergies has developed. These tests vary in their validity, and even the best have limited scientific support for their methodology so their results are difficult to interpret.

Patient leaflet

You can find the NICE patient information leaflet on dietary treatment for IBS at pulsetoday.co.uk/tools-and-resources

▶ Now go to pulsetoday.co.uk/tools-and-resouces to download the NICE patient information leaflet

Dr Peter Irving is a consultant gastroenterologist specialising in inflammatory bowel disease, functional gut disorders and endoscopy at Guy's and St Thomas' Hospital, London, and The London Clinic

Dr Peter Irving is involved in an active research programme investigating the low-FODMAP diet. Some of the research is funded by profits made from the low-FODMAP course and from sale of the dietary resources provided to patients by dieticians.

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

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GUIDELINE UPDATE

Preventing diabetes

GP and hospital practitioner in diabetes Dr Chris McDonald discusses recent NICE guidance on identifying pre-diabetes

The guideline

NICE. Risk identification and interventions to prevent type 2 diabetes in adults at high risk: summary of NICE guidance PHG38. NICE August 2012.

Almost three million people in the UK have diabetes, and about 850,000 are undiagnosed. It is thought that many people with type 2 diabetes may have had the condition for nine to 12 years before diagnosis and many will already have macrovascular and microvascular complications.[1]

About 15% of adults have impaired glucose regulation – pre-diabetes – and an estimated 5–12% of them will develop type 2 diabetes each year.[2] Increasing evidence that treating pre-diabetes early and aggressively can dramatically reduce the risk of developing the disease led NICE to develop this guideline.[3]

The latest such evidence – published in *The Lancet* in June – compared lifestyle intervention, metformin or placebo in 1,990 patients with impaired glucose tolerance. Six years later those patients whose blood glucose levels had dropped to normal when tested at least three times in that period were up to 70% less likely to have diabetes than those on placebo, regardless of how that drop was achieved.[4]

This article summarises the recommendations from the NICE guidance which are of particular interest to GPs. But it also identifies the barriers to its implementation, which are significant.

Identifying high-risk patients

The guidance recommends a two-stage approach to those at highest risk of developing diabetes – the first based on risk factors and the second using HbA$_{1c}$ measurement, or a fasting blood glucose.

Stage 1

- GP practices should use a validated, computer-based risk-assessment tool to search their register for those at higher risk of type 2 diabetes between the ages of 40 and 69.
- These tools will also identify younger patients with risk factors such as ethnicity (South Asian, African-Caribbean, Chinese, or black African descent), being overweight or obese, or having a first-degree relative with type 2 diabetes. Three such tools are mentioned in the guidance:
  - the Cambridge diabetes risk score
  - Leicester practice risk score
  - QDiabetes.
- Opportunistic screening can be carried out in other settings – either using one of these tools or a validated patient questionnaire such as the Diabetes Risk Score assessment tool provided by Diabetes UK which can be accessed at pulsetoday.co.uk/tools-and-resources.

Anyone who is identified as being at higher risk should be advised to see their GP for a blood test.

There are significant barriers to implementing this guidance

Stage 2

- Those identified as having a higher risk score should be invited to the surgery to have their HbA$_{1c}$ or fasting plasma glucose (FPG) checked, although it's likely HbA$_{1c}$ will be the preferred choice so those values will be used here. Equivalent values for FPG testing are available in the guidance.
- Those HbA$_{1c}$ levels should then be used to reclassify these patients into three groups.

Classifying according to risk

Moderate risk

- Patients with a HbA1c of less than 42mmol/mol (6%) are classified as moderate risk.
- This group should be offered what NICE terms a brief intervention – a GP or practice nurse consultation to discuss the risks of developing diabetes and give advice on modifying risk. Support services such as weight-loss programmes should be offered.
- Their risk should be reassessed at least every three years.

High risk

- Those with a HbA1c of between 42 and 47mmol/mol (6-6.4%) are classified as high risk.
- They should be referred to an 'intensive lifestyle change programme' – exercise, weight loss and changes to their diet.
- Their progress should be monitored at least annually by checking HbA1c or FPG and BMI.

Possible type 2 diabetes

- Anyone with a HbA1c of 48mmol/mol (6.5%) or over should be further investigated for type 2 diabetes with either a second HbA1c, a fasting blood glucose or an oral glucose tolerance test.
- If a diagnosis is not confirmed, these patients should be managed as high risk.

Referring for intensive lifestyle programmes

- This is one of the most ambitious parts of the guidance, as the criteria for such programmes are strictly defined and currently beyond the scope of most practices.
- An intensive lifestyle programme should be offered to those at high risk to:
  - undertake a minimum of 150 minutes of moderate-intensity physical activity a week
  - reach and maintain a healthy BMI
  - Increase consumption of wholegrains, vegetables, and other foods high in dietary fibre
  - reduce the total amount of fat in their diet
  - eat less saturated fat.
- These programmes can be delivered to groups of 10–15 people meeting at least eight times over nine to 18 months.
- Participants should have at least 16 hours of contact time within a group, either on a one-to-one basis or sometimes as a group.
- Follow-up sessions should be offered at regular intervals (for example, every three months) for at least two years after the initial intervention period.
- Those with a BMI of 30 or more (27.5 or more if South Asian or Chinese) should be offered a structured weight-loss programme.

Metformin for those who do not respond to lifestyle change

- NICE has recommended standard-release metformin should be offered to people whose HbA1c or FPG has not improved if:
  - this has happened despite their participation in an intensive lifestyle-change programme, or
  - they are unable to participate in an intensive lifestyle-change programme.
- Advice on diet and physical activity plus support to achieve goals should continue.
- Start with a low dose (500mg once daily) and then increase gradually as tolerated, to a maximum 2,000mg daily.
- If the patient is intolerant of standard metformin, consider using a modified-release formulation.
- Prescribe metformin for six to 12 months initially. Monitor FPG or HbA1c at three-month intervals and stop if no effect is seen.
- Although the guidance makes no reference to it, this is not a licensed indication and GPs are simply advised to 'discuss with the person the potential benefits and limitations of taking metformin' – and of course we should record this in the notes.

The role of orlistat

- Orlistat should be considered in patients with a BMI of 28 or more as part of an overall plan for managing obesity.
- Review after 12 weeks and, if the patient has not lost at least 5% body weight, consider stopping.
- Remember adults with type 2 diabetes lose weight more slowly, and the same may be true of those with pre-diabetes.

Barriers to implementation

As stated earlier, this is a hugely ambitious public health programme that will need considerable service design and funding to be effective. Some concerns are:

- The lifestyle interventions recommended are not of the level currently offered by many practices – although NICE does include primary healthcare teams as a group that should be developing these services. Without significant funding this seems unlikely and the hope is these services will develop in the same way that NICE's recommendations on CBT led to the IAPT program.
- Diabetes risk assessment is already part of the NHS health check programme – as the guidance states – it will take 'clear and timely communication' to co-ordinate risk identification across different settings.
- The use of metformin outlined here is unlicensed and widespread, and so must be addressed by the regulatory authorities.
- There are significant gaps in the evidence including:
  - limited evidence on how diabetes prevention trials translate into UK practice.
  - how incentives – to either patient or provider – could increase effectiveness – whether a risk-assessment tool alone and/or a FPG or HbA1c is more effective in detecting prediabetes.

