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PULSE

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BriefingMedia
At the heart of general practice since 1960

GPC prepares to go to war on contract

LMC leaders will press GPC to deliver robust response and consider commissioning boycott

EXCLUSIVE
By Helen Mooney

LMC leaders are to call on the GPC to lead a boycott of commissioning and other work not directly related to patient care in a last-ditch bid to stop ministers imposing sweeping changes to the GP contract.

A number of LMCs plan to raise the possibility of GPs withdrawing from commissioning work or working to rule at the LMC Secretaries' Conference this week, while Pulse understands the GPC has already begun internally debating a range of measures short of strike action.

GPC negotiators said legal issues would need to be addressed but refused to rule out 'widespread non-cooperation with Government policy'.

The BMA has also begun planning a series of roadshows to hear from grassroots GPs in 'early 2013'.

Last week the Department of Health reiterated its warning that its offer of a 1.5% funding uplift would be taken off the table if the GPC does not agree to the proposed deal, which includes a raft of new QOF work next year and the phasing-out of the MPIG over seven years from 2014.

As Pulse went to press, the publication of the DH's Statement of Financial Entitlements setting out the details of its offer was expected imminently, after which the GPC has said it will issue further guidance.

Meanwhile, LMC secretaries were planning to use their annual conference on Friday, which will be attended by GPC chair Dr Laurence Buckman and held in private, to call for a robust response.

Dr Ravi Mene: will be raising the possibility of GPs working to rule at this week's meeting of LMC secretaries

EDITORIAL ▶
If ever there was a time to fight... 19

Dr Paul Roblin, secretary of Berkshire, Buckinghamshire and Oxfordshire LMCs, said negotiators would use the meeting to take the temperature of grassroots GPs.

'If things from the working week need to be dropped because of a lack of funding, then commissioning should be first on the list,' he said. 'The trick is for us to achieve something that will not become a PR disaster.'

A second LMC was also understood to be due to call for a commissioning boycott, while Dr Nigel Watson, chief executive of Wessex LMCs, warned that if ministers imposed the deal, even the 'least militant GPs would start saying no to extra work' that was not directly about providing patient services.

Dr Ravi Mene, secretary of Salford and Trafford LMC, said: 'The best way forward for GPs would be to work to rule – to do exactly what is expected of us in our contracts and absolutely nothing more. We have to make our feelings known and I will be raising this.'

A senior GPC member who asked not to be named said the GPC decided at its meeting on 15 November to look at all the legitimate legal options.

'This could include complete non-engagement with the CCG agenda in order to stop dangerous service rationing and spend more time with patients,' he said.

'We will also look at our revalidation work and all the bureaucracy that entails - basically anything that does not involve direct patient care.'

GPC negotiator Dr Chaand Nagpaul said the LMCs' meeting, which he was attending this week, was 'very well placed to feed back the perspectives of grassroots GPs'. He added: 'In terms of disengagement from CCGs... if it was seen as the GPC instructing widespread non-cooperation with Government policy, there are legal issues involved. But that is not to say it can't be done.'

Dr Tom Frewin, a member of Avon LMC, said: 'The Government is ignoring fair play and saying sod you, so a boycott of commissioning could be the only thing that might bring them back to the negotiating table.

'The Government has invested a lot of political capital on commissioning so it could work.'

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Follow the contract latest
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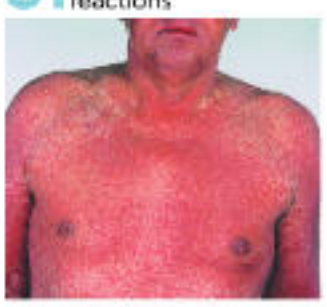
GP contract row: next steps

IMMINENTLY	30 NOV	20 DEC	EARLY 2013	FEB 2013
Statement of Financial Entitlements published	LMC secretaries meet to discuss response	Next GPC meeting	BMA roadshows to be held around the country	DDRB to recommend uplift



The week in general practice

INSIDE

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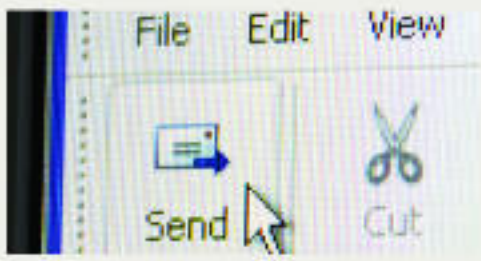
A health minister has claimed a third of GP consultations do not need to be face to face
▶ pulsetoday.co.uk/news

Download of the week
Read Jeremy Hunt's letter to the BMA on pensions
▶ pulsetoday.co.uk/pensions



Video of the week
Watch the Big Interview with outgoing RCGP president Iona Heath
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PULSENEWS

Practices will get 48 hours' CQC notice

CQC rules out longer notice period after GPs in pilots 'hired extra staff' ahead of inspections

By Madlen Davies

GPs will be given 48 hours' notice before a CQC inspection, after practices in the pilot scheme used a longer notice period to 'overprepare' and even hire extra staff ahead of visits.

The CQC's pilots ahead of the national roll-out of practice inspections in April found practices allowed more than 48 hours' notice for an inspection often produced unnecessary documents and made last-minute improvements to their premises.

Vicky Howes, design team leader for GP registration at the CQC, told Pulse: 'We found practices were over-preparing and doing more work than necessary. We don't expect any preparation. Some practices hired extra staff.'

She also said practices would be measured against just five outcomes – drawn from the CQC's 16 essential standards – to be chosen by the inspectors.

However, inspectors will be able to add an outcome if they are aware of a specific issue.

Other conclusions to come out of the pilots – which were carried out in August and involved 12 inspectors and 43 volunteer practices of various sizes – include CQC staff needing more training on which language to use when speaking to staff and patients, and when to approach patients.

The commission also needed to do more work on checking patient records and sharing information with other bodies such as the NHS Commissioning Board.

Practices are currently sending in registration applications, which include an opportunity to self-declare non-compliance.

A CQC spokesperson said practices were most worried they might not be compliant with standards on premises, infection control and safeguarding standards, although some of these would be GPs being 'overcautious'.

Dr John Canning, secretary of Cleveland LMC, said although 48 hours appeared to be 'very short notice' it was 'not unreasonable'.

'As I understand it, the inspectors will be looking to understand how the practice is functioning on a day-to-day basis and working with its staff, and that is something general practice should be prepared for any time.'

Meanwhile, the CQC said one practice has already received a

Where GPs fear they fall short

Premises

Infection control

Safeguarding patients from abuse

Source: CQC analysis of non-compliance declarations

PCTs award NHS

INVESTIGATION

By Julia Gregory

Harmoni and NHS Direct are the big contract winners so far from the roll-out of NHS 111, a Pulse investigation reveals.

An analysis of data released under the Freedom of Information Act shows PCTs across the country are making rapid progress with procurement of the new urgent care number.

The big winners among the providers were Harmoni, which was bought by Care UK for a reported £48m earlier this month, and NHS Direct, each of which won 11 of the 39 contracts announced so far.

Derbyshire Health United has won contracts for three NHS 111 services, as has the South East Ambulance Service and the North East Ambulance Service.

One of the largest contract wins was Yorkshire Ambulance Service/Local Care Direct which won the Yorkshire and Humber contract worth £11.5m over five years.

Many PCTs refused to release details of the cost of the contracts but, of those that did, the cheapest rate was £1.39 per head of population for the service in Nottingham City, which

'The GPC is concerned at the speed of the roll-out.'
Dr Peter Holden

The CQC does not expect practices to undertake any additional work in preparation for an inspection

GPs maintaining income and happy, claims DH

The Department of Health has claimed GPs are happier than ever and are earning the same amount they did two years ago, in evidence to the doctors' pay review body.

In a rosy assessment of the state of general practice, the DH estimated that average GP net earnings would remain static in 2012/13 at £107,700 for the third year running.

Pointing to evidence from the National Work Life Survey published in 2011 which it said represented the 'most up-to-date comparable evidence in measuring GP satisfaction', the DH said that in 2010 happiness was 4.9 points, up 0.2 points on a seven-point scale compared with 2008.

But Bob Senior, an accountant with RSM Tenon, said that the DH's evidence failed to highlight the trend of working less than full time.

And Dr Gillian Breese, a GP in Llandudno, Wales, said: 'This statement by the DH is so out of touch that it's farcical. I know of no GP who is "happy" in their current job and certainly none who feels income remains the same as it was several years ago.'

▶ Letters, page 22

MORE ONLINE
Read the DH evidence
pulsetoday.co.uk/contract

ANALYSIS

How will visits work?

The criteria
Inspectors will assess practices against a minimum of five of the CQC's 16 essential quality and safety standards, which include medicines management and infection control. The inspector can add any standard if appropriate.

The process
Inspectors will observe interaction between staff and patients and carry out document or record reviews.

They will spend most of their time talking to patients, staff or members of the patient participation group. The CQC says the amount of GP input required will depend on the practice. GPs need not block out the whole of their day, but should leave some time to speak to inspectors.

The frequency
Scheduled inspections will occur every two years. A 'responsive' inspection can take place at any point, usually if concerns are raised over whether a practice is meeting the essential standards or when the CQC is following up non-compliance from a previous inspection.

There may also be 'themed' inspections, when the CQC reviews a particular type of service or set of standards.

Preparation
Practices should fill out the relevant documentation, but other than that there is no need to prepare.

The CQC has said practices should not improve their premises or hire extra staff before an inspection.

visit after tweeting that it had ticked all registration form boxes as compliant because it 'couldn't be bothered'.

A spokesperson confirmed the CQC would gather information from 'a number of different sources' including Twitter, primary care organisations and the public. If the CQC suspects claims made on a registration form are inaccurate, the registration team will call the practice or visit the surgery in order to receive assurance that the practice should be registered, the spokesperson added.

@madlendavies

111 contracts

will be run by Derbyshire Health United.

The cost of the contracts also appears to be linked to how densely populated the region is.

In East London, the Redbridge, Havering, Barking and Dagenham and Waltham Forest cluster procured a service run by the Partnership of East London Co-operatives for £1.88 per head in the first year and £2.10 in the second year.

The figures are based on 997,097 registered patients and the service is due to go live in January next year.

However, in the sparsely populated Cornwall and the Scilly Isles region, the NHS 111 service will cost £3 per head of population per year over the five-year contract, which is worth £8,210,700.

Harmoni's contracts included the service for Surrey, Sussex and Kent and Medway's 4.5 million patients alongside the South East Ambulance Service. This contract was worth £28,659,062.

Dr Peter Holden, GPC negotiator, said the NHS 111 roll-out was 'unproven'.

'We are concerned at the speed of the roll-out, which means taking some big risks. The cost savings are mind-blowingly small.'

He added: 'The GPC view is that it should be rolled out over an extended number of months, if not years.'

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MORE ONLINE
See the full list of contract winners
pulsetoday.co.uk/111

'CQC box-ticking puts my patients at risk'
▶ page 22

'Signs of fairer deal' on pensions

BMA hails 'milestone' in campaign against hike in pension contributions after letter from Jeremy Hunt

By Madlen Davies

GPs may be set for lower pension contributions than previously thought from 2015, the BMA has claimed, after the health secretary accepted its argument for lower increases for higher earners was 'reasonable'.

In a move the BMA said showed 'signs of a fairer deal' on pensions, Jeremy Hunt acknowledged the BMA's argument that under a career-average pension benefits are more closely linked to contributions than under a final-salary scheme.

Mr Hunt said the Government would not backtrack on its decision that employee contributions should be an average of 9.8% by 2015.

However, he said tiering arrangements for the contributions – the so-called 'Robin Hood' element of the deal, which would see higher earners paying higher percentages of their salary compared with lower earners – were yet to be decided.

The letter to the BMA said the Department of Health was bringing forward discussions with unions on contributions, originally scheduled for early 2013.

Dr Mark Porter: ministers have acknowledged BMA arguments

Mr Hunt wrote: 'You raised a number of issues that should be taken into account... in particular, you acknowledged the need to protect the low paid; recognised the impact of tax relief; and take account of the fact that career-average pensions deliver benefits more closely related to the contributions paid than a final-salary pension.

'These seem reasonable, but there are also other issues to be considered.'

In a blog post on the issue, BMA chair Dr Mark Porter said: 'The latest response from Mr Hunt, opening up the potential for a much flatter contribution structure post-2015, is a significant milestone in our campaign.'

But Dr Peter Swinyard, chair of the Family Doctor Association, said concerns over contributions remained: 'If the BMA thinks this is worth spinning as a victory, then it sounds truly hollow.'

Dr David Bailey, deputy chair of the BMA's pensions committee, said: 'I wouldn't call it a victory, because we're a long way from knowing what the Government is going to do. But at least they've signalled they're listening.'

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Contribution hike

9.8% Average NHS contribution rate in 2014/15

6.6% Average NHS contribution rate in 2011/12

8% Average NHS contribution rate in 2012/13

MORE ONLINE
Read Mr Hunt's letter
pulsetoday.co.uk/pensions

ANALYSIS

GPs hit hard on tax relief

It is good that Jeremy Hunt has acknowledged that the reforms to pension tax relief have affected GPs.

From April 2011, people with more than £1.5m in their pension funds have had to pay a tax charge on everything over and above that £1.5m. This has affected both average and higher earners.

The Government also levied a tax charge if an individual's annual contributions are deemed to be more than £55k. This mainly affected higher earners, but there are rumours the annual limit will be reduced further in the Chancellor's Autumn statement next month.

The extra tax can be paid when they start drawing their pension, provided the tax charge is above £2,000 – meaning what they don't see, they don't miss, provided they end up with a pension they are happy with.

Mr Hunt might want to ask medical accountants for some live calculations. There are some horror stories around for GPs.

As for the tiered approach, any move towards a flat structure would help higher earners.

Mike Gilbert is a consultant at RMT Accountants

GP trainee numbers set to rise next year

The number of GP trainees starting training in August 2013 is set to increase to almost 3,000, according to Department of Health estimates.

Health minister Earl Howe confirmed the DH expects between 2,869 and 2,953 would-be GPs to begin their training next August, with applications due to close on 7 December.

This is an increase from this year's figure of 2,689 and is a step towards meeting the Government's ambitious target of 3,250 GP trainees a year by 2015.

The figures were revealed in a response to Dr Derek Greatorex, chair of South Devon and Torbay CCG, who had warned practices were under 'tremendous pressure' and struggling to backfill commissioning work.

RCGP chair Professor Clare Gerada said: 'We think there should be 20% more GPs by 2022.' This worked out at 10,000 more or about one per practice, she said.

She added: 'I estimated a year ago we had lost 600 full time equivalents from commissioning.'