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

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TEN TOP TIPS

Substance misuse in the elderly

Psychiatrists Professor Ilana Crome and Dr Tony Rao offer their top tips on substance misuse in older people

1 Alcohol and prescription drugs are the most commonly misused substances in the elderly.

Some 10% of women and 20% of men aged 65 and over drink above recommended limits. The highest rates of alcohol-related deaths in the UK are in people aged 55–74.[1] Rates of prescription drug misuse – both intentional and inadvertent – are particularly high in older women.

Illicit drug use is uncommon in older people, but significant increases are being seen in the over-40 age group. As this cohort ages, an increase in the number of older people using illicit drugs is anticipated.

2 Don't dismiss the possibility of substance misuse because of a patient's age.

It is estimated that the number of older people needing treatment for substance misuse is likely to double in the next two decades.

In older people there may not be any informant. This, plus unwillingness by health professionals to ask about substance misuse, lack of training and misattributing substance misuse to physical disorders or cognitive impairment, means that substance misuse in older people is often overlooked.

3 Symptoms include sleep and appetite changes, self-neglect and agitation.

Symptoms of substance misuse in an older person that should trigger further screening include changes in appetite and sleep, liver function abnormalities, poor hygiene and self-neglect, unusual restlessness and agitation, unexplained nausea and vomiting, changes in energy levels and frequent, unexplained falls.[2]

4 Recommended alcohol limits may need to be lower in older people.

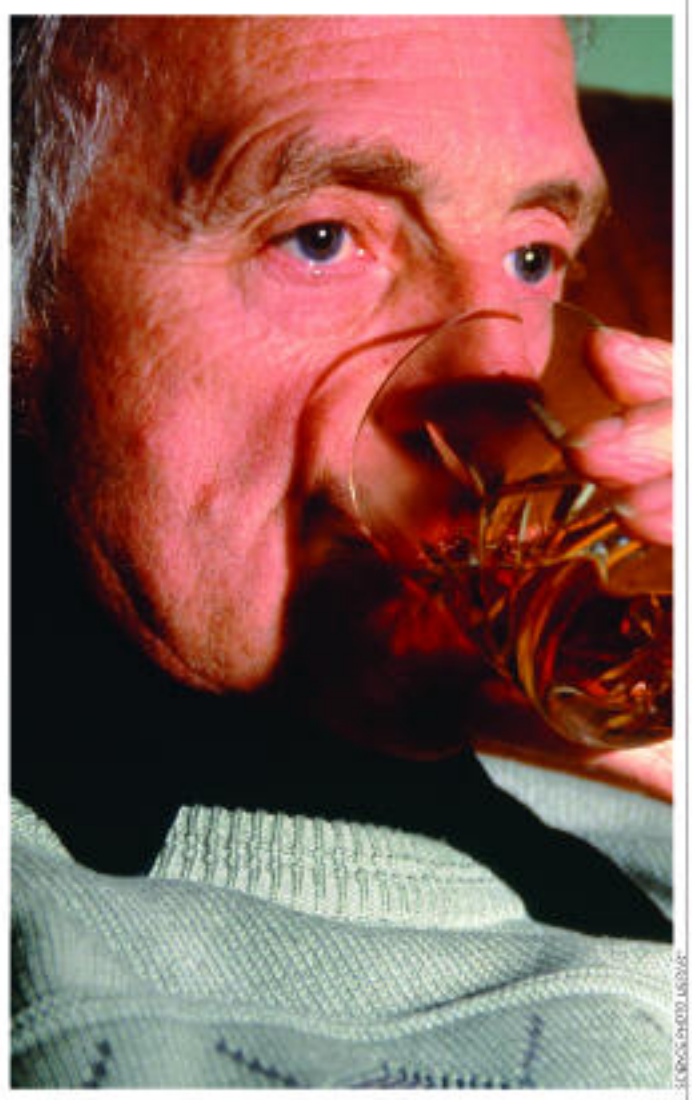
Lower recommended alcohol limits may be more appropriate for older patients with co-morbid physical and mental disorders and those taking anxiolytics, sedatives or hypnotics, or opiates.[3] Encourage patients who drink alcohol to drink slowly – sip not gulp – and to make sure they have eaten first.

Older people should be advised to consider carefully whether they should drink at all if they drive, swim or use machinery.

5 Be aware of different risk factors in older people.

Bereavement, retirement, boredom, loneliness and depression are strongly associated with alcohol misuse in older people, compared with younger people. Chronic pain and restriction in daily activities may also precipitate substance misuse.

Older people who misuse prescription and over-the-counter medication such as analgesics and anxiolytics or hypnotics are at high risk of subsequently misusing alcohol.



6 Opportunistic screening is invaluable.

All older patients presenting to primary care could be asked about substance use, so that you can do further screening if appropriate. In particular you should be vigilant in looking for significant changes in life circumstances, as this may help you to detect substance misuse at an early stage.

Initiating this conversation with the patient provides the chance for you to give credible, accessible and sensible messages to older people, their families and carers, who may feel stigmatised or be unaware of the consequences of substance use.

7 Alcohol misuse is commonly accompanied by other mental disorders.

In people with depression or anxiety, alcohol or other substances may be used as a way of self-medicating to reduce distress. Be alert for any evidence of self-harm, to prevent risk of suicide.

Alcohol misuse is known to be a contributory factor for dementia (alcohol-related dementia). This dementia differs from Korsakoff's syndrome in that it affects global cognitive function and there may also be some degree of reversibility after two months of abstinence.[4]

Patients with concomitant mental health problems should be considered for referral to old age psychiatry services, for specialist support.

8 Older people may experience more physical complications.

Older patients are at risk of adverse physical effects of substance misuse – even with relatively modest levels of consumption – because of the physiological changes of ageing. Presentation may be non-specific, and many systems may be affected, including cardiovascular, gastrointestinal, neurological and respiratory.

Treatment of co-existing conditions is very important. Older substance misusers with physical complications will need support from secondary care substance misuse and old age psychiatry services, with GP input into care planning.

9 Don't feel nihilistic – older patients can improve with treatment.

A common misconception is that older substance misusers are difficult to treat. But treatment produces similar – or in some instances, better – results compared with younger people. Many older people are receptive to support if it is offered and is accessible.

Older people should be offered psychological and pharmacological treatment. There is scope to offer brief interventions in primary care, as well as an appraisal of the patient's motivation. Referral pathways to addiction services need to be well defined.

10 Adjust treatment regimes in older people.

Pharmacological treatment for substance misuse should be initiated cautiously and monitored regularly in older people. Doses should be lower and more slowly titrated, and shorter-acting medications should be used. Remember to take account of other medications and any physical and mental co-morbidities.[5]

You should also have a lower threshold for inpatient admission for withdrawal in older people compared with younger patients.

Professor Ilana Crome is an honorary consultant addiction psychiatrist at South Staffordshire and Shropshire NHS Foundation Trust, and Emeritus Professor of addiction psychiatry at Keele University. Dr Tony Rao is a consultant old age psychiatrist and clinical academic group lead for dual diagnosis at South London and Maudsley NHS Foundation Trust, and visiting researcher at the Institute of Psychiatry, London

This article was produced in collaboration with the British Geriatrics Society. This topic will be covered at the British Geriatrics Society's Autumn Meeting, 28–30 November 2012, Harrogate. For more details and to register, go to bgsevents.org.

MORE ONLINE

After reading this article, go to pulsetoday.co.uk/tools-and-resources to download a copy of the Royal College of Psychiatrists' report – Our Invisible Addicts – which offers advice on risk factors, assessment and treatment of addiction in older people.

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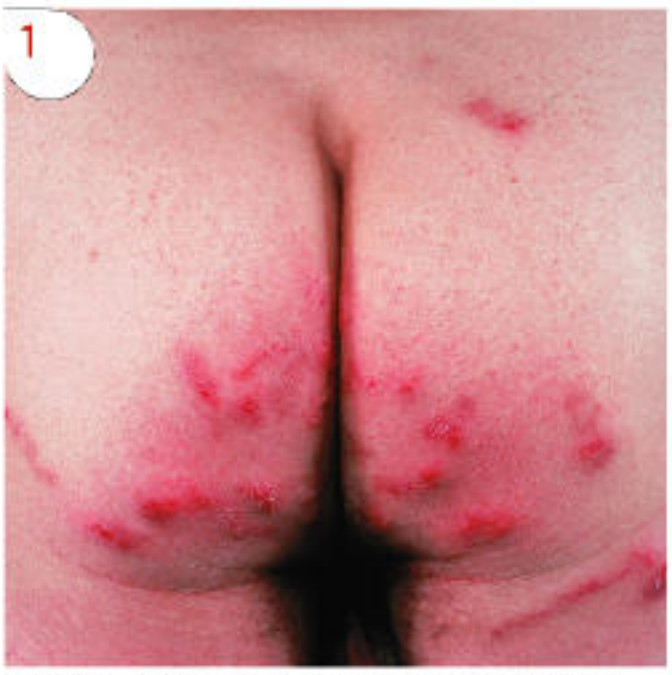
PICTURE QUIZ

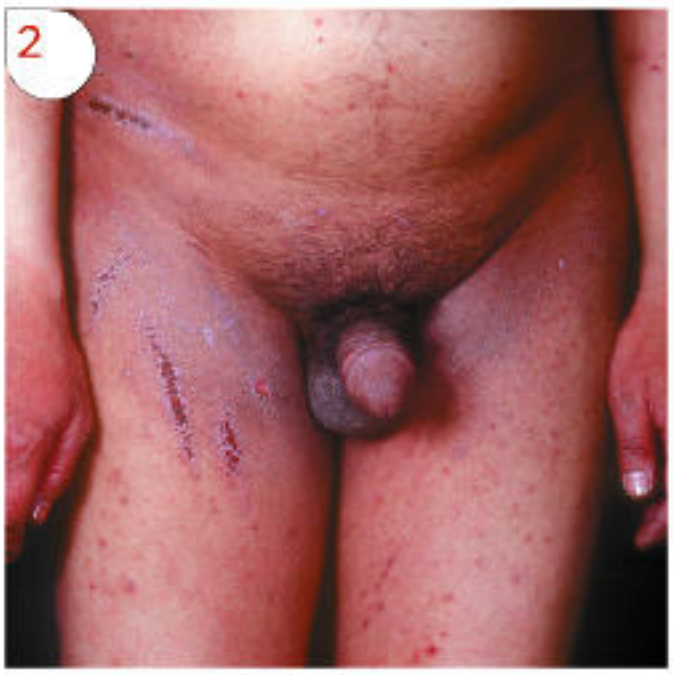
Invasions and infestations



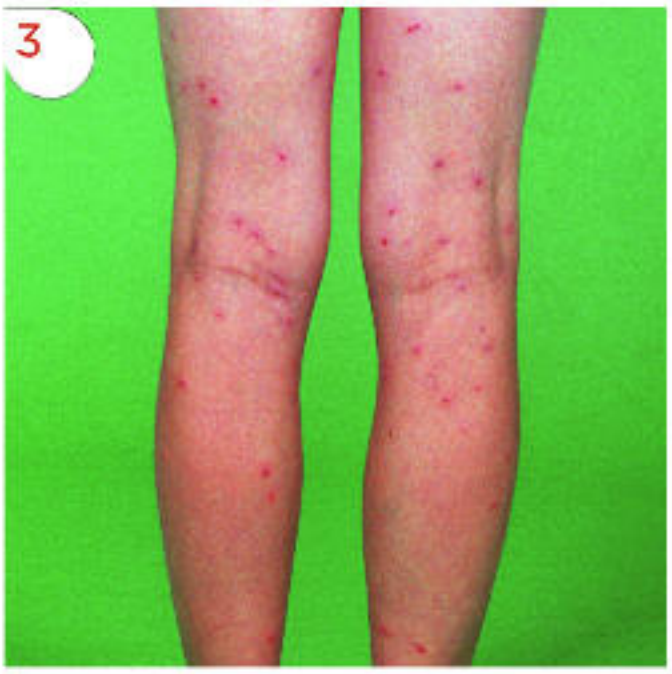
The main symptom in this case is recent onset of intense itching in the buttock area. Examination reveals a distinctive rash on the patient's buttocks. Further enquiry reveals that she is well, has no other dermatological problems, and has just returned from a holiday in the Caribbean.

Look at the pictures and case histories below – can you work out what is causing the lesions in these five patients? Answers are at the bottom of the page.

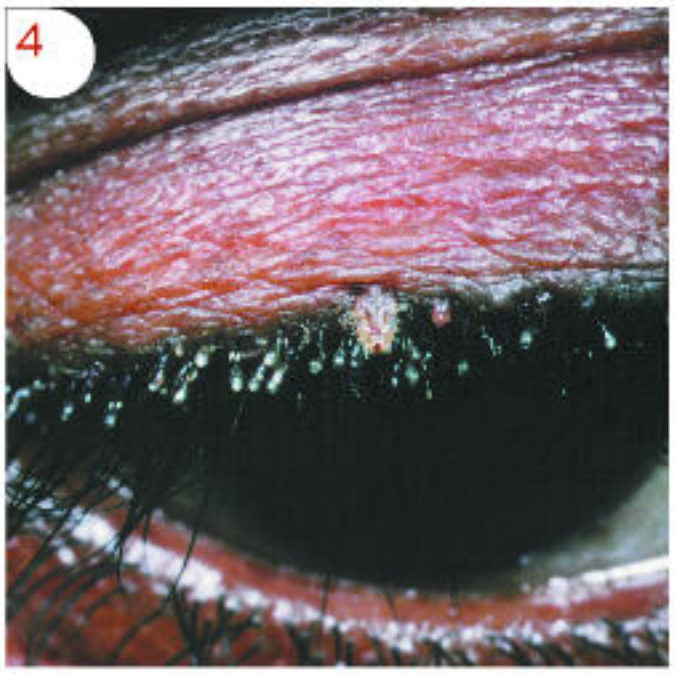
These cases are taken from Acute Adult Dermatology – A Colour Handbook by Daniel Creamer, Jonathan Barker and Francisco A. Kerdel. ISBN 9781840761023 (Manson Publishing); available from: www.mansonpublishing.com/colour_handbooks and all good booksellers priced £29.95