Don't let a single moment of weakness undo all of a patient's hard work

Sometimes cravings that strike at trigger moments, like whilst enjoying that glass of wine, can be tough to resist. In fact, these acute, breakthrough cravings can lead to smoking in just 11 minutes.[1]

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Prescribing information. NiQuitin 2 mg / 4 mg Lozenges, NiQuitin 2 mg / 4 mg Mint Lozenges, NiQuitin Pre-Quit 4 mg Mint Lozenges, NiQuitin Minis Mint 1.5 mg / 4 mg Lozenges and NiQuitin Minis Cherry Flavour 1.5 mg Lozenges (nicotine). For relief of nicotine withdrawal symptoms during abrupt / gradual / temporary smoking cessation and to aid reduction in smoking. **Dosage: Adults (18 and over):** Maximum 15 lozenges / day. Cessation to be encouraged, professional advice if no quit attempt after 6 months / difficulty discontinuing after quitting. *Lozenges & Mint Lozenges:* 4 mg if smoke within 30 minutes of waking, otherwise 2 mg. *Pre-Quit Lozenges:* for those who smoke within 30 minutes of waking only. *Minis Lozenges:* 4 mg strength if smoke > 20/day, otherwise 1.5 mg. ***Abrupt cessation:*** *Lozenges & Mint Lozenges:* Weeks 1 to 6, 1 lozenge every 1 to 2 hours (min. 9/day). Weeks 7 to 9, 1 lozenge every 2 to 4 hours. Weeks 10 to 12, 1 lozenge every 4 to 8 hours. Beyond 12 weeks, 1 to 2 lozenges per day if strongly tempted to smoke. *Minis Lozenges:* 8 – 12 lozenges/day, use a lozenge when urge to smoke. Taper use after 6 weeks. After treatment, use a lozenge if strongly tempted to smoke. ***Gradual cessation & Pre-Quit:*** Prior to schedule above use when strong urge to smoke to reduce cigarette consumption. Professional advice if no reduction after 6 weeks. ***Reduction in smoking:*** Use when strong urge to smoke to reduce cigarette consumption as much as possible. ***Temporary abstinence:*** 1 lozenge every 1 to 2 hours. **Adolescents (12-17 years):** Abrupt cessation only. Dosing as for adults. Seek professional advice if unable to quit abruptly. **Contraindications:** Hypersensitivity, non-smokers, children under 12 years. **Precautions:** Risk of NRT substantially outweighed by risks of continued smoking in virtually all circumstances. Supervise use in those hospitalised for MI, severe dysrhythmia or CVA who are haemodynamically unstable. Once discharged, can use NiQuitin as normal. Susceptibility to angioedema, urticaria. Renal/hepatic impairment, hyperthyroidism, diabetes, phaeochromocytoma. Swallowed nicotine may exacerbate oesophagitis, gastric / peptic ulcer. *Lozenges, Mint Lozenges & Pre-Quit Lozenges:* low sodium diet, phenylketonuria. **Pregnancy / lactation:** For those unable to quit unaided the risk of continued smoking is greater than the risk of using NRT. Start treatment as early as possible in pregnancy. Lozenge/gum preferable to patches unless nauseous. **Side effects:** At recommended doses, NiQuitin has not been found to cause any serious adverse effects. See SPC for full details. Dizziness, anaphylaxis, sleep disorders, anxiety, irritability, headache, cough, GI disturbances, oral irritation/ulceration. *Minis, 4 mg Lozenges, 4 mg Mint Lozenges & Pre-Quit Lozenges only:* Sore throat, chest pain/tightness. *Lozenges, Mint Lozenges & Pre-Quit Lozenges only:* Appetite change, pharyngitis, lower respiratory tract infection, respiratory disorders, dysphagia, aggravated asthma (2 mg only), throat swelling (4 mg only). *Minis Lozenges only:* Nervousness, depression. GSL. **PL numbers:** PL 00079/0606, 0607, 0369, 0370, 0610, 0611 & 0658. **PL holder:** GlaxoSmithKline Consumer Healthcare, Brentford, TW8 9GS, U.K. **Pack sizes & NHS cost:** *Lozenges & Mint Lozenges:* 36's £5.12, 72's £9.97. *Pre-Quit Lozenges:* 36's only, £5.12. *Minis Lozenges:* 20's £3.18, 60's £8.93. **Date of preparation:** July 2012.

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

Adverse events should be reported. Reporting forms and information can be found at http://www.mhra.gov.uk/yellowcard. Adverse events should also be reported to GlaxoSmithKline Consumer Healthcare 0500 100 222

GlaxoSmithKline Consumer Healthcare

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

Fracture risk in elderly patients raised with BP drugs
▶ page 16

Cost fears for CCGS as Pulse analysis reveals surge in non-elective hospital activity

UNSCHEDULED CARE

QP targets fail to stem emergency admissions

EXCLUSIVE

By Pat Anderson

CCGs are facing added financial pressures because of an unexpected rise in emergency admissions and a further rise in A&E attendances, a Pulse analysis of Hospital Episode Statistics data for England suggests.

The analysis, which compares the latest HES data with previous reports, reveals that between April and July this year A&E attendances increased by 5% and emergency admissions (including admissions via A&E) by 3.7% compared with the same period in the previous year.

This reversed the previous trend of decreasing emergency admissions. Between April and July 2010 and the same period in 2011, there was a slight fall in emergency admissions from 1,750,681 to 1,723,399. However, this increased to 1,786,341 between April and July this year.

A&E attendances continued their increase from 5.64m in April-July 2010 to 5.95m in April-July 2011 and 6.25m in April-July 2012.

Outpatient appointments also rose 5% between April-July 2011 and the same period this year.

The figures will come as a blow to the Department of Health, which introduced quality and productivity indicators into the QOF in April 2011 with the intention of bringing down emergency admissions and outpatient referrals. In 2010, the DH set GPs a target of cutting A&E attendances by 10% by the end of 2013, as well as a cut in unscheduled hospital admissions of 20%. At the time, the DH's clinical lead for quality and productivity, Sir John Oldham, warned there was 'no plan B'.

Emergency admissions have risen by 3.7% year on year

Dr Beth McCarron-Nash, a former GPC negotiator and a GP in St Columb Major in Cornwall, said the rise in emergency admissions should not be seen as a reflection on GPs' performance against the quality and productivity indicators introduced in the QOF.

'It's unfair to say the rise means the QP indicators have failed because we never thought that they would make a huge difference,' she said. 'The QP indicators were about looking hard at the data, understanding the patterns and making a plan to try and make services better for patients. They weren't about outcomes.'

Dr Michael Dixon, president of NHS Clinical Commissioners, said the figures were 'disappointing'.

He said CCGs 'would be worried about financial pressures' posed by emergency admissions, although they would not have to meet the full costs if these admissions rose beyond a certain point.

He said: 'You can only keep people at home who would otherwise need referral if you have got good community resources. To date, there are insufficient resources in the community, particularly if patients are frail and elderly or have complex conditions.'

He said there were places where unscheduled admissions were being avoided successfully, but support for patients 'costs money, takes time and needs considerable will to set up'.

Dr Agnelo Fernandez, urgent and emergency care lead for the RCGP and joint chair of Croydon CCG, said emergency admissions were going up 'everywhere' and CCGs needed to explore the reasons behind the rise, although he added that 'GPs are not likely to be a factor in rising admissions'.

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HAVE YOUR SAY
Is it time for the QP targets to be scrapped?
pulsetoday.co.uk/forums

Rise in emergency admissions and A&E visits

	Apr-Jul 2010	Apr-Jul 2011	Apr-Jul 2012	% rise 11-12
Emergency admissions (including via A&E)	1,750,681	1,723,399	1,786,341	+3.7
A&E attendances	5,644,396	5,949,633	6,250,014	+5.0
Outpatient appointments	29,234,773	29,488,028	30,948,254	+5.0

ANALYSIS

Figures come as no surprise

There is a long-term trend of patients going to A&E, rather than out-of-hours services or their GP surgery. It's been a historic problem for 30 years. If you look at the data from the past 10 years, A&E admissions and emergency admissions have been rising. Demand on OOH care has been going up too.

It can't be explained by population changes or changes in disease patterns, so what we're seeing is a behavioural change, although this is a hypothesis rather than something we've absolutely demonstrated. In some areas there are patients who attend A&E weekly.

In terms of the QP indicators, there's not much sign that they've had a significant impact. At the level of individual practices, the numbers are small and the information is difficult to interpret.

We were also asking practices to tackle these new QOF indicators at the same time we were asking people to go through NHS reorganisation, so maybe it's no surprise.

Nigel Edwards is a senior fellow at the King's Fund

PATIENT CHOICE

Private firms give 20% of NHS care

Almost one NHS patient in five seen in secondary care is now treated by a private firm, according to a report by the Nuffield Trust and the Institute of Fiscal Studies.

Private firms are now a 'significant' provider of NHS-funded operations, carrying out 17% of hip replacements, 17% of hernia repairs and 6% of gall bladder removals each year in England, the report reveals.

The number of 'independent-sector treatment centres' – private providers that carry out treatment funded by the NHS – expanded rapidly between 2006/07 and 2010/11.

By 2010, GPs referred patients to an average of 18 providers, compared with 12 providers in 2006, in the wake of the last Labour Government's 'patient choice' reforms.

The report also found patients were less likely to be treated at their nearest trust, although this was still the norm.

The Nuffield report concluded: 'The analysis here has not demonstrated the extent to which the shift in treatment location represents a shift from lower- to higher-quality providers.

'Exploring which patients have been affected will be important in understanding how different types of individuals have been, and will be, affected by increasing choice and competition.'

A&E

Little evidence to place GPs in A&E

A major study has found little evidence to suggest siting GPs in accident and emergency wards results in safer or more effective care.

The Cochrane review of the effectiveness of placing GPs in A&Es looked at three different studies from the UK and Ireland, which involved a total of 11,203 patients, 16 GPs and 52 emergency physicians.

Two of the studies showed that having GPs in A&E departments resulted in fewer blood tests, X-rays, admissions and referrals.

To be effective, you would need GPs in there when people are going to A&Es

Dr Steve Kell

In one study, GPs ordered 1,702 blood tests compared with 2,939 ordered by emergency physicians.

But despite these results, the report concluded: 'The evidence suggests that there is an insufficient basis upon which to draw conclusions regarding the effectiveness and safety of care provided by GPs versus emergency physicians for non-urgent patients in the emergency department.

'Overall the evidence is of very low quality.'

Dr Steve Kell, chair of Bassetlaw CCG and a GP in Worksop, said: 'We did this a few years ago with not much impact to be honest.

'To make it really effective, you would need GPs in there when people are going to A&Es but that's difficult for GPs, as they have day jobs.'

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Beclometasone + formoterol

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If an individual patient should require a combination of drugs other than those available in the combination inhaler, appropriate doses of beta$_2$-agonists and/or corticosteroids by individual inhalers should be prescribed. Beclometasone dipropionate in Fostair is characterised by an extra-fine particle size distribution which results in a more potent effect than formulations of beclometasone dipropionate with a non-extrafine particle size distribution (100 micrograms of beclometasone dipropionate extrafine in Fostair are equivalent to 250 micrograms of beclometasone dipropionate in a non-extrafine formulation). Therefore the total daily dose of beclometasone dipropionate administered in Fostair should be lower than the total daily dose of beclometasone dipropionate administered in a non-extrafine beclometasone dipropionate formulation. Adults 18 years and above: one or two inhalations twice daily, maximum four inhalations daily. Children and adolescents under 18 years: The safety and efficacy of Fostair has not yet been established. No data are available with Fostair in children under 12 years of age. Only limited data are available in adolescents between 12 and 17 years of age. Therefore Fostair is not recommended for children and adolescents under 18 years until further data become available. The dose should be titrated to the lowest dose at which effective control of symptoms is maintained. Fostair may be used with the AeroChamber Plus® spacer device. Patients should be advised in the proper use and care of their inhaler and spacer. **Contraindications:** Hypersensitivity to any of the components. **Warnings and Precautions:** Cardiovascular disorders including cardiac arrhythmias and QTc prolongation, thyrotoxicosis, diabetes mellitus, phaeochromocytoma, untreated hypokalaemia, active or quiescent pulmonary tuberculosis, fungal and viral infections. Fostair should not be used as the first treatment for asthma, should not be initiated during an exacerbation, or during significantly worsening or acutely deteriorating asthma, and should not be stopped abruptly. If patients find the treatment ineffective medical attention must be sought. Paradoxical bronchospasm may occur with an immediate increase in wheezing and shortness of breath after dosing, treat immediately. Patients should take Fostair as prescribed even when asymptomatic. Systemic effects of inhaled corticosteroids may occur, particularly at high doses prescribed for long periods. These effects are much less likely to occur with inhaled than with oral corticosteroids. Possible systemic effects include: Cushing's syndrome, Cushingoid features, adrenal suppression, decrease in bone mineral density, growth retardation in children and adolescents, cataract, glaucoma and more rarely a range of psychological or behavioural effects (particularly in children). Titrate to the lowest dose at which effective control of asthma is maintained to minimise systemic effects. Special care is needed in transferring patients from oral steroids. Fostair contains a small amount of ethanol (alcohol) approximately 7 mg per actuation; at normal doses the amount of ethanol is negligible and does not pose a risk to patients. Patients should rinse mouth after inhalation to minimise risk of oropharyngeal candida infection. **Interactions:** Beclometasone dipropionate undergoes a very rapid metabolism via esterase enzymes without involvement of the cytochrome p450 system. Avoid beta-blockers (including eye drops). Caution is required when diuretics (non-potassium sparing) or other beta$_2$ adrenergic drugs are prescribed concomitantly with formoterol. Concomitant treatment with quinidine, disopyramide, procainamide, phenothiazines, antihistamines, MAOIs and TCAs can prolong the QTc interval and increase the risk of ventricular arrhythmias. Lidocaine, L-thyroxine, oxytocin and alcohol can impair cardiac tolerance. Concomitant administration with NNRTIs, including agents with similar properties such as furazolidone and procarbazine, may precipitate hypertensive reactions. Risk of arrhythmias in patients receiving anaesthetics with halogenated hydrocarbons. Theoretical potential for interaction in sensitive patients taking diuretics or monoamine oxidase. **Pregnancy and Lactation:** No relevant clinical data. Should only be used during pregnancy or lactation if the expected benefits outweigh the potential risks. **Undesirable effects:** Common: pharyngitis, headache, dysphonia. Uncommon: influenza and fungal infection, oropharyngeal and oesophageal candidiasis, nasopharyngitis, gastroenteritis, sinusitis, rhinitis, gland enlargement, dermatitis allergic, hyperglycaemia, hypertriglyceridaemia, restlessness, tremor, dizziness, palpitations, tachycardia, arrhythmias, hypertension, flushing, cough, productive cough, throat irritation, asthmatic crisis, diarrhoea, dry mouth, dyspepsia, dysphagia, burning sensation of the lips, nausea, dyspepsia, pruritus, rash, hyperhidrosis, muscle spasms, myalgia, C-reactive protein increased, platelet count increased, free fatty acids increased, blood insulin increased, blood ketone body increased. Rare: ventricular extrasystoles, angina pectoris, bronchospasm paradoxical, urticaria, angioedema, nephritis, blood pressure increased, blood pressure decreased. Very rare: thrombocytopenia, hypersensitivity reactions, adrenal suppression, glaucoma, cataract, atrial fibrillation, dysphonia, exacerbation of asthma, growth retardation in children and adolescents, oedema peripheral, bone density decreased. Unknown: psychomotor hyperactivity, sleep disorders, anxiety, depression, aggression, behavioural changes (predominantly in children). **Legal Category:** POM. **Packs and Prices:** Fostair 100/6 (PL16626/0156) £25.32. Each inhaler contains 120 actuations. ® denotes Trademark. AeroChamber Plus® is a Trademark of Trudell Medical International. Full prescribing information is available from the **Marketing Authorisation Holder:** Chiesi Limited, Cheadle Royal Business Park, Highfield, Cheadle, SK8 3GY. **Date of preparation:** February 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 Chiesi Limited. (address as above) Tel: 0161 488 5555.

1. NHAS. October 2012. 2. De Backer W, Devolder A, Poli G, et al. Lung deposition of BDP/formoterol HFA pMDI in healthy volunteers, asthmatic, and COPD patients. J Aerosol Med Pulm Drug Deliv 2010; 23(3): 137-148. 3. Fostair Summary of Product Characteristics. Chiesi Ltd. October 2011. **Date of preparation:** October 2012. CHF1562012089701.

Chiesi

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

LAMA = long-acting muscarinic antagonist.

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

Prescribing Information (UK) SPIRIVA® (tiotropium) Inhalation powder, hard capsules containing 18 microgram tiotropium (as bromide monohydrate). **Indication:** Tiotropium is indicated as a maintenance bronchodilator treatment to relieve symptoms of patients with chronic obstructive pulmonary disease (COPD). **Dose and Administration:** Adults only age 18 years or over: Inhalation of the contents of one capsule once daily from the HandiHaler® device. **Contraindications:** Hypersensitivity to tiotropium bromide, atropine or its derivatives, or to the excipient lactose monohydrate which contains milk protein. **Warnings and Precautions:** Not for the initial treatment of acute episodes of bronchospasm, i.e. rescue therapy. Immediate hypersensitivity reactions may occur after administration of tiotropium bromide inhalation powder. Caution in patients with narrow-angle glaucoma, prostatic hyperplasia or bladder-neck obstruction. Inhaled medicines may cause inhalation-induced bronchospasm. In patients with moderate to severe renal impairment (creatinine clearance ≤ 50 ml/min) tiotropium bromide should be used only if the expected benefit outweighs the potential risk. Patients should be cautioned to avoid getting the drug powder into their eyes. They should be advised that this may result in precipitation or worsening of narrow-angle glaucoma, eye pain or discomfort, temporary blurring of vision, visual halos or coloured images in association with red eyes from conjunctival congestion and corneal oedema. Should any combination of these eye symptoms develop, patients should stop using tiotropium bromide and consult a specialist immediately. Tiotropium bromide should not be used more frequently than once a day. Spiriva capsules contain 5.5 mg lactose monohydrate. **Interactions:** Although no formal drug interaction studies have been performed, tiotropium bromide inhalation powder has been used concomitantly with other drugs without clinical evidence of drug interactions. These include sympathomimetic bronchodilators, methylxanthines, oral and inhaled steroids, commonly used in the treatment of COPD. The co-administration of tiotropium bromide with other anticholinergic-containing drugs has not been studied and is therefore not recommended. **Fertility, Pregnancy and Lactation:** No documented clinical data on exposed pregnancies are available. The potential risk for humans is unknown. Tiotropium bromide should therefore only be used during pregnancy when clearly indicated. It is unknown whether tiotropium bromide is excreted in human breast milk. Use of tiotropium bromide during breast feeding is not recommended. A decision on whether to continue or discontinue breast feeding or therapy with tiotropium bromide should be made taking into account the benefit of breast feeding to the child and the benefit of tiotropium bromide therapy to the woman. Clinical data on fertility are not available for tiotropium. **Effects on ability to drive and use machines:** No studies have been performed. The occurrence of dizziness, blurred vision, or headache may influence the ability to drive and use machinery. **Undesirable effects:** Common (≥ 1/100 to <1/10) Dry mouth. Uncommon (≥ 1/1000 to <1/100) Dizziness, headache, taste disorders, vision blurred, atrial fibrillation, pharyngitis, dysphonia, cough, gastrooesophageal reflux disease, constipation, oropharyngeal candidiasis, rash, dysuria, urinary retention. Serious undesirable effects consistent with anticholinergic effects include glaucoma, constipation and intestinal obstruction including ileus paralytic as well as urinary retention. An increase in anticholinergic effects may occur with increasing age. Prescribers should consult the Summary of Product Characteristics for further information on side effects. **Pack sizes and NHS price:** Combopack HandiHaler device and 30 capsules (3 blister strips) £34.87 Refill Pack 30 capsules (3 blister strips) £33.50. **Legal category:** POM. **MA Number:** PL 14598/0062. **Marketing Authorisation Holder:** Boehringer Ingelheim International GmbH, D-55216 Ingelheim am Rhein, Germany. Prescribers should consult the Summary of Product Characteristics for full prescribing information. **Prepared in** August 2012.

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

Date of preparation: August 2012 UK/SPI-121330

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1 in 4

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

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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WORKLOAD

Hunt: I'll free up time for GPs

Health secretary says CCGs tackling variation in standards and improved IT will ease pressure on practices

By Sofia Lind

'Peer review' by CCGs and the Government's pledge on IT will help free up time in general practice, the health secretary has told GPs.

Answering questions after his closing speech at the NHS Alliance conference in Bournemouth last week – his first address as health secretary to an audience of GPs – Jeremy Hunt said addressing variability in standards across GP services marked the Government's first step towards easing the pressure on busy GPs.

He said: 'GPs are overstretched. [There has been a] 3.7% increase in appointments, but there has not been a 3.7% increase in GPs, so there is a big challenge.

'The first thing [CCGs] are going to want to do is to raise standards among their peers, where they think the standards are not as high as everyone else's. I think that will be a way... to reduce pressure on the system.'

Mr Hunt admitted there had been an increase in GP workload, pointing to 1.5m more diagnostic tests in primary care since the general election.

He also said technology would help save time for GPs. 'We need to bring the technology revolution into the NHS; we're really missing an opportunity if we do not do this. We have to have a single digital record that can follow people around the system. The argument I have to make to the NHS is that this is going to save you time,' he said.

He also opened up debate on controversial plans for email access to GPs, saying more research was needed.

Mr Hunt said: 'I don't know if emailing GPs will save time or create work – we've got to do that work before we open up the floodgates. But things like online prescribing I think will save a huge amount of time for GPs.'

Responding to the health secretary's comments, Dr Peter Swinyard, chair of the Family Doctors Association and a GP in Swindon, said: 'How can spending hours on navel-gazing save time? I have seen 37 patients this morning and they are the people who need my time. Peer review might be a brilliant idea but it won't save time.'

Dr Louise Irvine, a BMA Council member and a GP in Lewisham, south-east London, said: 'My response to this? Baloney. It is absolutely not the case that peer review will free up time. The best GPs are the ones who are already going the extra mile for their patients, spending more time with them and providing longer appointments.'

@pulsetoday

Jeremy Hunt: GPs are increasingly overstretched

The rise in GP workload

1.5m
Additional diagnostic tests being carried out in primary care since the election

3.7%
Increase in number of GP appointments over the past year

FUNDING

GPs urged to show 'Churchillian spirit'

GPs should be more willing to dip into their own pockets to help protect patient care, the chair of the NHS Alliance has said.

Dr Michael Dixon called for GPs to show 'red-blooded passion' and 'Churchillian spirit', giving the example of his own practice, where partners have self-funded a health facilitator to organise public health initiatives for the past few years.

He told Pulse: 'I am not saying that this is what we should all do, that we should reduce our pay. But what I am saying is that there is a bit of give and take here and what really matters is that these things happen. I think we need to summon up that Herculean, Churchillian spirit that we had in prior years.'

Dr Dixon's comments came as a new-look NHS Alliance was unveiled at the conference. It will focus on advising GP members wanting to take advantage of 'the full effect of clinical commissioning' by getting together across practice boundaries to deliver additional services as companies or social enterprises.

But GPC chair Dr Laurence Buckman said: 'Spirit and passion do not pay the staff nor develop premises. They do not enable days to lengthen to 28 hours. Sadly, Churchill is dead.'

CCGS

CCGs will help shape contracts, says Hakin

The NHS Commissioning Board will work with CCGs to determine what services should be provided under the GP contract, the Government's commissioning tsar has said.

Dame Barbara Hakin, national director of commissioning development, said while the NHS Commissioning Board would be responsible for holding the GMS and PMS contracts, CCGs would feed into that process.

She said: 'The board hold the basic GMS and PMS contracts but CCGs have a duty of partnership and a duty to improve the quality of primary care.

'This is not about delegating the management of contracts for primary care to CCGs; that will be the responsibility of the board.'

She also reiterated that CCGs are membership organisations with which GPs should engage and that CCGs will be responsible for commissioning local enhanced services on the ground.

A board spokesperson said: 'CCGs will be able to commission a wide range of community-based services that meet the health needs of local communities, including primary care services that go beyond the scope of the GP contract.'

"Sometimes it seems to take over your life"

"Don't feel normal" **"Cannot sleep"**

"Part of your mind is on your **pain,** and another part of your brain is taken up with **constipation"**

"I know I have to take my pain meds but it's *awful* to always feel constipated"

"Makes one feel isolated"

"It is a constant discomfort and makes me unhappy"

"It dominates ***everything*** I can do"

"Constantly worrying or upset"

Real patient quotes taken from a survey commissioned by Napp Pharmaceuticals of 2,000 UK opioid treated patients.

When was the last time you asked them about it?

59% of patients taking opioids suffer from constipation.[1]

They might not tell you unless you ask.

NAPP

1. Napp Pharmaceuticals Limited. Constipation survey of 2,000 UK adults taking opioids. July 2012. Data on file.

UK/PAIN-12272D. Nov 2012.

Fears for the next generation

As Dr Iona Heath steps down as RCGP president, she tells Pulse why GP morale has hit rock bottom

By Madlen Davies

On her last day as president of the RCGP, Dr Iona Heath has lost her voice. Yet even at the level of whispers she speaks with real conviction about the Government's failure to safeguard the morale of GPs.

Funding cuts, the NHS reforms and now the proposed revamp of the GP contract have all been blows to the profession's morale, she says – and she fears these issues could prompt weary partners to retire or young trainees to head overseas.

'If you damage morale further – for example, by imposing a contract – you are likely to see departures,' she says. 'If you're 58, why would you hang about if life is getting more and more difficult?

'It's the responsibility of those charged with the stewardship with public service to foster the morale of public servants,' she adds. 'Successive governments have been lax in that imperative.'

Now retired clinically – she was a GP in Kentish Town, north London, for 35 years and made her name writing on ethics and the core values of general practice – Dr Heath has served as the college's president for the past two years.

It's a largely ceremonial role, but one she has been widely acclaimed for. And as well as being uncompromising in her criticism of governments past and present, she doesn't shy away from highlighting areas of general practice that need a redesign.

Chief among these is out-of-hours care, she says, where GPs need to do some 'creative thinking'.

'The contract in 2004 where GPs lost responsibility for out-of-hours care has been a very serious issue for patients,' she says. 'I think as a profession we see the benefits of continuity of care all the time, and yet we don't extend it into out-of-hours care.

'There will have to be some move there because people don't get the best care out of hours if they see someone who is not familiar with them.'

She adds that the increasing scaling up of general practice has particularly dangerous implications out of hours. 'We have out-of-hours services that cover huge populations where nobody knows who they're talking to or who they're dealing with.'

Instead, she advocates small, local out-of-hours rotas – although not a return to the pre-2004 system.

'There is a generation of doctors who came into general practice precisely because they didn't want to do out-of-hours, and that is a problem,' she says.

Dr Heath is handing over to her successor Professor Mike Pringle at a time when there are both causes for celebration and concern at the college. Its bid for four-year training – hailed by RCGP chair Professor Clare Gerada as a 'gift to future generations' – has been accepted by the Government, and the college is thrashing out funding details.

But elsewhere the RCGP has come under attack. Its decision to help the Government explore how to give patients electronic records access by 2015 was recently denounced by one senior GPC member as 'politically naive' for allowing extra work to be foisted on GPs.

'It's wonderful,' says Dr Heath with a wry smile. 'You can be criticised for opposing the Government and then you're criticised for "getting into bed" with them.'

And then there's the legal threat the RCGP is facing over the high failure rates of international GP trainees in the MRCGP exam.

A question about this draws a stern intervention from the college press officer. All she can say is that the RCGP expects ongoing research from King's College London into the performance of international trainees to produce only 'subtle' results.

A fire alarm signals the end of the interview with Dr Heath, who was described as a 'hero' during Professor Gerada's speech at the RCGP annual conference. Her successor will hope to receive such accolades – though he might have to help put out a few fires first.

@madliendavies

Dr Iona Heath: successive governments have been 'lax' in safeguarding GP morale

MORE ONLINE
Watch the video interview in full
pulsetoday.co.uk/the-big-interview

Dr Iona Heath on...

Continuity of care
'Young, fit patients are not interested in continuity of care. They want an immediate service from the first doctor they can see in a convenient time. Fair enough. But as soon as someone has a significant health problem, continuity of care becomes really important for them.'

Privatisation
'Care becomes proportionately much more difficult the more different providers there are involved. If you get physiotherapy from one provider and tests from another – how does that lead to continuity of care?'

Partnerships
'People in partnerships are more committed to the practice, to the area and to their patients, and so you get better continuity of care. If you're just a paid employee, why would you hang around if things get difficult?'

Demands on GPs will rise with e-consulting

Study shows patients with online access make more GP and hospital visits

By Emma Wilkinson

Government plans to increase online access to medical records and e-consultations will push up demands on clinicians and increase costs, a study suggests.

Patients given online access had a significant increase in consultations, out-of-hours visits, trips to A&E and hospital admissions, analysis of data from an online access system used by the US healthcare organisation Kaiser Permanente showed.

The researchers from Kaiser Permanente's Institute for Health Research concluded that, contrary to current thinking, online services do not cut the need to see the doctor.

The study compiled data from almost 159,000 patients and compared the healthcare use of those with access to MyHealthManager and those without. It showed patients who had electronic access to their medical records and test results and the ability to email their doctor made an average 0.7 extra clinic visits a year after they signed up.

Phone consultations went up by 0.3 per patient per year and out-of-hours visits rose by 19 per 1,000 patients, the study found.

Trips to A&E also went up by 11 per 1,000 patients per year and there were 20 more hospital admissions a year for every 1,000 people signed up to the online service.

The researchers, writing in the *Journal of the American Medical Association*, concluded: 'If these findings are evident in other systems, healthcare delivery planners and administrators will need to consider how to allocate resources to deal with increased use of clinical services.'

A separate UK Cochrane review found there was no evidence to support the increased use of email in healthcare.

The Government has pledged that all patients will be able to email their GP practice by 2015 and also plans to expand e-consultations by GPs. Radical plans are also in place to dramatically expand patients' online access to their records.

Dr Paul Cundy, chair of the joint GPC and RCGP IT committee, said the figures in the American study were 'a disaster', and said the GPC had already raised concerns over increased workload.

'In the US there is a positive disincentive to seeking healthcare because they have to pay but this shows it still resulted in more consultations,' he said.

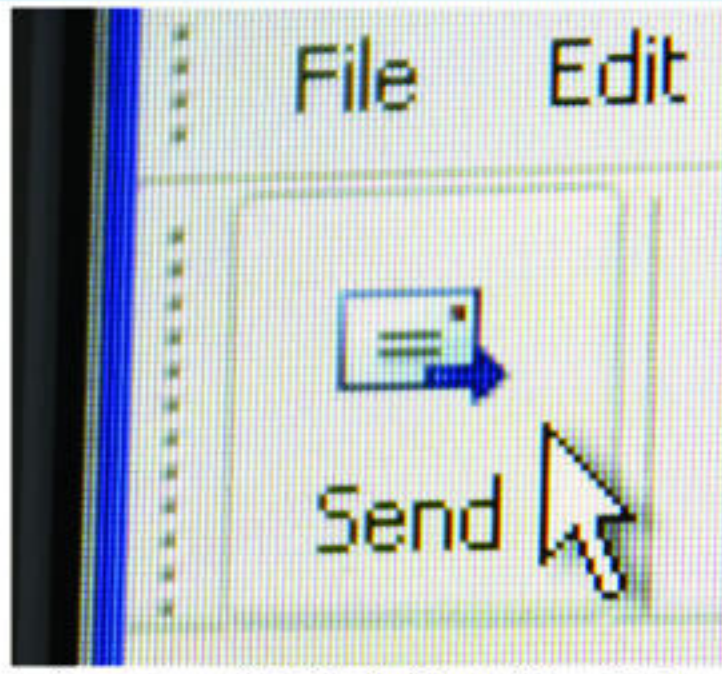
'In the UK system, it is highly likely the effect will be even greater... there is no capacity in general practice for additional work from the IT-literate, worried well.'

Dr Brian Fisher, patient and public involvement lead for the NHS Alliance and a GP in south-east London, said he would not recommend communicating by email as it was insecure, but suggested using secure messaging instead.

He said: 'There is evidence that, if you combine messaging and patients having access to their records, you can save time, telephone calls and appointments... It is a synchronous communication so easy to manage.'

An NHS Commissioning Board spokesperson said giving patients online access to their GP records was a priority.

HAVE YOUR SAY
Join the debate in Pulse's new-look forum
pulsetoday.co.uk/forums



Email access was associated with a rise in doctor visits and telephone

How online access increases demand

Average annual increase in use of healthcare among patients given online access

Asthma
- 0.8 doctor visits
- 0.2 phone consultations
- 18 per 1,000 out-of-hours visits

Diabetes
- 0.6 doctor visits
- -0.2 phone consultations
- 32 per 1,000 out-of-hours visits

Coronary artery disease
- 0.5 doctor visits
- 0.5 phone consultations
- 45 per 1,000 out-of-hours visits

Congestive heart failure
- 0.9 doctor visits
- 3 phone consultations
- 21 per 1,000 out-of-hours visits

Imperial errors review finds no patient harm

A review into internal 'data reporting' issues at a major NHS trust which delayed hundreds of urgent two-week referrals, has found no patients came to clinical harm as a result of the errors.

The independent Waiting List Clinical Review group was set up in July, after Pulse revealed the records of 1,023 patients referred by GPs to Imperial College Healthcare NHS Trust were found to be incomplete. This forced the trust to write to GPs to ask for their help in tracking patients to check they had attended their appointment.