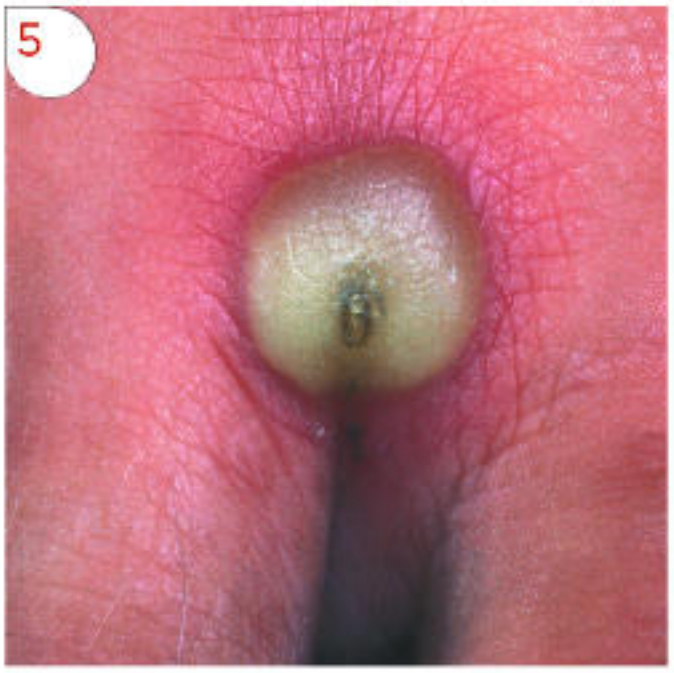
This homeless patient has multiple medical problems as he has been neglecting himself for some time. His main concern though is this itchy rash, which has been widespread on his body for some weeks.



This young girl has just returned from voluntary work in Africa. These itchy lesions appeared two days ago, within hours of her swimming in a lake. She is otherwise perfectly well.



This 40-year-old man presents with itching, soreness and excoriation in the pubic area, which has been present for a couple of weeks. While taking the history, you notice this odd lesion on his eyelid.



This teenage boy has just returned from a gap year in South America. A week or so ago he developed this itchy, pale lesion between his toes. Over the last few days, it has become painful, and looks secondarily infected.

ANSWERS

1 Cutaneous larva migrans

Cutaneous larva migrans results from invasion of the skin with the larvae of animal hookworms – most frequently larva of the dog hookworm, Ancylostoma braziliense, from faeces of infected dogs and cats. Human infection is usually acquired from walking, sitting, or lying on contaminated beaches in the Caribbean, Central and South America, Africa, South East Asia, and southeastern USA. Cutaneous larva migrans is found at sites of larva penetration, often the sole of the foot or the buttocks. The typical lesion is a solitary red, serpiginous track, which is very itchy. Vesicular areas may occur. The track extends gradually, progressing at a rate of a few millimetres per day. The diagnosis is usually made clinically immediate management is with cryotherapy to the larva (situated in front of the leading end of the track).

2 Body lice

Lice are wingless insects which are obligate human parasites. Body lice are transmitted via infested bedding or clothing. The patient complains of generalised pruritus, especially severe on the trunk. The patient is usually unkempt and shows signs of self-neglect. Examination reveals bites and excoriations usually most marked at the sites of clothing seams. If it is allowed to persist the eruption resembles chronic eczema. Inspection of the clothing will reveal eggs in the seams. Infested clothing and bedding must be washed at a high temperature to kill the lice. Management is with general emollient therapy, aqueous cream containing 1% menthol can be soothing. Steroid ointment, twice per day, is helpful and crotamiton cream is a useful antipruritic agent.

3 Swimmer's itch

Swimmer's itch, or cercarial dermatitis, is a form of cutaneous schistosomiasis – endemic in many countries of the tropics and subtropics. Swimmer's itch occurs within hours of contact with infected water. There is an itchy eruption on exposed sites. Red macules appear initially which develop into small pruritic papules. The lesions tend to persist for five to seven days before resolving spontaneously. The diagnosis is usually made clinically and immediate management is with steroid ointments twice per day.

4 Pubic lice

Pubic lice are spread by sexual contact. There is severe itching in the pubic area, nits will be visible on the pubic hair, and bites may be seen on the pubic skin. Blue-grey macules on the lower abdomen and thighs are also secondary to bites. Pubic lice can also be found on facial hair, including eyelashes – as seen in this case. You should screen for other sexually transmitted diseases (herpes, warts, syphilis, gonorrhoea, chlamydia, trichomoniasis, and HIV). Immediate management includes 5% permethrin cream or 0.5% malathion lotion (aqueous base) to all skin surfaces, including scalp and face, with attention to beard and eyebrows. Wash off after 12 hours and repeat after seven days. For infested eyelashes, use white soft paraffin ointment. The patient should launder clothing and bedding and avoid sexual contact until the infestation is eradicated.

5 Tungiasis

Tungiasis is a localised inflammation of the skin caused by infestation with the female sand-flea, which is common in Africa and Central and South America. The pregnant female flea burrows into the skin of the foot, develop and enlarge her abdomen to the size of a pea. The eggs are released over a two week period, after which the female flea dies. Common sites are between the toes, on the soles, or under the toenails. Initially all that may be visible is a small black dot which is intensely itchy. Later a pale nodule with a dark centre develops. Examination with a dermatoscope demonstrates pustules of the embedded female flea. You should remove the flea surgically via curettage; give oral antibiotics if secondary infection is present and a tetanus booster, if necessary.

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Writing a business plan to develop your premises

Securing funding for building new premises or expanding your surgery is always a challenge – and particularly so when times are tight. **Dr Mohamed Roshan** offers a guide

GETTING FUNDING FROM YOUR PCT'S premises approval panel for all but essential development is a challenge, particularly in these cash-strapped times. Having said that, a sound business case that demonstrates a significant improvement in service and a well thought-out options appraisal will go a long way.

1 Gather background information

Your practice demographics are vital in making your case. Information on health needs in the area, deprivation, causes of morbidity and mortality will help the panel assess the need for new premises. Fortunately there are many relatively easy sources for this information. Area health profiles are available for most parts of the country. They will pick up on issues such as a need for improved sexual health services, for instance if the local teenage pregnancy rate is high. Other important sources include public health information and indices of social deprivation. Balanced scorecards for your practice will inform you of pressing social and health issues.

If services are being moved into the practice, there's a case for extra rooms

While it is true that most GP premises need more room and could do with upgrading, the panel will be looking for substantive reasons to justify funding. Most PCTs, before CCGs took over under the shadow arrangements this year, had been carrying out surveys of GP premises and rating them under a number of headings.