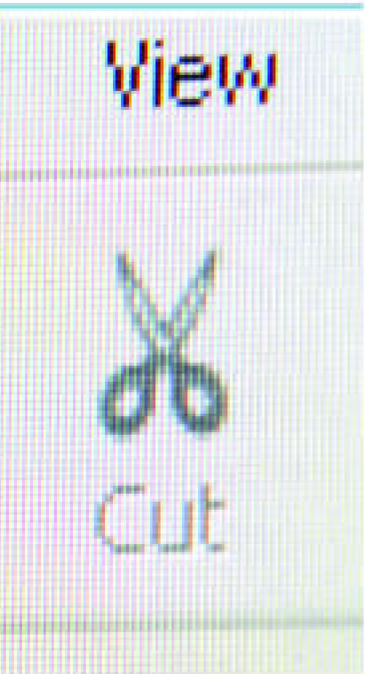
The group reviewed over 1,800 patients and a full year's worth of trust data relating to measures of patient safety, but found none had come to any clinical harm following the delays.

The review included 74 suspected cancer patients who died following referral and 303 patients who died while on the inpatient waiting list.

Mark Davies, chief executive of Imperial College Healthcare NHS Trust, said he accepted the review and recognised the failures of systems, management and record-keeping were clearly not acceptable.

▶ Practice dilemma, page 34

Offering antibiotics without a prescription is a backwards step ▶ page 19



consultations

'Five to 10' quality premium targets

By Helen Mooney

The quality premium payments for CCGs are likely to be based on a set of five to 10 measures drawn from the NHS Outcomes Framework, a senior figure from the NHS Commissioning Board has disclosed.

The targets, for which CCGs are understood to be going to be awarded up to £5 per head of population – up to an average of £1.25m per CCG – are to be called 'CCG outcome measures' and will form part of the new Commissioning Outcomes Framework.

CCGs will then be free to distribute these payments to GP practices in their area according to criteria they set themselves.

The proposals, if approved by the NHS Commissioning Board this week, would become secondary legislation in January next year and dictate the quality premium targets for 2013/14, said Alison Westmacott, strategic programme lead for the NHS Commissioning Board.

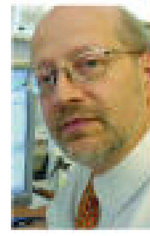
Speaking at an NHS Clinical Commissioners event in Bournemouth, Ms Westmacott said: 'I think it's safe to say the [Government's] mandate [to the NHS Commissioning Board, published last week] has set the NHS Commissioning Board the targets of what has to be delivered in the NHS Outcomes Framework, so the quality measures are likely to be aligned to those five domains.'

The domains are:

- Preventing premature deaths
- Improving quality of life in long-term conditions
- Improving patient experience
- Reducing avoidable harm
- Helping people recover from ill health.

She said the feedback from CCGs was 'small number equals high impact' adding that she was looking at 'eight… so maximum 10, but think looking at five to eight probably.'

According to Ms Westmacott, the measures chosen will be based on those where data is already available and collated, so practices would not have to commit resources to collect new data.



'It doesn't sound like something that is good for patients or GPs.'
Dr Rob Barnett

A spokesperson for the NHS Commissioning Board said the board had worked and engaged with a wide range of stakeholders over recent months, adding: 'Key details of the quality premium scheme for 2013/14 will be finalised over the coming weeks.'

But Dr Rob Barnett, secretary of Liverpool LMC, told Pulse the quality premium was 'absolute madness'.

'I am not in favour of rewarding GPs or practices in this way,' he said. 'It risks providing an incentive for GPs to work in a way in which they would not otherwise work and does not help to build trust with patients.

'It doesn't sound like something that is good for patients or good for GPs.'

Patients warned over self-test kits

The MHRA has warned patients that self-test kits should not be used to replace a GP consultation.

Self-help kits are now available for a range of conditions, including infertility, STIs and cancer, and new guidelines released by the MHRA provides patients with advice on using kits.

It said self-test kits can have a role to play in healthcare but warned they could 'rarely exclude a disease and may not be as helpful as a GP consultation and laboratory testing'.

The MHRA stressed access to high-quality tests was available on the NHS and home tests should never replace results from a national cancer screening programme.

John Wilkinson, the MHRA's director of devices, said: 'While they can act as a useful guide to the state of your health, they should never replace a GP consultation.'

Rabies jab drought leads to unlicenced vaccine use

GPs are facing a national rabies vaccine shortage, which is forcing them to use an unlicensed product, Pulse has discovered.

Novartis' Rabipur is out of stock in the UK and GPs are using the licensed Sanofi Pasteur MSD (SP MSD) vaccine BP, leading to a shortage.

As a result, an agreement between the MHRA and DH has allowed SP MSD to import the unlicensed Verorabvaccine.

Dr George Kassianos, a GP in Bracknell, Berkshire, and RCGP spokesperson on immunisation, said: 'Not only are we not able to make vaccination available but often we are not able to complete courses we have started.'

IN BRIEF

Detecting lung cancer

GPs are not 'up to speed' at spotting symptoms of lung cancer and need to be better linked to multidisciplinary teams, a report from the Lung Cancer Coalition has claimed.

Full story ▶ pulsetoday.co.uk/clinical-news

DH boss goes private

Private health firm Care UK has announced that Jim Easton, national director of improvement and efficiency at the Department of Health, will take over as managing director of its healthcare division in January.

Full story ▶ pulsetoday.co.uk/political-news

Walking helps elderly

Offering patients over 65 a pedometer and two consultations with practice nurses to discuss a walking plan increases activity levels, a new study has found.

Full story ▶ pulsetoday.co.uk/clinical-news

Primary care study reveals extent of hip fractures in elderly patients soon after initiation of medication

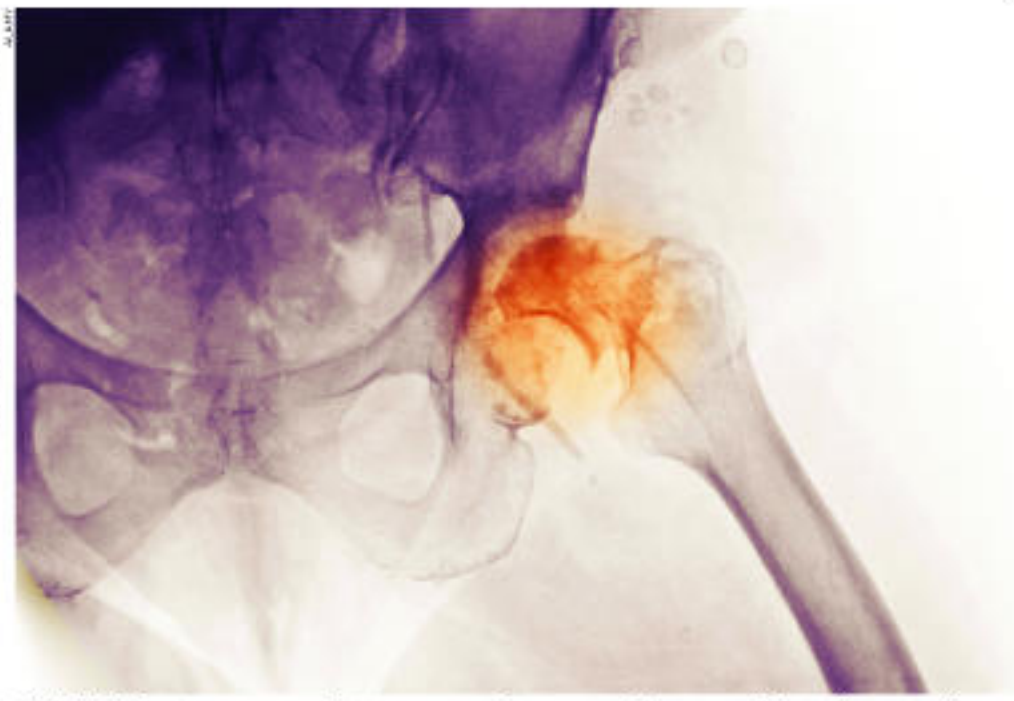
HYPERTENSION

Fracture risk raised by BP drugs

By David Swan

Initiating an antihypertensive in elderly patients is associated with a 43% increased risk of hip fracture during the first 45 days, suggests a new study.

Although other studies have shown an increase in the risk of falls, this is the first to show antihypertensive medication is associated with an immediate increased risk of hip fracture in older people - with a particularly strong association for ACE inhibitors and ß-blockers.



Risk of hip fracture may necessitate a more cautious approach to prescribing antihypertensives

Online CPD

Key questions on falls

pulselearning.co.uk

The Canadian study looked at 301,591 patients aged 66 or over, newly treated with a thiazide diuretic, ACE inhibitor, ARB, calcium channel blocker or a ß-blocker.

Researchers looked at their risk of fracture in the 45 days after antihypertensive initiation and found it increased by 43% compared with three control periods of 45 days pre-exposure.

All drug classes increased the risk of falls, but this was most marked with ß-blockers and ACE inhibitors, which increased the risk of fracture, by 58% and 53% respectively.

The period of 15 to 44 days after initiation appeared particularly high risk, with ß-blockers associated with more than double the risk of fracture and a 58% increased risk for ACE inhibitors.

Study leader Dr Debra Butt, a GP and assistant professor in community medicine at the University of Toronto said: 'Our findings suggest the underlying mechanism is orthostatic hypotension.

'We know ACE inhibitors are associated with a risk of first-dose hypotension - related to venodilation - and that ß-blockers have adverse effects such as bradycardia, decreased cardiac output and depression or confusion which may result in falls.'

Dr Ivan Benett, a GPSI in cardiology in Manchester, said that while caution should be taken in extrapolating the results, they should make GPs more careful when prescribing the drugs in older patients.

He said: 'It is doubly important to ensure the accuracy of blood pressure diagnosis using ambulatory readings or frequent home monitoring in older patients. Patients should be monitored closely and perhaps have further ambulatory monitoring if they have symptoms suggestive of orthostatic hypotension.'

He added that different discussions about hypertension should take place with older patients. 'We need to explain the possible side-effects of medication and include them in the decision-making about whether to manage with drugs at all.'

***Arch Intern Med* 2012, available online 19 November**

@pulsetoday

Raised risk of fracture

58% ß-blockers

53% ACE inhibitors

41%* ARBs

33%* Thiazide diuretics

30%* Calcium channel blockers

*not statistically significant
Source: *Arch Intern Med* 2012

TYPE 2 DIABETES

Exercise plus diet cuts diabetes risk

Increasing physical activity only reduces the incidence of type 2 diabetes in at-risk patients when combined with diet, according to a new review.

Exercise plus diet change was found to reduce the risk of developing type 2 diabetes by 37%, compared with standard recommendations such as advice or education on increasing physical activity.

Exercise on its own reduced the risk of type 2 diabetes incidence by 31% compared with standard recommendations, but this was not significant.

A combined exercise and diet intervention also reduced fasting plasma glucose, compared with standard recommendations, with a mean difference between the two of -0.19 mmol/L.

The review featured eight trials with a total of 5,956 participants, all of whom were in a major risk group for the development of type 2 diabetes, such as impaired glucose tolerance or impaired fasting glucose.

The conclusions reinforce recent NICE guidance on preventing diabetes that emphasises the need for structured, intensive lifestyle modification programmes in those with impaired glucose tolerance.

***Cochrane* 2012, available online**

STROKE

SSRIs cut disability and depression after stroke

SSRIs are effective in improving some stroke outcomes, including depression, according to a new review.

The analysis found that SSRIs significantly improved neurological deficit in post-stroke patients compared with placebo or usual care.

Similarly, disability - measured on a number of disability scores - improved in patients treated with SSRIs compared with usual care.

SSRIs also reduced the risk of depression by 57% compared with placebo or usual care.

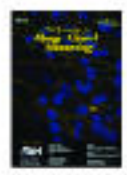
The review included 52 randomised controlled trials, totalling 4,059 patients with a diagnosis of stroke who had been given an SSRI within the first year of stroke onset. There were no restrictions on dose or length of time with regard to SSRI prescriptions and no SSRI appeared more effective than another.

Study lead Professor Gillian Mead, professor of stroke and elderly care medicine at the University of Edinburgh, said: 'This review data provides evidence of benefit of SSRI for reducing disability and neurological impairment scores in people with stroke.'

***Cochrane* 2012, available online 14 November**

ASTHMA

Inhalers not used during pregnancy



Over a third of women with asthma stop their asthma medication when they become pregnant, warn researchers.

Their retrospective study of prescriptions dispensed in northern Holland between 2004 and 2009 found that 38.2% of women in the first trimester of pregnancy stopped using their asthma medication. Prescription data from almost 26,000 pregnant women was included in the study.

Of the asthma medications included in the study, long-acting bronchodilators and combination preparations were the drugs that were most likely to be stopped in the first months of pregnancy compared with the months before.

Medication use generally returned to normal within six months post-partum.

The authors conclude that almost 30% of women with asthma stop whatever preventive therapy they are taking when they become pregnant. Although they were unable to determine how many women stopped asthma treatment without telling their doctor, previous research suggests around a third of women who stop medication while pregnant do so.

***Journal of Allergy and Clinical Immunology* 2012, available online 11 October**

CONFERENCE ROUND-UP

Longer-term data on dabigatran

New 2.3-year follow-up results from the RELY-ABLE study, which featured 5,851 patients receiving dabigatran, found that a 150mg dose reduces stroke risk by 9% and the likelihood of death by 3%, compared with the 110mg option. It did, however, produce 26% higher risk of major bleeding and 31% increase in risk of intracranial bleeding.

American Heart Association 2012 scientific sessions

Warning over high-dose satins

Two trials, with a combined 15,056 patients at risk of diabetes, found that in low-risk patients there was no difference between high- and low-dose statins with regard to risk of new onset diabetes. But in the high-risk population, a high-dose statin increased the risk of new onset diabetes by 24%.

American Heart Association 2012 scientific sessions

Multivitamins do not reduce CV risk

A total of 14,641 men were randomised to receive either multivitamin or placebo and followed for 13 years. There was no difference between the groups for risk of major cardiovascular events. There were no significant differences in the MI rates, all stroke and angina between the groups.

American Heart Association 2012 scientific sessions

SMOKING CESSATION

No difference between quitting strategies

Cutting down on cigarettes before quitting is as effective as abruptly stopping, suggests a Cochrane review.

The UK authors compared outcomes in studies that used both approaches and found quit rates similar although there was a non-statistically significant 6% higher success rate among those who cut down before quitting.

Ten studies with a total of 3,760 participants were included and no evidence was found to suggest the use of pharmacotherapy, behavioural support or self-help therapy were likely to make one approach more effective than another.

The research concluded patients can be given a choice to quit smoking either by reducing cigarettes smoked before quit day or by quitting abruptly, but the researchers stress that studies still need to be done on another strategy - advising patients to cut down and quit when they feel ready.

***Cochrane* 2012, available online 14 November**

CPD TIP OF THE WEEK

Negative swabs of doubtful value in PID

A negative swab in a woman with symptoms of pelvic inflammatory disease does not exclude an infection and should not influence a decision to treat, according to an updated CPD module. Swabs should be taken, but a negative swab in the presence of the classic clinical features and suggestive history outlined in the module mean the woman should be treated, say the authors. Currently recommended regimes are:

- **oral ofloxacin 400mg twice daily plus oral metronidazole 400mg twice daily for 14 days**
- **ceftriaxone 250mg single dose IM, followed by oral doxycycline 100mg twice daily plus metronidazole 400mg twice daily for 14 days.**

ONLINE CPD
See the Key questions on pelvic inflammatory disease at www.pulse-learning.co.uk

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* Based on the cost of 1 Spiriva® Handihaler® vs. Eklira® Genuair® initiation at month 1

† Network meta-analysis and phase III study evaluation of aclidinium vs. tiotropium

** Measured by St George's Respiratory Questionnaire

†† Assumes use of 1 Spiriva® Handihaler® and 11 refills in 1 year or 12 EKLIRA GENUAIR® packs in 1 year

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1. Jones PW *et al. Eur Respir J.* 2012;40(4):830-6. **2.** Kerwin EM *et al. COPD* 2012, 9(2):90–101. **3.** Data on File AB01. **4.** Data on File AB02. **5.** EKLIRA GENUAIR Summary of Product Characteristics, 2012. **6.** Chrystyn H *et al. Int J Clin Pract.* 2012;66(3):309-17. **7.** MIMS September 2012.