Your business case is likely to be more favourably received if there were recognised deficiencies in your present premises. The assessment takes into account the surgery's physical condition, functional stability, service capacity, how it meets statutory requirements and even its energy performance. The case may already be clear from the premises survey if the existing premises are graded 'amber' or 'red'. If the assessment rating is 'green', the PCT does not perceive further development as a priority at this stage and your case will become harder to justify; but there have been instances where the initial assessment has overlooked existing flaws. It will be up to you to identify and highlight these so the rating can be amended.

2 Look for opportunities to support your CCG

One of the most important goals for the new CCG is being able to meet QIPP targets. If there are issues with your premises that impact on emergency admissions, outpatient referrals or A&E attendance, these should be highlighted. Now that services are being moved out of secondary care, clinics for ECGs, spirometry, some minor surgery or an enhanced diabetes service are considered more essential. If there is a need for more training practices in your area, this would be worth pursuing with the deanery as training requires more consulting rooms.

While it is partly true that highlighting areas of poor performance may demonstrate the need for better premises, it is also essential that you can demonstrate your commitment to clinical quality and safety. Improvement in performance, especially against targets discussed in your annual quality reviews, is important. The PCT panel will be impressed if there have been improvements in access and patient satisfaction and particularly in the provision of enhanced services that are nationally mandated. This commitment to improving services will help convince the panel that further premises improvements will lead to better clinical outcomes.

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3 Build a business plan

The five essential areas to include in the business plan are:

- a room plan
- an appraisal of your options
- a patient consultation
- a project plan
- a risk management plan.

Room plan

This is a complex area, whether you are proposing getting an extension or brand-new premises. A projected list size is essential. Just as important is an estimate of the workload generated by your patients. A good idea of consultation rates and demand is needed. An inner-city practice that can demonstrate a high demand will be able to make a case for more rooms more easily than one where demand is average.

A need for training practices may sway the PCT to agree to more rooms than are usually required for a certain list size. Do not forget to include rooms for other purposes such as therapists, health visitors and patient interviews.

Options appraisal

Apart from the financial details, this is the most important part of your business plan and you are well advised to work with local business developers and your PCT premises manager on this. If you are proposing brand-new premises, the panel will need to know you have considered alternatives such as refurbishing or extending your present site. You will also need to have considered building a new surgery on the existing land versus moving to a new site. In many cases it might be that the existing site does not allow for further extension, or there may be a new housing development nearby where the need for a new surgery can be demonstrated.

Patient consultation

Having a patient participation group (PPG) is extremely beneficial to your application. Ideally you will have worked with the group and come to an agreement on the need for better premises. Many practices find PPGs to be a necessary chore, but I have found them a great source of wisdom and support.

Many members are involved in local networks and provide excellent feedback on the need for better services and indeed examples of good work done in other disciplines that may be transferable to healthcare. Some have even directed the practice to sources of funding such as local grants.

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Project plan

No premises business case would be complete without projected milestones and timelines for the construction project. Having a starting date and including information on timings for planning approval, building regulations, land acquisition and lead times for your building contractors is essential – not just for your business case but for planning your services during the new build. A plan to 'decant' into temporary accommodation will also need to be considered.

Risk management plan

Most GPs are used to the idea of 'making things happen' and see risk as a necessary part of everyday life. Finding ways to mitigate such risk is usually instinctive and we are not used to writing risk-management plans.

The plan usually takes the form of a table with columns highlighting the risk, the likelihood of that event and the seriousness of the event should it occur. Another couple of columns will then be needed to show what you have already done or are planning to do to address this risk.

An example of a risk may be that local stakeholders may not be engaged. Actions might include organising stakeholder meetings with patient groups, local residents and councillors. Not doing this may prevent you obtaining planning permission.

4 Get third party support to make the financial case

Unless you are an expert in financial projections, this area will need external input from your financial manager, accountant and local developers. It is essential basic costs such as land acquisition, construction, VAT, consultant costs for architects, project management and planning applications are highlighted. Remember to include contingency funds.

Plans for additional income such as renting space to local pharmacies should be built in. These affect the notional rent payable and influence the loan-to-value ratio. Many lenders work on a multiple of notional rent to value premises and take the extra rental income as part of this. As the multiple is generally 14-16 times the rental value, the extra income influences greatly the amount loaned.

If you are working on a third-party developer scheme, it is likely that the financial work-up will be done for you. You will still need to work out the viability of your project. Fund lenders will need to see your practice accounts, projected profits and cash flow for at least three years from the time of the new build.

Most practices aim to increase their list when considering new premises. Any such projections, including increased staff costs, service charges and increase in practice income need to be detailed.

Above all, remain positive and accept that business case approval moves slowly. Have your plan looked at by trusted colleagues with dispassionate eyes. Remember that as hard as it is, the business case is only the beginning of the really complex work that will follow.

Dr Mohamed Roshan is chief executive of GP provider company LLR PCL, which provides business support to GPs in Leicester, and a GP in the city.

Ten tips for commissioning COPD care

Dr Noel Baxter offers a step-by-step guide to evidence-based commissioning for this respiratory condition

GP COMMISSIONERS are not the only health professionals managing care for people living with COPD, but they may find themselves in a unique position to improve outcomes for these patients. Challenges can also become opportunities to provide more patient-centred care, and create value in service provision for what is quite a common long-term condition. Around 900,000 people have diagnosed COPD in the UK and an estimated two million people have COPD that remains undiagnosed.[1]

The following 10 tips for commissioners aim to minimise the impact and cost of the disease. More detailed advice on commissioning COPD services is now available in the DH respiratory team's commissioning toolkit, including detailed specifications on four key areas of the COPD pathway and a costing tool.[2] (Download this online at pulsetoday.co.uk/commissioning.)

1 Know your mortality and budget spend

The Respiratory Atlas of Variation can help commissioners compare key performance areas for COPD and consider where improvements can be made.[3] Domain 1 of the NHS Outcomes Framework requires us to commission to reduce premature mortality from COPD. Using around 5% of your respiratory budget differently now can help reduce premature respiratory mortality in the long run.

Consider which interventions increase life expectancy in COPD: smoking cessation as treatment; long-term oxygen therapy for hypoxic patients; pulmonary rehabilitation completed after a hospital admission for exacerbation.

What is your respiratory medicine spending as a proportion of your total spend? Do you have a responsible respiratory prescribing policy? Avoid waste – for example by ensuring every pressurised measured-dose inhaler (pMDI) is prescribed with a spacer to ensure optimal efficacy and making sure your health professionals know when and how to prescribe inhalers.

2 Be aware of what patients need and how long care takes

Reviewing the length of hospital stay is important, as this may vary, and could in the long run affect what you spend. Not every case is the same, so understanding the causes of variance for COPD is also important – are there some distinct patient 'archetypes' who need particular services? These archetypes might include patients with severe mental illness, minority and ethnic groups with particularly high prevalence of smoking, and also workforces with a large prevalence of smokers or who are or have been exposed to harmful dust. There may be a case in your locality for looking beyond practice lists and hospital attenders to the local population for people with current undiagnosed COPD or future risk of it.

3 Monitor the prevalence of smoking among COPD and asthma patients

A 1% higher practice smoking prevalence leads to a 1% higher rate of admissions, so reducing smoking prevalence in patients on COPD and asthma registers will help keep costs down. At the moment, few CCGs will know the current prevalence of smoking in their locality. Getting a sense of the scale of this problem is important. Agree in year one to record and share your smoking prevalence data in COPD and asthma, and then set a benchmark for an improved uptake of evidence-based stop-smoking treatment and a reduction of smoking in these conditions in year two. Before prescribing any new inhaler ensure that evidence-based stop-smoking support has been offered.

4 Make sure GPs and other professionals who work with COPD patients receive training on smoking cessation

Having GPs who can readily give good advice on how to stop smoking will not only help reduce future COPD cases, it will also reduce admissions from COPD and asthma registers. A quick, easy way this can be achieved is by asking GPs to complete an online Very Brief Advice on Smoking training module from the National Centre for Smoking Cessation and Treatment within the next year.[4]

5 Set targets for the number of COPD patients completing pulmonary rehabilitation

Pulmonary rehabilitation is one of the most effective ways that people with COPD can cope with their breathlessness, and also get fitter. But it is crucial that people who are referred go on to complete the course of pulmonary rehabilitation. Current completion rates average around 50%. Consider enhancing your pulmonary rehabilitation service with a dedicated psychologist. Emerging evidence suggests this improves completion rates.

As with tackling smoking prevalence on COPD and asthma registers, use year one to record and report the proportion of people with diagnosed COPD who have Medical Research Centre breathlessness scores of three, four and five, who are therefore eligible for pulmonary rehabilitation. This is likely to be 40% of your practice COPD register (see the IMPRESS guide to pulmonary rehabilitation for further advice).[5]

Once that group of patients has been established, you can set a benchmark for year two for completers of pulmonary rehabilitation in this population. When a patient is fast-tracked to pulmonary rehabilitation after an exacerbation, the number needed to treat is four to avoid an admission and six to save a life.

6 Use patient discharge bundles

The COPD discharge care bundle is a short list of evidence-based practices that should be implemented before discharge for all patients who have been admitted with acute exacerbations of COPD. It is based on a review of national guidelines and other relevant literature, expert opinion and consultation with patients. The bundle is being adopted in hospitals across the UK and can be accessed online.[6] COPD admissions are preventable if the patient has better care co-ordination and access to good advice that can help them improve self-management. Providing patients with good discharge bundles will help reduce emergency admission. Incentivise hospitals to provide this service through a CQUIN payment or your community respiratory provider by working with respiratory specialists. Two weeks after discharge is a good time for your practice COPD lead to review what happened and what interventions may help prevent a future admission.

7 Set up a smoking cessation CQUIN payment that includes mental health providers

Stopping smoking is one of the key ways to improve respiratory health, but stopping smoking can be very difficult, and including mental health providers can be an effective way to make sure those giving up have access to sufficient support. Quit-smoking CQUIN payments can include incentives to support staff to stop smoking too. Severe mental health patients smoke 42% of all the tobacco smoked in England and on average die 16–25% sooner than the rest of the population.

8 Have a prescribing team working with stakeholders across the respiratory pathway

A responsible respiratory prescribing team working and listening to stakeholders across the respiratory pathway is very important. Such a team would make sure that all healthcare professionals prescribing and dispensing inhalers do it for the right people in the right way at the right time – and better than it is done presently.

9 Ensure good-quality service for oxygen therapy and pulmonary rehabilitation

Along with stopping smoking, long-term oxygen therapy and pulmonary rehabilitation are the two interventions that may improve survival rate in people with COPD. Ensuring suitable services for assessment and provision of these, possibly in collaboration with other CCGs, can help. Commission services where clinical staff work across different elements of the COPD pathway. An oxygen assessment can include a stop-smoking intervention, a safety at home check, an inhaler technique demonstration and a phone call to a GP, specialist or social care to enhance and join up the patient's care.

10 Collaborate where possible

Collaborating, for example with social care and end-of-life programmes such as Co-ordinate My Care, can help patients play a major role in getting the care they need.[7] Working with third-sector organisations such as the British Lung Foundation (BLF) can help make sure COPD patients get good quality treatment. The BLF user representative training programme can provide COPD commissioners with the patient and carer expertise they need to make services that patients will appreciate.

Dr Noel Baxter is co-lead of the NHS London respiratory team and a GP in Southwark, south London

References

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2 DH toolkit for commissioning COPD care. 2012. tinyurl.com/8sn7V2t
3 Respiratory Atlas of Variation rightcare.nhs.uk/index.php/atlas/respiratorydisease/
4 NCSCT. ncsct.co.uk/Vbo
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7 Co-ordinate my Care Video. Vimeo.com/40534583

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DOCTORS/GPS REQUIRED

Wheatfield Surgery
Part-time Partner

We are looking for a part-time partner as part of a job share. Working 4 sessions over 2 days covering Monday plus either Tuesday or Wednesday. We are interested in an enthusiastic GP to join our busy and friendly practice team.

- Long established 7 Partner practice (currently 6 ¾ wte)
- List size 13,500
- PMS
- Purpose built leased premises
- Fully computerised (Synergy)
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- 7 week annual leave includes 1 week study leave (pro rata)
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- On site counsellor, midwife, 100hr pharmacy
- Actively involved in CCG
- Excellent road links, easy to access close to junction 11 M1

Informal enquires and visits welcome.

Please apply in writing with CV to: Dr Tina Archdeacon, Wheatfield Surgery, 60 Wheatfield Road, Luton, LU4 0TR. Tel: 01582 601116 or email tarchdeacon@doctors.org.uk

Closing date: 14th November 2012

Staffordshire
Salaried GP

Friendly five Doctor, well managed practice situated in the attractive market town of Leek in Staffordshire, looking to employ a 5/6 session (negotiable) Salaried GP for twelve months with a view to partnership.

- **Full complement of primary care staff**
- **8,200 patients**
- **4 GP WTE**
- **GMS**
- **InPS Vision system**
- **Paperlight**
- **High Q&OF achievement**
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- **Well established training practice**
- **No OOH commitment**

Please apply in writing with CV to:
Mrs Maria Malkin
Health Centre Manager
Leek Health Centre
Fountain Street
Leek
Staffordshire
ST13 6JB
Tel 01538 398658

Closing date: Friday 9th November 2012

NEWPORT, SOUTH WALES

We are looking for a full time partner from Jan 2013 initially salaried for 6 months.
Friendly City Practice
High QOF achievement
Well organized practice with excellent management, nursing & administrative support
More details on request from:
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4 & 6 Bryngwyn Road
Newport. NP20 4JS T: 01633 263463
Sandra.bogue@gp-w93046.wales.nhs.uk
Closing date 30 10 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

SALARIED GP

Due to the retirement of a partner, a vacancy has arisen at Park Medical Practice, St. Anne's on Sea, Lancashire.

We are looking for an enthusiastic GP to join our busy, friendly practice. Initially 4 sessions per week with a view to increasing to full time and eventual partnership.