Date of preparation: October 2012

UKACL1332

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

internis.

If ever there was a time to fight...

It's now more than a month since the Department of Health issued its ultimatum over the GP contract – and for many GPs, it has felt like a phoney war.

There is no doubt the proposed changes would have a huge impact on every practice, with the QOF changes in particular likely to ramp up workload, and the phasing out of MPIG and Carr-Hill adjustments set to radically reshape practice funding.

But since the initial announcement there's been little movement. GPC negotiators have made it clear they oppose the changes. But they have held fire on any detailed response until after the publication of the Statement of Financial Entitlements – which was expected any day as Pulse went to press and would signal the start of the Government's formal consultation ahead of a possible imposition.

The news that the BMA is planning roadshows around the country to discuss the changes in early 2013 suggests negotiators are digging in. It is unlikely to be all over by Christmas.

In the meantime, as we reveal today, behind the scenes both GPC members and LMCs are agitating for a robust response. The talk is of some kind of bureaucracy boycott, perhaps non-cooperation with revalidation or the CQC, or maybe working to rule. But it is the suggestion that GPs could be asked to withdraw from commissioning that is most likely to grab ministers' attention, coming as it does at a delicate moment in the transition from PCTs to CCGs.

Steve Nowottny
Editor

The elephant in whichever room GPs meet to discuss the profession's response is, of course, the 'Day of Action' debacle. The BMA's industrial action over pensions – which somehow managed to annoy patients and attract negative media coverage while having little practical impact – was an unmitigated failure.

The pensions failure must not inhibit GP leaders' response

But that must not inhibit GP leaders as they determine their response.

For a start, as many argued on pensions, action targeted at bureaucracy is a very different prospect from action explicitly designed to interrupt patient care. A boycott of commissioning would be uncharted territory, and there are arguments against, but withdrawing support from controversial reforms would play better with the public and the media than stopping appointments.

Then there's the sheer scale of the changes under consideration – and the DH's bully-boy tactics in threatening to impose them without negotiation. The full long-term ramifications on practice finances are yet to become apparent, but they will be profound.

Worryingly, after the last GPC meeting, chair Dr Laurence Buckman wrote to GPs promising to 'deliver tools and guidance to help you understand what the changes will mean for your practice'. That's useful, of course – but also sounds a little bit like the changes may be a *fait accompli*.

The GPC and LMCs' primary function is to fight for GPs' terms and conditions, and if ever there was a time to fight for them, it is now. The BMA must consider using every weapon in its arsenal – even if, post-pensions, that arsenal feels a little barer than GPs would like.

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

OPINION

Offering antibiotics without a prescription is a backwards step

A new pharmacy drugs access scheme could jeopardise the drive against antimicrobial resistance, writes **Dr Steve Kell**

There are many issues to consider in a GP consultation – prevention, discussion, examination, ruling out serious illness. So why do patients assume that dealing with infection is a simple business?

The rise of antimicrobial resistance and acquired infections, such as *C. difficile*, has increased the importance of prescribing antibiotics appropriately.

The need for careful prescribing was debated recently, as the chief medical officer again highlighted the issue of antibiotic resistance to mark Antibiotic Awareness Day on 18 November. And yet, as Pulse reported last week, the National Pharmacy Association (NPA) is planning the national roll-out of a scheme giving patients access to some 16 medicines – including antibiotics – without a GP consultation, via a patient group direction.

GPs everywhere notice an increase in consultations when winter approaches, as infections increase and hospitals report increased admissions. And allowing pharmacists to offer certain antibiotics without a prescription would indeed reduce workload during this busy period.

Increased resistance and perhaps the failure to identify other conditions is often not an immediate 'adverse event'. Delayed diagnosis may not become apparent for some time, particularly if information is not shared to ensure appropriate follow-up. Coughs persisting for three weeks may be a chest infection, but chest X-rays are recommended to exclude lung cancer. How do we identify patients with recurrent urinary infections who may require investigations if they attend multiple pharmacies? Patients with chlamydia may benefit from easy access to azithromycin, but is contact tracing likely to occur?

The list of antibiotics available in the scheme is interesting. Most local antibiotic guidelines recommend amoxicillin as first line for chest infections, based on evidence, cost and reducing resistance, and yet it is not on the NPA's list. Should patients presenting to a pharmacist not expect to be treated in the same way?

In Bassetlaw, where I work, we identified the need to reduce prescriptions for certain antibiotics due to a high local rate and concerns about the number of *C. difficile* infections. There is evidence of an association between cephalosporins and quinolones (such as ciprofloxacin) and the risk of *C. difficile*, as well as resistance. We reduced the percentage of these antibiotics from 14% of all antibiotics to 4%. This was a sustained change, and has led to a significant reduction in local *C. difficile* infections. Yet ciprofloxacin is included in the NPA's list.

I wouldn't support the introduction of the NPA scheme in my area.

We already know how difficult it can be to persuade patients that antibiotics may not be needed. They often use walk-in centres for a 'second opinion' when their GP refuses a request for antibiotics. Just think how easy it could be for a patient to get what they want if they had half a dozen pharmacists to harangue. An NPA spokesman describes the proposals as 'all about improving access to self-care', but buying antibiotics without obtaining a GP prescription isn't necessarily self-care; it's just using a different route to get them.

Reviewing medication, reducing polypharmacy and improving prescribing in nursing homes are excellent initiatives that allow pharmacists to improve quality and reduce morbidity and admissions. But pharmacists are experts at medication, not diagnosing, safety netting or consulting.

We need a consistent message on antibiotics: they are essential, but it is important to use the right one at the right time. It is difficult to understand the rationale of reducing antibiotic prescribing and encouraging patients to self-care, but then making antibiotics available without an individual prescription. The World Health Organisation has repeatedly identified antibiotics being accessed without a prescription as a factor contributing to resistance in many countries. The UK should not join that list.

Dr Steve Kell is chair of NHS Bassetlaw CCG and a GP in Doncaster

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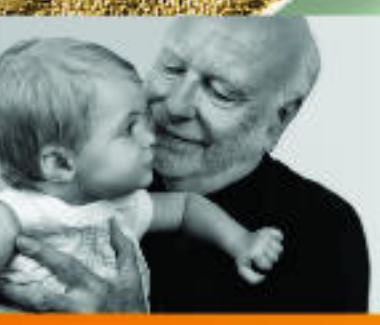

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The injection site should be varied periodically. Inadvertent intravascular administration must be avoided. **Contraindications:** Hypersensitivity to LHRH, its analogues or any other component of the medicinal product. **Precautions and Warnings:** Long-term use of LHRH agonists is associated with an increased risk of bone loss and may lead to osteoporosis and increased risk of bone fracture. Particular caution in patients with risk factors for or established osteoporosis is necessary. Rarely, LHRH agonist treatment may reveal the presence of a gonadotropin cell pituitary adenoma. Mood changes, including depression have been reported. Patients with known depression should be monitored closely during therapy. Initially, Decapeptyl SR, like other LHRH agonists, causes a transient increase in serum testosterone levels. As a consequence isolated cases of transient worsening of signs and symptoms of prostate cancer (tumour flare) and cancer related (metastatic) pain may occasionally develop during the first weeks of treatment and should be managed symptomatically. During the initial phase of treatment, consideration should be given to the additional administration of a suitable anti-androgen to counteract the initial rise in serum testosterone levels and the worsening of clinical symptoms. As with other LHRH agonists, isolated cases of spinal cord compression or urethral obstruction have been observed. Careful monitoring is indicated during the first weeks of treatment, particularly in patients suffering from vertebral metastases, at risk of spinal cord compression, and in patients with urinary tract obstruction. After surgical castration, Decapeptyl SR does not induce any further decrease in testosterone levels. 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Decapeptyl SR is a suspension, therefore once reconstituted it should be used immediately. **Legal Category:** POM. **Basic NHS cost:** Decapeptyl SR 3mg £69.00 per vial. Decapeptyl SR 11.25mg £207.00 per vial. Decapeptyl SR 22.5mg £414.00 per vial. **Marketing Authorisation Numbers:** Decapeptyl SR 3mg: PL 34926/0002. Decapeptyl SR 11.25mg: PL 34926/0009. Decapeptyl SR 22.5mg: PL 34926/0013. **Marketing Authorisation Holder:** Ipsen Ltd, 190 Bath Road, Slough, Berkshire, SL1 3XE, UK. Tel 01753 627777. Date of preparation of PI: December 2011.
Ref: UK/DEC/0632a (6m Adjuvant licence)

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* At NHS list price and licensed posology.
Date of preparation: January 2012. DEC0621b

Revalidation? Do patients first

Texting, spittle-spraying and a strange refusal to wear pants all point to a marked decline in patient standards, says **Copperfield**

I'm writing this column with doc flu, which is even worse than man flu. And because I'm a man doc, it's actually man doc flu, which is the worst of all. I know when I've got man doc flu, because patients say to me, 'you should see a doctor', an utterly hilarious joke for those with a pounding headache, a sandpaper throat and a bulging waiting room, particularly at the eighth time of hearing.

And I know why I've got it, too. It's because, roughly the incubation period of a rhinovirus ago, a middle-aged man with a URTI coughed, long and hard, in my face. He made absolutely no attempt to turn away or cover his mouth; I could feel his catarrhal aerosol pepper my cheeks.

'You disgusting oik!' I exclaimed. 'That's appalling. Have you really reached the age of 50 without learning any decency or manners? Don't you know anything about personal hygiene? Can't you keep your revolting germs to yourself? Next time, I hope it's Ebola, you spittle-spraying troglodyte.'

Not out loud, obviously. After all, I'm not sure where the GMC stands on this. I'm dimly aware that it doesn't like us insulting patients – but why should I let this phlegm machine scattergun his vile droplets everywhere, potentially causing doctors to be off sick and thereby compromising the care of other patients? Suck on that, duty ethicist.

Anyway, this is just the tip of an iceberg of declining patient standards. As I'm sure you'll have noticed, the buggers just can't be arsed about anything these days.

Take dress sense, for example. 'You're worried about your earache?' I said, incredulously, to a patient the other day. 'Yet you're unconcerned about wearing pleated trousers with turn-ups?' And personal grooming: 'So, you want treatment for your ingrowing toenail? Sure. But have you seen your hair?'

I could go on, so I will. Here are some other ways in which patients have let themselves go. They turn up to my Saturday morning surgery in pyjamas. They drop litter in the corridor on the way to my consulting room. They come in still holding a conversation on their mobiles and they're perfectly happy to take, and respond to, text messages during the consultation. They turn up 20 minutes after their appointment time and then try to justify it by pointing out that I always run late anyway. They think it's acceptable to try to become my 'friend' on Facebook, and if you'd argue that this is hardly evidence of a drop in standards, I'd say it's a drop in the standard distance we should safely put between ourselves and patients.

Patients think it's acceptable to try to become my 'friend' on Facebook

Oh, and they don't always wear pants. Revolting.

Clearly, the punters need to up their game. If we GPs are supposed to respond appropriately to draconian scrutiny in an effort to raise standards, then so should they. So I propose that we revalidate patients every five years.

And forget about remedial training: those who don't make it simply forfeit their right to any treatment, for anything, forever. Some would say that's harsh. I say it's evolution.

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

More online

Can't wait for his next column? You can now get your regular blast of the world according to Copperfield via Twitter @doccopperfield or on his blog at pulsetoday.co.uk/copperfield

CQC box-ticking puts my patients at risk

LETTER OF THE WEEK

From Dr John Cormack
South Woodham Ferrers, Essex

Congratulations to Copperfield for his column highlighting the damage done by the CQC ('One more policy and I'll scream,' pulsetoday.co.uk/copperfield). We too have had to take clinicians away from the task for which they trained (looking after patients) and set them to work in the back office to produce mountains of documents that are at best worthless.

Nobody is immune to the epidemic of insanity that currently threatens to engulf the NHS but, in a grossly underfunded practice, we fare worse than most. The additional resources required for the preparatory work for the CQC visit cannot be generated by a reduction in the 'profit' – because there isn't one.

Here we have to cut to the bone and beyond, given that the costs of all such misguided activity has to be diverted from the already dangerously inadequate budget we've been given for looking after our patients. This time-wasting exercise poses a greater threat to my patients than MRSA, *C. diff* and meningitis B put together, with a seasonal flu epidemic thrown in for good measure.

For the past 30-odd years that I've worked in general practice, I've provided affordable medicine. The CQC will do away with all that at a stroke.

Whoever is running the NHS now really has to look carefully at what is happening in a health service in which patient care is at the bottom of the agenda. General practice, the jewel in the crown, is under attack as never before. The combination of measures now unfolding contains all the ingredients for the perfect storm – droves of first-rate, experienced GPs are looking to grab the first opportunity to retire, find alternative employment or emigrate. As ever, those in charge won't realise the consequences of their actions until it is too late.

When an updated account of general practice is written in years to come, all those who have been responsible for the chaos in which we now attempt to work will be named and shamed.

But it is the CQC that will be given the ultimate accolade – it's the most damaging initiative to have hit general practice in the history of the NHS.

Dr John Cormack: CQC work will distract from patients

Salaried plan would destroy continuity

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

The Policy Exchange report suggesting GPs should relinquish their partnership status to work as salaried GPs ('Government urged to pay GP partners £160k to go salaried,' pulsetoday.co.uk/news), raises more questions than it answers.

Would a salaried service improve the commitment of senior GPs to continuity of care for their patients? Would it come under the European Working Time Directive, which has destroyed consultant firms at hospitals and destroyed continuity and joined-up care in hospitals? Would I get a company car? Who would buy my premises? And for how much?

What incentive can we offer to the young doctors of today that could convince them a salaried service would offer as good a job as that of a partner in general practice – which, for all the pressures, stresses and strains, I still consider the best job in the world?

The only compensation is that I have in the past been labelled as 'unmanageable', which I took as a great compliment. But being unmanageable is not conducive to working in a salaried service.

● From Dr Sally Dowler
Tottenham, north London
via pulsetoday.co.uk

We need to wake up. This is the ultimate long-term plan: get us all to go salaried by waving a fat salary at us and this apparent option to stick to the contracted hours. Once we are all there, then you screw down the salary – then we are all left with no voice, no options and no money.

Employment may be lesser of two evils

From Paul Conroy,
Practice manager, Mersea Island, Essex
via pulsetoday.co.uk

GPs refused to be part of the NHS when it was formed, preferring to remain independent contractors. Now we will be pushed to one logical conclusion or the other – either we will be fully privatised or we will be employees of the NHS. I know of a number of practices unable to find partners as no one wants the workload and responsibility that partnership entails.

Recruitment is tough now, and there may be a temporary rise in costs as organisations fight for the best GPs, with high retirement and emigration rates and low pass rates on the MRCGP. Practices will be forced to either negotiate harder and push the Government to pay for its demands, or employment will be the less of two evils. Being a salaried doctor in an organisation that is viable may be better than being a partner in a practice that no longer is.

● From Dr Mark Struthers,
Prison GP and GPSI in drug misuse, Bedford
via pulsetoday.co.uk

What planet is GPC deputy chair Dr Richard Vautrey on? He says this model 'would be the ultimate privatisation of primary care and would see the end of GPs being independent advocates for their patients'. Targets and the QOF have already seen the end of GPs being independent advocates. It's time for a salaried service.

● From Dr Richard Fieldhouse
Chair of the National Association of Sessional GPs, Chichester
via pulsetoday.co.uk

Existing GP partners are already resigning from their partnerships to join freelance GP chambers. Surely that's a model whereby GPs can regain full control of their profession?

● From Dr Hazel Drury
Rhuddlan, north Wales
via pulsetoday.co.uk

£160k? With holidays? With a pension and sick pay? Where do I sign?

The worrying business of antibiotics

From Dr Neil Iosson,
Chichester
via pulsetoday.co.uk

I'm not so worried about salbutamol – after all theophylline and aminophylline are available over the counter – it's more an historical anomaly than anything else ('DH alarm over pharmacy drugs scheme,' pulsetoday.co.uk/news). But offering antibiotics without an individual prescription does concern me – as does the commercial imperative for selling them.