- List size 6,100
- High QOF achievers
- Emis Web
- Long established training practice
- Modern purpose build premises
- GMS practice
- Clinical support team includes Practices Nurses and Health Care Assistant
- Happy and enthusiastic admin team

Please send CV and covering letter to Practice Manager, Park Medical Practice, St. Anne's Health Centre, Durham Avenue, St. Anne's on Sea. FY8 2EP.
Closing date: 9th November 2012

SALARIED GP with a view to PARTNERSHIP

FAVERSHAM, KENT

Due to retirement of our Senior Partner we are looking for a Part Time or Full Time GP (6 or 8 sessions) to join our forward looking, enthusiastic team from July 2013.

We are a long-established GMS practice of 4 partners (3 wte) in a pleasant semi-rural historic market town, working from a purpose built Health Centre. We have a list size of 6,200 with High QOF achievements.

If you would like to enjoy working in a friendly and committed environment, find out more by contacting:

Ann Richardson, Practice Manager, Dr Curry & Partners, Faversham Health Centre, Bank Street, Faversham, Kent ME13 8PR.

Tel: 01795 562004, Email: annrichardson@nhs.net

Practice Website: www.dcurryandpartners.nhs.uk

Interviews will be held in Dec 2012-Jan 2013 period

SALARIED GENERAL PRACTITIONER VACANCY

Up to 3 sessions a week

Bevan Healthcare CIC - Bradford

At Bevan House we provide sensitive and responsive Primary Care services for people who are homeless, asylum seekers, refugees and hard to reach groups.

If you want to find out more about this innovative and successful service, we would love to hear from you. Please contact our Practice Business Manager, Lisa Jones-Tinsley on 01274 323764 or by e-mail at: lisa.jones-tinsley@bradford.nhs.uk

Closing date for applications is 12.00 Monday 12th November 2012.

SALARIED GP

Hodnet Medical Centre in North Shropshire invites applications for the position of Salaried GP, 4 sessions per week plus holiday cover.
We are a 2 partner rural dispensing practice, shortly migrating to EMIS Web, and committed to delivering high quality care.

Key requirements for the post are full GMC registration, and inclusion on the GP register and PCT performers list.

Applications in writing please to Mrs C Charlesworth, Practice Manager, Hodnet Medical Centre, Hodnet, Shropshire, TF9 3NF.
Closing date 30th November 2012.

Associate Partners

Ridgacre Medical Centres www.ridgacremedicalcentres.com is a highly regarded group of GP surgeries based in the Quinton and Nechells areas of Birmingham offering a comprehensive range of medical services.

We wish to recruit two enthusiastic and motivated GPs to join our growing organisation as Associate Partners. These are full time roles although part time working could be considered for the right candidate. The roles will mainly be based at our Nechells practice and start dates can be mutually agreed.

About us:

6 Partners and over 50 staff based in 3 sites

PMS, APMS contracts with additional provider and enhanced services

Special interest in substance misuse with additional contracts in this area

Training & teaching practice

Provide services to Birmingham and Solihull PCT cluster – QOF assessor and appraisers

Provide services to the NHS Revalidation Support Team

SystmOne clinical system

Near Maximum QoF Achievement

List Size – 12,500 patients

No Out of Hours requirement

We are looking for someone who:

Has enthusiasm, energy and commitment towards the growth and development of the practices

Shares our commitment in providing high quality patient care

Remuneration to be negotiated according to contribution agreed and will be a fixed-share arrangement.

Apply with your CV and covering letter to Ian Middleniss, Business Manager

Ridgacre Medical Centres, 83 Ridgacre Road, Quinton, Birmingham, B32 2TJ or via email to ian.middleniss@nhs.net You can also call Ian on 0121 423 5028 for more information or for an informal discussion.

Closing date for applications is 21st October 2012.

SALARIED GP REQUIRED
(POSSIBLE FUTURE PARTNERSHIP)
FOR SOUTH EAST LONDON PRACTICE CLOSE TO THE THAMES.

We are a well established practice

with 6000 plus patients occupying brand new state of the art premises

looking for a committed enthusiastic doctor.

No out of hours

Supportive friendly administration team

We welcome a doctor who specializes in obstetrics, gynaecology and sexual health

For informal discussion and further details please contact:

Dr Y Lefeuvre 020 8854 0356

yannlefeuvre@nhs.net

Closing date: 11 November 2012

This busy inner city practice is looking for 2 Part time or 1 full time highly motivated and enthusiastic Salaried GP to join our existing team.

- **Emis Web Clinical system**
- **GMS Practice with approximately 4000 patients**
- **High QOF achievement**
- **Actively engaged in commissioning**
- **Situated in newly built multi-storey health centre**
- **Salary according to experience**

Please apply by email to karen.bliss@nhs.net.

DOCTORS/GPS REQUIRED

PARTNER GP AND SALARIED GP VACANCY
NORTH HOUSE SURGERY
RIPON, NORTH YORKSHIRE

As a result of a retirement and the continued expansion of our clinical team, we are looking to recruit an enthusiastic and highly motivated partner and a salaried GP to join our friendly innovative PMS training practice.

The successful candidate will be team orientated, committed to clinical excellence, open to change and have a strong desire to develop the practice further.

- 5 to 9 sessions
- 4 Partners (3.5 FTE) & 4 Salaried GPs (2.5 FTE)
- List size – 9,300
- Single site owned by the Partners
- Full nursing support team
- Active Training Practice with Registrars, F2s and Medical Students in training
- High Clinical and non clinical QOF scores
- EMIS LV (moving to EMIS Web)
- Local Community Hospital

If you feel that you have the motivation and commitment to help take our Practice forward, please visit www.northhousesurgery.co.uk to download our information pack. Please email your cv with a covering letter to nigel.peacock@gp-b82008.nhs.uk

Closing date for applications: 31st October 2012

For any further assistance, please contact Nigel Peacock, Business Manager on 01765 690666 Ext 203 or email nigel.peacock@gp-b82008.nhs.uk

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.

London Road Surgery, Canterbury, Kent
Part/Full time Salaried GP Required

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

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

Salary according to experience.

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

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

BEDFORD

SALARIED/Long term LOCUM GP's Required (hrs Flexible)
For friendly training APMS practice (11,800pts)
and Nurse led NHS Walk-in-Centre
ideally to start January 2012.
Please contact: Sam Paul, Practice Manager,
Putnoe Medical Centre.
Tel: 01234 319990, email: sam.paul@nhs.net

Kingswood Surgery, Harrogate, North Yorkshire
GP PARTNER

Due to the Senior Partners retirement, our happy, friendly, efficient training practice seeks a motivated and enthusiastic full time (8 sessions) GP to join the remaining 3 full-time partners.

We offer:

- 4 Partner GMS practice, 7000 patients
- Consistently very high QOF achievement
- Modern, purpose built premises in leafy, suburb near the Harrogate Stray
- Mixed population, slight bias towards the elderly
- SystemOne computer system, paperlight.
- 3-strong specialist practice nursing team.
- Training practice for GP Registrar and FY2s

Salary negotiable for the right candidate.
Planned start date April 2013.