Good record for women at College

From Dr Maureen Baker,
RCGP honorary secretary, Lincoln
via pulsetoday.co.uk

The relative dearth of women on CCGs is disappointing ('Earl Howe calls for more women on CCG boards', pulsetoday.co.uk/news). This is linked to the difficulty that sessional doctors have in obtaining positions on CCGs. I would like to see some active support in encouraging sessional doctors and women to take up these roles.

The RCGP is fortunate in its record of appointing women to senior roles. Our current chair is female and there will be at least one female candidate for the next chair, given that I will be standing for this role.

Feigning empathy is key to CSA

From Dr Imran Ali
Tooting, south London
via pulsetoday.co.uk

As a new graduate from the MRCGP who completed training at St George's Medical School seven years ago and as a member of an ethnic minority, I found the AKT and CSA typical of most UK based exams – most foreign nationals will struggle with it, but only initially.

Once one understands the 'game' that is played here, it is relatively easy to pass the CSA. The acting and language used in it favour UK-trained individuals. However the CSA has other elements – for example, time pressure and confidence. I saw many foreign nationals go into the exam with little confidence or over-confidence based on the experiences of their peers.

The RCGP is looking for candidates who can feign empathy during the CSA exam. Learn that trick and you pass.

For the record

Our story 'DH alarm over pharmacy drugs access scheme' included a picture of amoxicillin, but this antibiotic was not one of the drugs listed in the patient group direction in the story. We apologise for any confusion caused by this.

Spend your money on recipes, Pev

From Dr Stewart McCormick
Paisley
via pulsetoday.co.uk

Poor Peverley ('The sad folly of the food diary', pulsetoday.co.uk/peverley). Seeing your food diary, I know why you need a personal trainer. But I can also think of better ways to spend £60 a week!

GPs happier than ever? Only in Cloud Cuckoo Land

The Department of Health's claim in its submission to the Review Body on Doctors' and Dentists' Renumeration that GPs are happier than ever and maintaining income prompted incredulity from readers:

Dr Douglas Bannatyne, Harrogate, Yorkshire
That is absolutely hilarious. The global sum has gone up 1% in six years. Income is falling year on year. I am working 12- or 13-hour days and still it's not enough to satisfy demand. That is a ludicrous assessment of 'evidence'.

Dr Gillian Breese
Llandudno, Wales
This statement by the DH is so out of touch that it's farcical. I know of no GP who is 'happy' in their current job and certainly none who feels income remains the same as it was several years ago. I hope our representatives dismiss this rubbish as soon as possible.

Dr Charlotte Ferriday
Plymouth
Our partnership can no longer go on with the increasing secondary care and other work, unless we decrease our average list size. I work two days for 13 to 15 hours a day minimum as a partner and my pay is going down 10% this year. I cannot go on for 15 more years like this.

Dr Diana Lowry
Epping, Essex
'GPs happier than ever and maintaining income levels'? Only in Cloud Cuckoo Land.

Dr Anne-Marie Houlder
Stafford
I have just read this out to a group of GP colleagues sitting in a CCG meeting that is due to end after 9pm, and that's after we've done our day jobs! Made us laugh, though.

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

Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard
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Pulse Clinical

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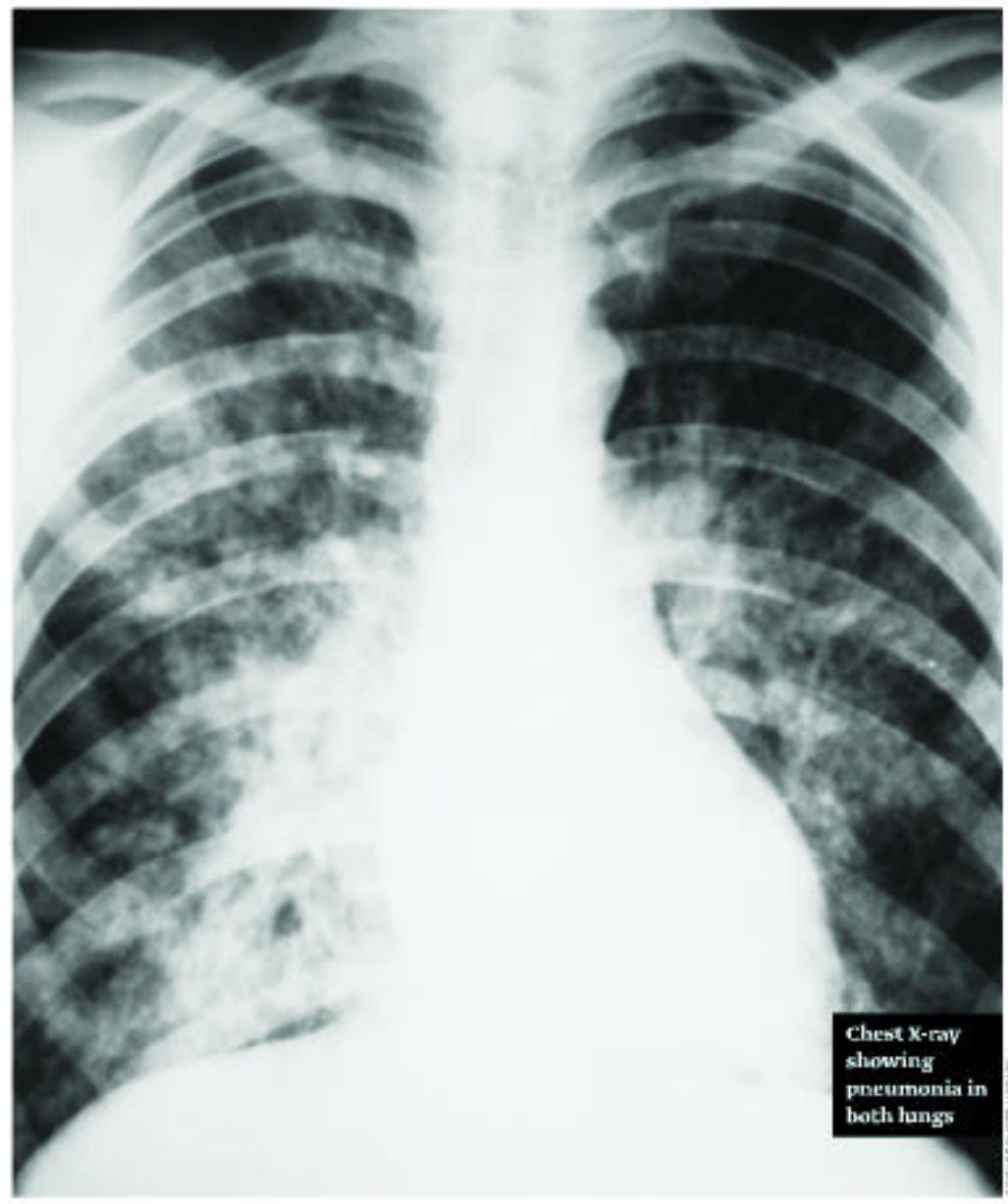
Resource of the week After reading this week's Tricky 10 Minutes article on recurrent thrush, go online to pulsetoday.co.uk/tools-and-resources to download a helpful leaflet to give to patients

KEY QUESTIONS

LRTIs in adults

Respiratory specialist Professor Mark Woodhead answers questions from GP Dr David Russell on acute bronchitis, pneumonia, bacterial infections and antibiotics



Chest X-ray showing pneumonia in both lungs

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1 How useful are the traditional chest signs, such as dullness to percussion and crepitations, in assessing an LRTI?

In a patient with symptoms of an LRTI, traditional chest signs such as dullness to percussion and crepitations are not a sensitive predictor of pneumonia – only about one third of those with chest signs will have a radiographic change. But patients who don't have these signs are very unlikely to have pneumonia – about 2% of patients with no chest signs will have radiographic pneumonia. So chest signs are the best clues that we have.

Patients who don't have chest signs are unlikely to benefit from antibiotics, while some patients who do have chest signs will benefit from antibiotics, but predicting who will benefit is still not possible.

There is a lot of research into whether near-patient biomarker testing – such as CRP and procalcitonin – has added value in guiding LRTI diagnosis and management. Currently the evidence does not support their routine use.

2 Which patients with pneumonia need to be admitted? What role do CRB-65 scores have to play when assessing patients we think may have community-acquired pneumonia?

GPs should decide whether to admit a patient on the basis of the severity of their illness. Your clinical judgment can be supported with severity scores such as CRB-65 in cases where you suspect pneumonia (Go to pulsetoday.co.uk/tools-and-resources for an online version of the CRB-65 score). A recent study has shown that CRB-65 scoring is not useful in LRTI where pneumonia is not suspected,[1] so CRB-65 scoring should not be applied to all patients with LRTI. CRB-65 high-risk patients should always be referred to hospital, unless the pneumonia is deemed to be the terminal event in some other chronic disease, where palliative care might be more appropriate.

There are also reasons other than severity for which hospital admission may be beneficial, for example if the patient has another chronic disease such as diabetes, and so it is sometimes appropriate to admit patients even if they have a low-risk CRB-65 score.

3 When is taking a sputum sample helpful?

There is no hard evidence on when it is useful to take a sputum sample, but I would suggest only in patients where initial antibiotic therapy has failed, where there is underlying bronchiectasis, or when you suspect tuberculosis.

The antibiotics used in routine practice – ß-lactams, macrolides and tetracyclines – are all broad spectrum and are active against the common bacterial causes of LRTI. *Streptococcus pneumoniae* and *Haemophilus influenzae* are fortunately not usually resistant to these antibiotics in the UK, so routine sputum sampling will rarely alter therapy and would not be cost effective.

In patients where initial antibiotic therapy has failed there is an increased risk of a resistant or unusual bacterial cause and sputum examination may be helpful. In patients with bronchiectasis, the most common bacterium causing exacerbations is *H influenzae*, but a small proportion of cases will be colonised by *Pseudomonas aeruginosa* and these will require different antibiotics to those usually prescribed.

4 I suspect many of us are occasionally coerced into prescribing antibiotics by patients based on the colour of the sputum they cough up. Is there a correlation between the colour of sputum and the likelihood of a bacterial infection?

There's no correlation between the colour of sputum and the likelihood of bacterial infection in patients with uncomplicated LRTI. But the colour of sputum does correlate with bacterial infection in patients with underlying COPD.

Many doctors probably remember being taught at medical school that purulent sputum means there is bacterial infection, but recent studies have shown this not to be the case in patients with uncomplicated LRTI.[2] Many people have a short period of purulent sputum when they have a cold - so this finding is perhaps not surprising. A recent large study found no additional benefit of antibiotic therapy whether sputum was purulent or mucoid.[2] Sputum purulence simply implies the presence of neutrophils which can be present for reasons other than bacterial infection. Besides, bacterial infection, especially in non-severe illness, may be self-limiting.

There is no benefit from antibiotics in patients with mucoid sputum in a COPD exacerbation. But in these patients, purulent sputum does correlate with bacterial presence and increased likelihood of response to antibiotics, especially if there is also increased sputum volume and increased dyspnoea.

5 GPs are often told that if the oxygen saturation level goes below 92% in a patient with an LRTI, then the patient requires admission. Do you agree?

In general I do agree that a patient with an LRTI whose oxygen saturation is below 92% needs admission - routine oxygen saturation measurements are probably of value when assessing illness severity in a patient.[1]

An oxygen saturation of less than 92% implies a significant defect in gas exchange. Such levels of hypoxia will lead to significant cellular dysfunction and increased cardiac risk. This suggests the patient has a severe illness and that they need active gas exchange management such as supplemental oxygen - they will benefit from hospital admission.

The only exception to this is in patients with chronically severe COPD who are normally hypoxic and who are receiving long-term home-oxygen therapy. In these patients, a saturation level of lower than 92% may be normal and only much lower levels would indicate a need for admission. The specific oxygen saturation level at which these patients would need admission would have to be decided on an individual basis , depending on their usual oxygen saturation when well.

6 What clinical features should make us suspicious of pulmonary TB and what investigations can we do in primary care?

The most important feature which should make you suspicious of pulmonary TB is the presence of a risk factor. The most important TB risk factor is having been born in a high-prevalence country (where prevalence is more than 40 per 100,000), or having parents who are from a high-prevalence country. Other patients at high risk of TB are those with known or suspected contact with a case, those with a previous case in a family member and the immunosuppressed, including those with HIV.

Specific symptoms that might signal the possibility of TB are haemoptysis, drenching sweats occurring in the night and significant weight loss - particularly if they have persisted for a long time. If the patient is unwell or if they are in a position where they could be putting others at risk - for example they are a schoolchild, teacher or healthcare professional - refer straight to the local TB service and do not worry about tests. If the patient poses less of a risk, then request a chest X-ray and send at least three sputum samples for TB examination. Preferably these should be early-morning sputum samples, though this is not essential.

7 We are often faced with patients who have inspiratory chest pain. How can we differentiate between musculoskeletal pain, pleuritic pain and pain caused by a pulmonary embolus?

It's not easy to differentiate between musculoskeletal pain, pleuritic pain and a PE in patients with chest pain. But look for risk factors and use Wells' score. Absence of risk factors makes the diagnosis of PE much less likely and a PE is unlikely if the score is four or less (Go to pulsetoday.co.uk/tools-and-resources to access an online version of Wells' score).

The absence of an alternative plausible diagnosis is important in considering whether the patient could have a PE. If there are features pointing to infection - fever, rigors, purulent sputum production - infection is more likely than PE. However if pleuritic pain is associated with unilateral leg swelling or haemoptysis then a diagnosis of PE should be seriously considered.

A diagnosis is often most difficult when pleuritic-type pain occurs in isolation. If the pain is particularly made worse by twisting or stretching the arms then a musculoskeletal cause is likely. A musculoskeletal cause is also likely if the chest wall is tender at the site of pain, but be aware that chest wall tenderness has been reported in the presence of PE as well.

8 Our local antibiotic policy recommends amoxicillin, doxycycline and clarithromycin as the antibiotics of choice when treating LRTIs. Do you agree or do other antibiotics have a role to play in primary care? If so, which?

I would agree that amoxicillin, doxycycline and clarithromycin are the antibiotics of choice when treating LRTIs. The common bacterial causes of LRTI are *S pneumoniae* and *H influenzae*, both of which are usually sensitive to all of these antibiotics. For the most part, these antibiotics have a good side-effect profile and we have years of familiarity with their use. There is no evidence that any other antibiotic produces quicker recovery than these.

Which of the three you choose will depend on patient circumstances - doxycycline should be avoided in young females, while doxycycline or clarithromycin would be a good choice for a patient with genuine penicillin allergy. Otherwise amoxicillin is perhaps the antibiotic of choice.

Co-amoxiclav has the advantage that it acts against the small proportion of *H influenzae* infections that are penicillin resistant. It would be a good choice for the patient with a COPD exacerbation where penicillin-resistant infections may be more common, especially if they have had a recent course of amoxicillin.

More Q&As online

▶ pulse-learning.co.uk

Go to the online version of this article at pulsetoday.co.uk/clinical to see additional questions on:

- What clinical features help differentiate patients with acute bronchitis, lobar pneumonia and bronchopneumonia.
- How to differentiate in the community between those likely to have pneumonia caused by viral, atypical and typical organisms.
- The use of confusing chest infection terminology.

9 Do all patients with suspected pneumonia need a chest X-ray? If so, when is the most appropriate time to arrange it?

The answer to whether all patients with suspected pneumonia need a chest X-ray is that we don't really know, but probably not. When pneumonia is suspected and severity markers such as CRB-65 indicate a mild illness, antibiotics should be prescribed and an uneventful recovery at home is to be expected.

In these mild cases, the practical difficulties of sending the patient to the X-ray department and then awaiting the radiologist's report outweigh any benefit that the chest X-ray might bring. Patients who are severely ill should be sent to hospital as discussed earlier, where they will be X-rayed anyway.

A chest X-ray should be considered where the diagnosis is not clear, especially in the presence of unusual features such as long symptom duration. Also consider a chest X-ray if you suspect TB, or lung cancer (for example in patients with red flag symptoms such as haemoptysis or weight loss and smoking history). In smokers with pneumonia the best time to perform a chest X-ray is six weeks or more after illness onset. This will allow infective consolidation to reduce so that any underlying pathology is easier to see.

Professor Mark Woodhead is a consultant and honorary clinical professor in respiratory and general medicine at Manchester Royal Infirmary. He is chair of the NICE Pneumonia Guideline Development Group and the European Respiratory Society 2011 lower respiratory infection guidelines group

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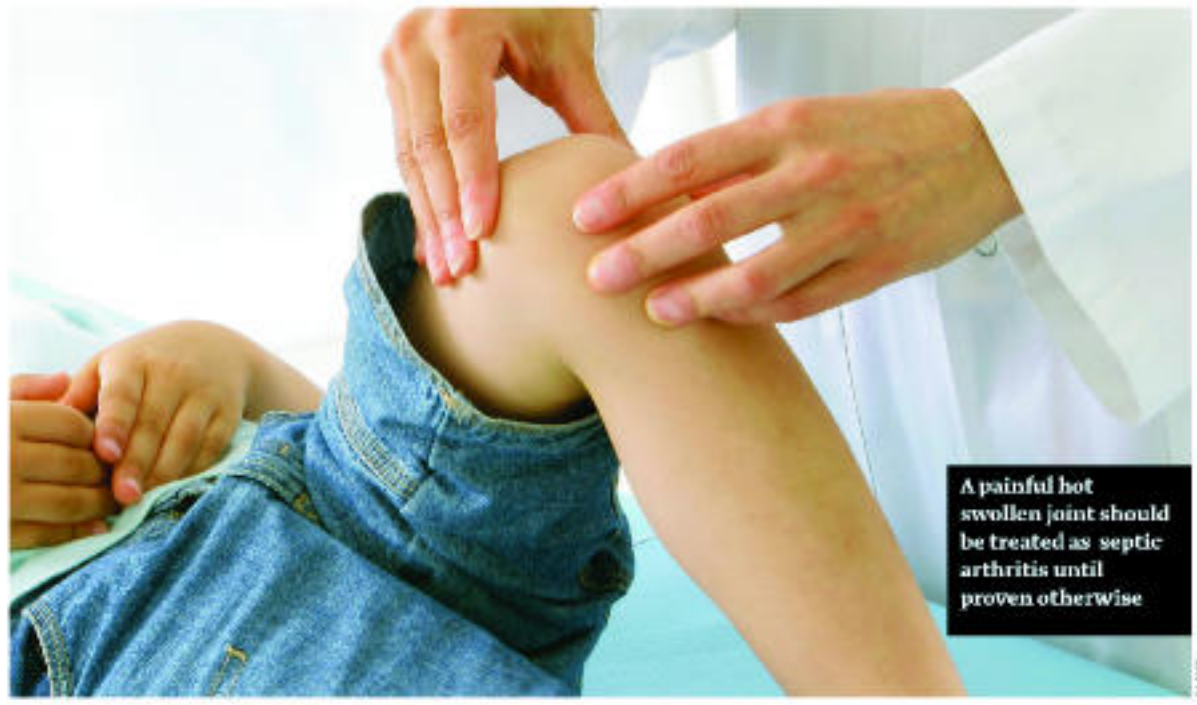
PAEDIATRIC CLINIC

Septic arthritis

Dr Liza McCann, consultant paediatric rheumatologist, and colleagues discuss the case of a child with septic arthritis and how to manage this serious but uncommon presentation



A painful hot swollen joint should be treated as septic arthritis until proven otherwise

CASE

A previously healthy two-year-old boy presents GP with a two-day history of fever and irritability. He is refusing to weight bear, although there is no recent history of injury. The child is fully immunised. He is pyrexial with a temperature of 38.7°C, tachycardic with a heart rate of 160bpm, and his respiratory rate is 30 breaths per minute. He keeps his left knee flexed and is reluctant to move it. Further examination reveals his knee is swollen, warm and painful. Systemic examination is unremarkable.

An urgent referral to orthopaedics with suspected septic arthritis is made.

The child has a raised white cell count and elevated CRP. X-ray of the knee is unremarkable. He has a joint aspiration which reveals increased white cell count and positive gram stain.

The problem

Septic arthritis is a microbial infection in a joint space. Haematogenous spread of bacteria into the synovium is the most common route of acquisition. Other aetiologies include septic arthritis following a penetrating trauma or adjacent osteomyelitis.

All age groups are affected, but in children, septic arthritis is most common in those under three years.

The most common organism is *Staphylococcus aureus*. Other pathogens include Streptococcus species, *Pseudomonas aeruginosa*, *Neisseria meningitidis*, *Escherichia coli*, Klebsiella and Enterobacter species. Gonococcal septic arthritis should be considered in sexually active teenagers or adults, or newborns who may acquire it through vertical transmission.[1] In the non-immunised child, consider *Haemophilus influenzae* type B.

Early diagnosis and treatment is essential to prevent permanent joint damage.

Features

The classic presentation in a child is a short history of fever with a hot, swollen and tender joint with limited movement, though absence of fever at presentation does not exclude the diagnosis. The child is usually unwell.

Typically one joint is involved and in most cases this is a lower extremity joint, especially the knee or hip. The elbow is the most common upper extremity joint to be infected. Neonates are more likely to have infection in multiple joints.

In patients with an infected hip joint there may be no erythema or swelling due to the deep location of the joint, but typically the patient is reluctant to weight bear. Children often orient an affected joint to minimise the pain – for example the hip is flexed, abducted, and externally rotated, the knee, ankle, and elbow are partially flexed, whereas the shoulder is adducted and internally rotated. Psuedoparalysis of the affected limb is seen in neonates and younger children.

Investigation

Joint aspiration and blood culture should be performed promptly. Typically, these are done in hospital.

- The synovial fluid analysis should include cell count and differential white cell count, gram stain and culture.
- Blood analysis often shows elevated white cell count, but a normal value does not rule out septic arthritis. CRP and ESR are more sensitive markers.

Other investigations may include:

- Plain X-ray – often normal in septic arthritis but can exclude other causes of joint pain.[2]
- Ultrasonography – the modality of choice to reveal hip effusions and to guide needle aspiration.
- Bone scan – may be helpful if multifocal disease is suspected. It also helps to detect associated osteomyelitis.

Diagnosis

A painful hot swollen joint – or joints – should be treated as septic arthritis until proven otherwise. Diagnosis is established by a combination of clinical findings and results of synovial fluid analysis. A low index of suspicion is required.

Management

- Septic arthritis is a medical emergency and requires urgent referral to orthopaedics.
- Joint aspiration and blood cultures are required, followed by early treatment.
- IV antibiotics are then changed to oral once clinically indicated. Antibiotics are generally continued for three to six weeks.

Dr Liza McCann is a consultant paediatric rheumatologist, Dr Raja Syahance is a specialist paediatric registrar in rheumatology and Dr Thomas Morgan is an SHO in rheumatology at Alder Hey Children's Hospital, Liverpool

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Alder Hey is one of Europe's busiest children's hospitals providing care for over 275,000 patients each year. Alder Hey has a broad range of hospital and community services for direct referral from primary care. The Trust 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. For more information visit: alderhey.nhs.uk

▶ **Still to come in this series: Henoch-Schonlein purpura and Kawasaki disease**

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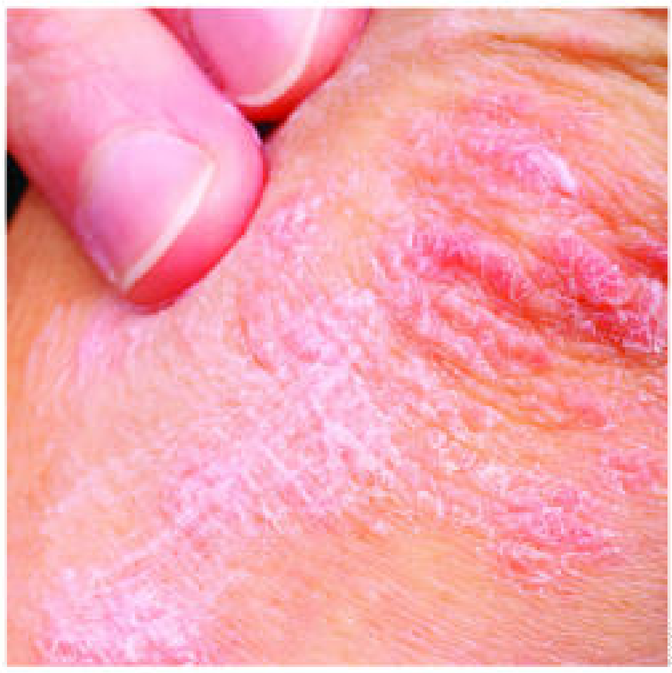
TEN TOP TIPS

Psoriasis

Dr Andy Jordan, GP and hospital practitioner in dermatology, on managing psoriasis in primary care



1 Take a thorough history

This is a condition where it really is important to establish the patient's ideas, concerns and expectations. Try to elicit the aspects they find most troublesome – for example discomfort, itch, embarrassment, social effect and so on.

2 Examine the whole body

In a patient presenting with suspected psoriasis, examine the whole body in a good light. Examine the scalp because scaling is often very troublesome, and the nails because changes may cause significant distress to the patient. Ask about genital psoriasis, which can be painful and hugely embarrassing. Look for signs of Koebnerisation to help confirm the diagnosis.

3 Look for triggers

- Stress – psoriasis often presents after severe stress.
- Trauma – psoriasis can develop at the site of injury to skin (Koebner phenomenon).
- Drugs – ß-blockers, lithium and antimalarials can trigger psoriasis – patients going to a malarial area can use doxycycline for prophylaxis.
- Infection – guttate psoriasis often presents after ß-haemolytic strep sore throat.

4 **Be alert to the psychological impact**

Even if the condition does not look severe, it may have a severe psychological impact on the patient. Every year about 100 patients with psoriasis commit suicide and surveys have shown that its psychological effect is equivalent to ischaemic heart disease or diabetes.

5 **Check CVD risk and other systemic conditions**

Psoriasis is a systemic disease and is associated with an increased risk of ischaemic heart disease, hypertension, CVA, metabolic syndrome, erectile dysfunction, Crohn's disease, coeliac disease, psoriatic arthropathy, inflammatory eye disease and depression. The inflammatory load of the disease is thought to cause vascular endothelial dysfunction. Do an annual check of blood pressure, smoking, alcohol, lipids and glucose.

6 **Encourage lifestyle changes**

Explain that psoriasis is caused by rapid skin growth, there is often a family history and there is no cure, but the condition can be controlled. Encourage the patient to stop smoking and reduce alcohol consumption to reduce the vascular risk associated with psoriasis. The online version of this article includes details of patient associations.

7 **Consider concordance when prescribing topical treatments**

When prescribing topical treatment, write instructions for the patient on where, when and how it is to be used. If the patient has very large plaques, if there are lots of small plaques or plaques are inaccessible, concordance will be poor. Use emollients first line for all types of psoriasis and advise patients to stop using soap. Take care with superpotent topical steroids – these can precipitate pustular psoriasis.

8 **Refer generalised pustular psoriasis and erythroderma immediately**

If you suspect generalised pustular psoriasis or erythroderma, refer as an emergency as these conditions can be life threatening.

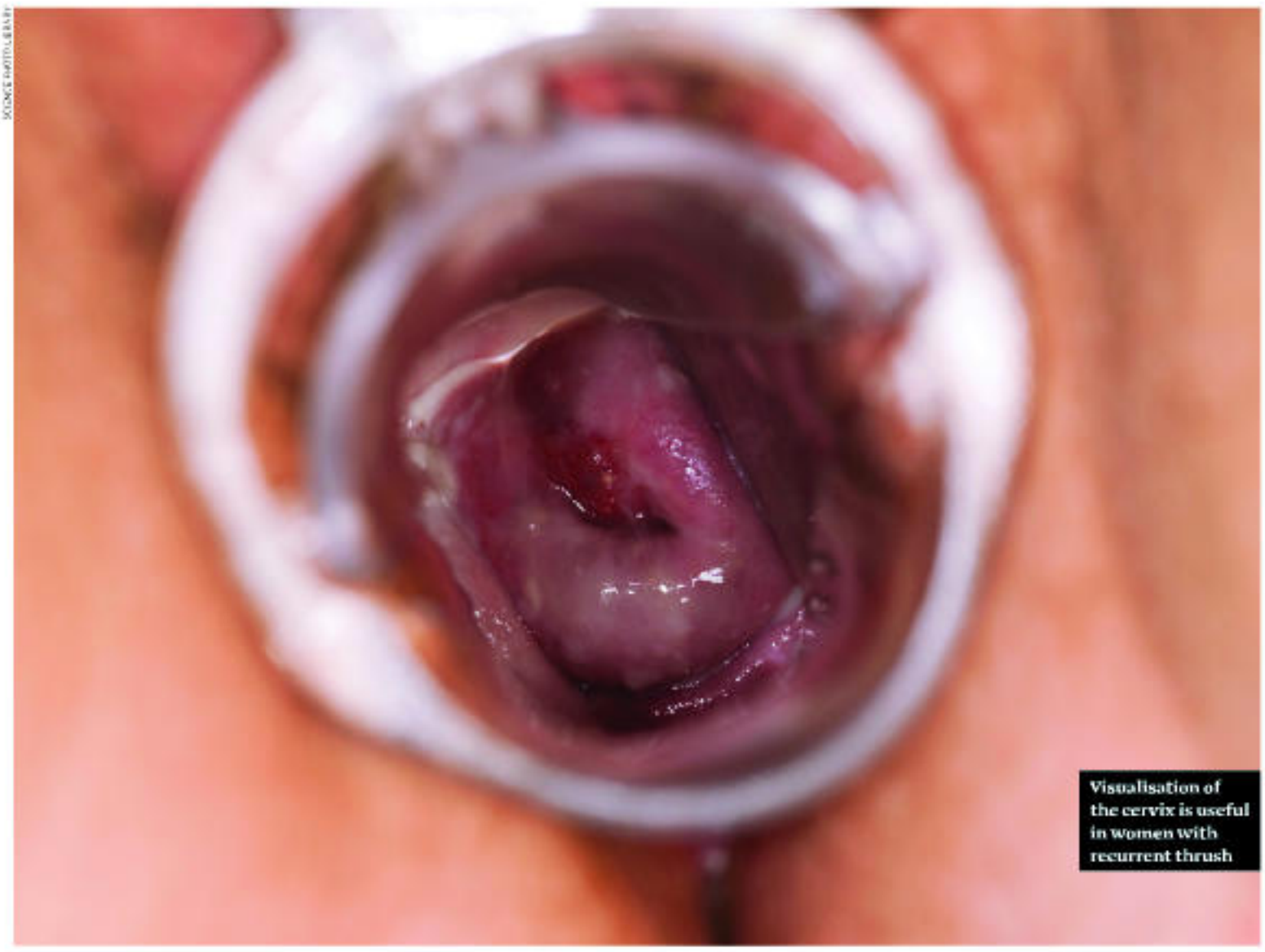
9 **Refer psoriatic arthropathy to rheumatology**

If psoriatic arthropathy is present it is often best to refer to a rheumatologist or to a combined clinic, as biological therapy appears to be easier to access through rheumatology than dermatology.

10 **Review the diagnosis if treatment fails**

Check whether psoriasis is the correct diagnosis and then check concordance with treatment. If in doubt, refer to dermatology.

Dr Andy Jordan is a GP and hospital practitioner in dermatology in Amersham, Buckinghamshire



Visualisation of the cervix is useful in women with recurrent thrush

TRICKY 10 MINUTES

'Why do I keep getting thrush?'

Genitourinary medicine specialist Dr Usha Kuchimanchi discusses how to manage this difficult presentation in a 10-minute consultation, with a patient information leaflet to print out

Candida is considered part of the normal vaginal flora and can be found in about 40% of adult women at any given point. About half of these women will have at least one episode of symptomatic candidiasis and a minority of those who have an episode will have recurrent symptoms.[1]

True recurrent vulvovaginal candidiasis is thought to occur in 5% of healthy women.[2]

History

Many of the symptoms of thrush overlap with other causes of vulvovaginitis and so are not specific to candida. Some of the women who self-diagnose and treat with over-the-counter preparations will have other causes for their symptoms – none of the symptoms or signs of thrush are pathognomonic. A good history, supported by corroborative laboratory evidence, is essential if a women presents with recurrent thrush. It is important to go through the following questions to establish diagnosis and exclude other causes.