Closing date for applications: 24 October 2012

Please request an information pack. Applications should be submitted on the application form provided, with CV and covering letter . Phone 01423 887733 and ask for Rachel Simpson, Practice Manager, or email rachel.simpson@gp-b82014.nhs.uk Kingswood Surgery, 14 Wetherby Road, Harrogate, HG2 7SA.

STAR LANE MEDICAL CENTRE
Training Practice
SALARIED GP

Star Lane Medical Centre is looking to recruit a motivated, forward thinking salaried GP for 8 sessions per week to join our existing 8 doctor team.

The successful candidate will be a committed team player who will take a full and active role in providing excellent patient care.

We are a very busy training practice situated in East London delivering a wide range of services and care to our patients

- Training Practice
- PMS Practice
- List size 13,000
- High QOF
- Consortium member for Practice Based Commissioning
- Experienced nursing team
- Experienced first class management and administration team

To apply please send a current CV and written letter to:

Mrs Irene Glover, Practice Manager
Star Lane Medical Centre
121 Star Lane, London E16 4QH

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

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

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

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

Closing date: 31st October 2012

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GP Salaried position with view to partnership

The Practice is looking for an enthusiastic, highly motivated GP to join our friendly rural dispensing practice in the beautiful Vale of Belvoir. The practice has five thousand patients is fully computerised and scores highly in QOF and patient surveys. The vacancy is for a full time and part time General Practitioner.

- Emis clinical system moving to System One
- PMS practice
- Leicester Medical School Training Practice
- No OOH commitment
- Good Schools within the local area

For more information or to arrange an informal visit
Contact Lisa Wild Practice Manager
Please apply in writing with your CV by 31st October 2012
Main surgery:
The Welby Practice
Walford Close
Bottesford
Nottinghamshire
NG13 0AN
Direct line to Practice Manager 01949 845366
Email: lisa.wild@lpct.nhs.uk

WHITEHALL MEDICAL PRACTICE
PARTNER OR SALARIED GP VACANCY

We are a busy, friendly, high QOF achieving training practice looking for a replacement for our retiring partner.

- 14100 patients
- Purpose built leased premises (2000)
- Medical Officers for Rugby School
- Training practice (registrar and undergraduate)
- Full complement of staff including Nurse Practitioner and Healthcare Assistant
- Excellent road and rail links

The practice is looking for a friendly and enthusiastic GP to join our team to offer a high standard of care. Interested in all aspects of general practice to work six sessions per week. We are willing to wait for the right candidate.

Informal enquiries/visits are welcome.

Please send covering letter with full CV to Mrs Wendy Jennings, Whitehall Medical Practice, Morton Gardens, Rugby, CV21 3AQ or via email wendyjennings@nhs.net telephone: 01788 545350 website: www.whitehallmed.co.uk

Closing date for applications: 31st October 2012

SALARIED GP
(with a Potential Partnership Opportunity)
Up to 9 Sessions per week

We are looking for an enthusiastic GP to join our busy friendly Rural GMS Practice from December 2012.

- 2 GP partners and 1 Salaried GP (3 WTE) (with a view to becoming 4 Partner Practice)
- Friendly Experienced Practice Nurses (1 Prescribing), Health Care Assistant and Admin Support
- List Size 4000
- One Main Surgery and 2 Outer Island Branches with visiting Surgeries.
- VISION -Paper light
- No OOH Commitment
- High QOF Achiever

As a key member of the team you will be innovative and a flexible team player.
Salary negotiable depending on experience

Enquires Welcome, Contact Dr Chimene Taylor or Dr Marjolein Van Schayk - Partners

Letters of application and CV to:
Mrs Melanie Miller – Practice Manager
Heilendi Practice
Scapa Crescent
Kirkwall, Orkney
KW15 1RL

Tel 01856 872388 – Email ork-hb.heilendi@nhs.net

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DOCTORS/GPS REQUIRED

COURSES/CONFERENCES

PREMISES

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

EDITOR'S CHOICE

How to have it all as a GP and mum

Over the past 10 years, Dr Vicky Blackburn has learned to juggle a busy GP partnership with being a mother of three. How?

Accepting that you cannot be all things to all people is an important lesson to learn.

Pick your husband well. My husband is a non-medic but accepts that my career, as a GP partner, takes priority. Another GP or medic can empathise with your responsibilities and even update you on the latest thesis on CKD over supper, but having similar responsibilities can cause friction.

Pick your practice well. Working in a small practice suits me as I like to feel I have some knowledge of the patients. Who is really ill? Palliative? Bereaved? Weird? In a large practice with more patients, it is not always possible to share this knowledge with everyone, particularly if the practice operates named patient lists. There are benefits in having more GPs around to cover sickness, and there are more GPs to ask if you are uncertain of something.

Pick your staff well. Have robust interview processes and never take on anyone permanently without a six or 12 month get-out clause – it's fairer for everyone.

Learn to say yes. Say yes to study leave, even if it's inconvenient as you have to get childcare. Say yes to help – people will stop offering if you don't start accepting.

Dr Vicky Blackburn has learnt to say yes

Dr Vicky Blackburn is a GP in Cheltenham, Gloucestershire

MORE ONLINE Read the full article at pulsetoday.co.uk/off-duty

THE DEEP END

GPs at the Deep End

GPs at the Deep End is a Glasgow-based project working with the 100 most deprived practices in Scotland. Dr Anne Mullin explains why a strong GP voice is essential for the vulnerable children and families she works with.

MORE ONLINE Read the full article at pulsetoday.co.uk/opinion

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"I assume it's the same boffins who came up with a one-day 'strike-but-not-really-a-strike' action

... on the BMA debating plans to lead a mass patient opt-out from privately provided NHS care

"Absolutely £@&*ing brilliant

... on Copperfield's blog about just how incomprehensible consultants' notes can be

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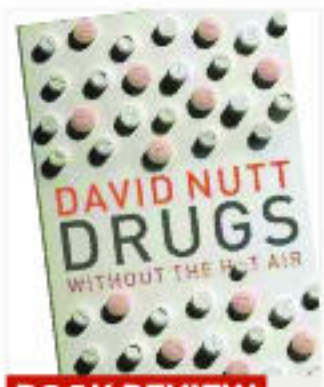
... on claims risk-averse young GPs make too many referrals



BOOK REVIEW

Drugs – without the hot air

Professor David Nutt was sacked from his role as chair of the Government's Advisory Council on the Misuse of Drugs in 2009 after he claimed taking Ecstacy was no more dangerous than horse riding.

Read Dr Holly Simms's review of his book *Drugs – Without the hot air*, and find out why she gave it nine out of 10.

MORE ONLINE Read Dr Holly Simms's review at pulsetoday.co.uk/book-reviews

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Are blanket 28-day prescription policies a false economy?

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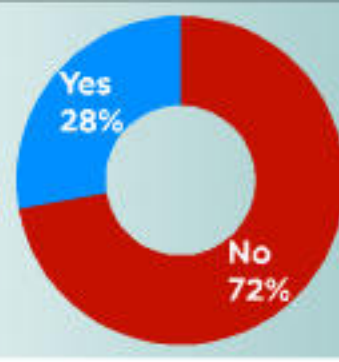
Last week's poll

Should the BMA help patients opt out of private sector treatment?



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