- **What are the symptoms and when did they start?**[2,3] Episodes of symptomatic thrush typically present with vulval itching, soreness and vaginal discharge (although discharge may be absent). There might be superficial dyspareunia and external dysuria, especially if there are erosions and fissures secondary to scratching. There is typically no malodour.
- **What is the sexual history and why has the patient attended now?** Has there been a change in symptoms? Are there underlying concerns, for example about STIs?
- **How frequently do the symptoms occur?** Recurrent vulvovaginal candida is defined as four or more episodes of symptomatic infection annually. There is at least partial resolution of symptoms between episodes. Positive microscopy or a moderate to heavy growth of candida should be documented on at least two occasions when symptomatic.[4]

Differential diagnoses

Establish whether a formal diagnosis has ever been made. Other causes need to be excluded. These include infections causing vaginal discharge such as bacterial vaginosis, trichomoniasis, genital tract chlamydia, gonorrhoea and genital herpes. Non-infective conditions, like irritants, vulval eczema, psoriasis, lichen simplex and sclerosus, and atrophic vaginitis[2] also need to be excluded.

Examination and investigation

Examination may reveal a thick, white discharge. Depending on severity, there may be signs of vulvovaginal inflammation with erythema, oedema, vulval excoriation and satellite lesions. Vaginal discharge may be normal in appearance or may be typically 'curdy-white'. Speculum examination is needed and swabs should be taken as follows:

- Gram stain or 'wet film' (saline and/or potassium hydroxide preparation) examination of a vaginal swab taken from anterior fornix or lateral vaginal wall is needed. Blastospores and pseudohyphae are looked for. The sensitivity of each of these tests would be no more than 65% to 70% at best. If two of the tests were done, sensitivity would be increased and bacterial vaginosis can be picked up as well.
- Culture of above specimen in Sabouraud's media should be considered in all cases of recurrent candidiasis as this would give information on species.

Patient resource

Go online to download a patient information leaflet
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- A swab should be taken from the posterior fornix and examined for trichomonas (refer to local laboratory guidance).
- *Chlamydia trachomatis* and *Neisseria gonorrhoeae* nucleic acid amplification tests should be offered.
- Visualisation of the cervix is useful.

Referral to a GUM clinic would mean that full microbiological tests can be done to establish an accurate diagnosis. As microscopy is routinely done, an immediate diagnosis may be available for many patients.

Management

Once the diagnosis is confirmed, any predisposing conditions should be identified. These include diabetes mellitus, which should be excluded, use of antibiotics and systemic immunosuppression or immunodeficiency, for example because of steroid use or HIV infection. Hyperoestrogenemia, because of use of HRT or the combined oral contraceptive pill, may contribute.

The pathogenesis of recurrent disease probably involves host factors that find it difficult to tolerate the resident yeast. Current guidelines advocate an induction regimen consisting of vaginal imidazole or oral fluconazole. This should be followed immediately by a maintenance regimen – weekly maintenance with either a clotrimazole pessary (500mg) or oral fluconazole (150mg) to suppress clinical attacks. It is generally given for a period of six months and reviewed. Symptoms may recur after treatment is stopped.

Speciation and sensitivity testing is important to guide management. If resistant *Candida albicans* or *Candida glabrata* is identified, longer courses or alternative treatments may be needed. Prevalence of the latter is thought to be 10–15% in women with recurrent symptomatic candidiasis.

General advice should be given regarding symptomatic relief, genital skin care and use of emollients.

There is no evidence to support the treatment of asymptomatic male sexual partners.

Dr Usha Kuchimanchi is a consultant physician in genitourinary medicine at the Wilberforce Health Centre, Hull

Competing interests None declared

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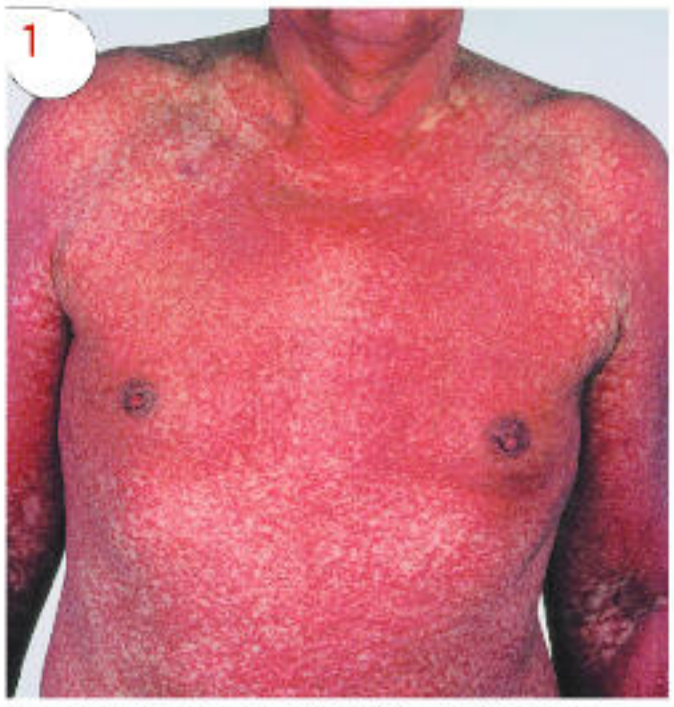
PICTURE QUIZ

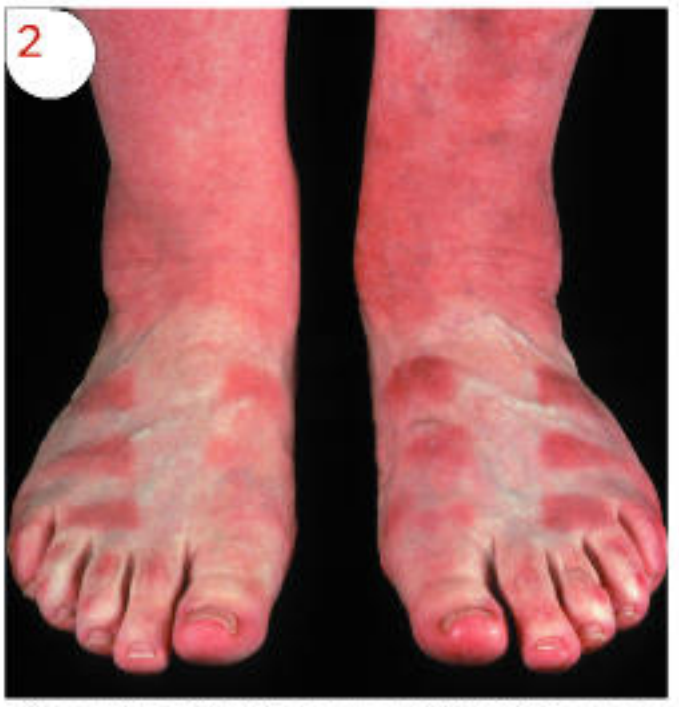
Skin drug reactions

These five patients presented with skin conditions that appeared to be linked to their medication. Can you work out what each reaction is? Answers are at the bottom of the page

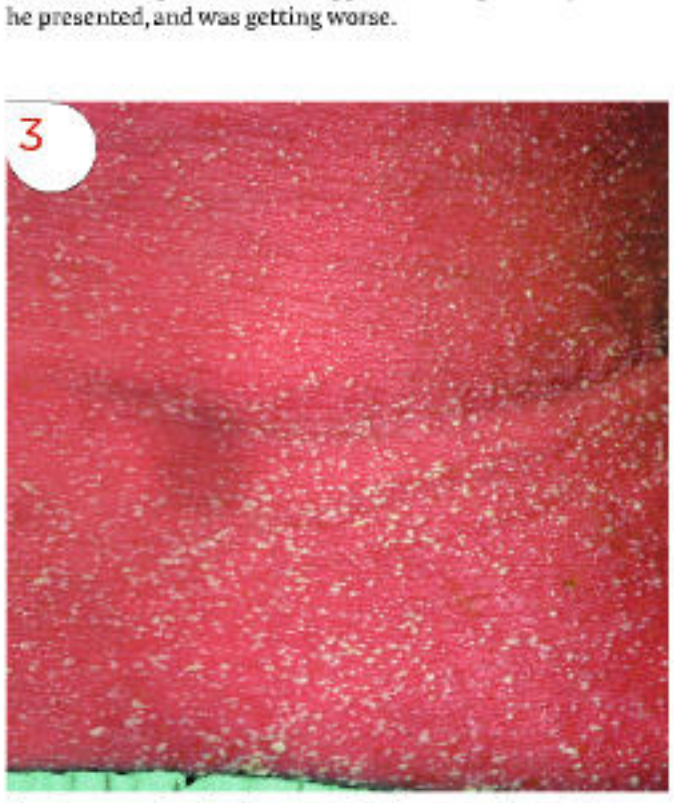


This patient was coming to the end of a one-week course of flucloxacillin which he'd been taking for an episode of cellulitis. The cellulitis was much improved and he felt well, but this widespread rash had appeared a couple of days before he presented, and was getting worse.

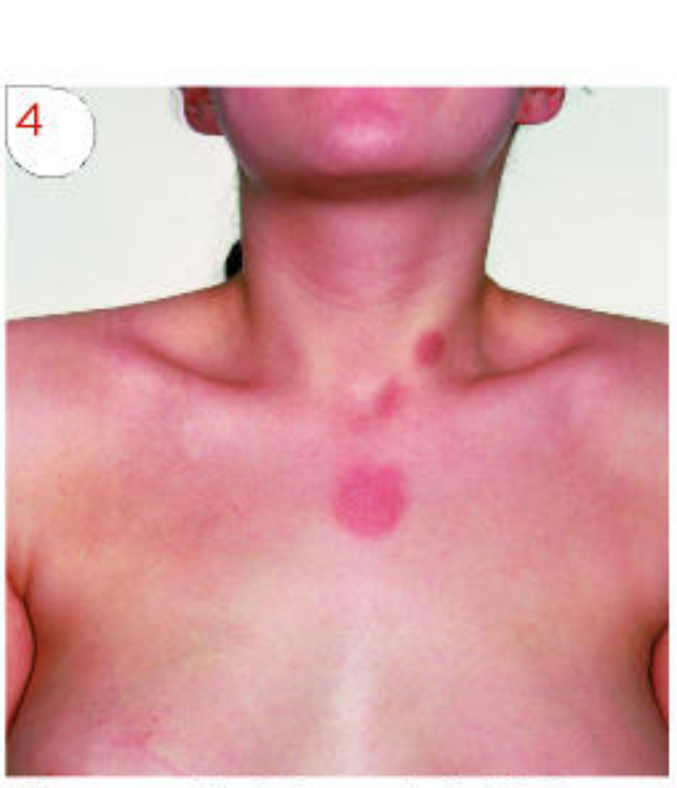
These cases are taken from *Acute Adult Dermatology – a colour handbook* by Daniel Creamer, Jonathan Barker and Francisco A Kerdel (£29.95, Manson Publishing, ISBN 9781840761023).
Available from: mansonpublishing.com/colour_handbooks and all good booksellers



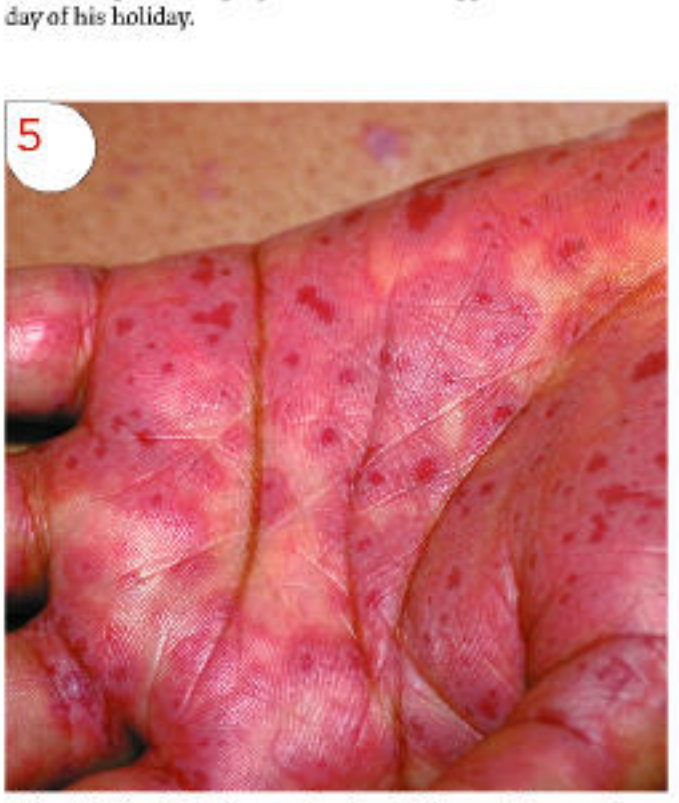
This man, who suffered long-term acne, attended for a repeat prescription of doxycycline just before leaving for a summer break in Spain. He reattended soon after his return because of this widespread stinging rash which had appeared on the first day of his holiday.



Two days previously, this woman had seen another doctor about her fungal toenail infection. Within 24 hours of starting an oral anti-fungal, she developed a fever and this widespread, dramatic rash.



This woman complained of a recurrent rash which always appeared in the same area of her neck and chest. She insisted that it seemed to be triggered by the mefenamic acid which she took for her heavy, painful periods.



This patient with inflammatory bowel disease had recently been started on sulphasalazine by his specialist. In the past few days, he had developed this rash, together with mouth and lip blisters, and felt very unwell.

ANSWERS

1 Drug-induced exanthem
Drug-induced exanthems represent a range of cutaneous reaction patterns characterised by a maculopapular rash or papular eruption. They usually occur within the first 10 days of starting the culprit medication, but occasionally the eruption may not appear until three weeks after drug exposure. The most commonly implicated drugs are penicillins, trimethoprim-sulphamethoxazole, anticonvulsants and NSAIDs. They is typically a symmetrical eruption of small pink-red macules or papules on the trunk, limbs and extremities. The face is usually spared. Drug-induced exanthems can be itchy but are often asymptomatic. Once the triggering drug has been stopped, the exanthem resolves over one to two weeks.

2 Phototoxic drug reaction
Drug-induced photosensitivity can occur in a patient receiving a photoactive drug who is concomitantly exposed to strong sunlight. Culprit drugs include amiodarone, tetracyclines, sulfonamides, phenothiazines, tricyclic antidepressants, thiazide and loop diuretics, sulphonylureas, and NSAIDs. The dermatosis is confined to the light-exposed areas – face, neck, dorsal aspect of arms, and hands. Symptoms include itching, burning and stinging. The implicated drug should be stopped. General emollient therapy can be given, and you can advise sun avoidance. Once the acute reaction resolves, scaling, lichenification and hyperpigmentation can persist.

3 Acute generalised exanthematous pustulosis
Acute generalised exanthematous pustulosis is a drug hypersensitivity dermatosis characterised by the onset of a fever with an eruption of sterile pustules. It usually occurs within 24 hours of exposure to the implicated drug. The most common culprits are penicillins, macrolide antibiotics, terbinafine and NSAIDs. There is macular erythema, often appearing on the face or flexures, covered by tiny, superficial pustules. The eruption, which is usually oedematous. Once the offending drug has been stopped, the eruption will resolve after around one week.

4 Fixed drug eruption
Fixed drug eruption is characterised by one or more inflammatory patches that recur at the same cutaneous or mucosal site each time the patient is exposed to the offending drug. Sometimes the eruption has settled by the time the patient consults a doctor, but a history of localised skin inflammation shortly after taking a medication is highly suggestive of fixed drug eruption. Common culprits are penicillins, tetracyclines, trimethoprim-sulphamethoxazole, aspirin and NSAIDs. The typical clinical features are a deep-red, well-demarcated, circular patch. Lesions are usually 2–6cm in diameter if the offending drug is not discontinued the inflammation commonly intensifies, resulting in blistering or desquamination.

5 Stevens-Johnson syndrome
Stevens-Johnson syndrome is a life-threatening mucocutaneous drug-hypersensitivity syndrome characterised by blistering and epidermal sloughing. Common culprits are sulphonamides, trimethoprim-sulphamethoxazole, anticonvulsants, allopurinol, oxicam NSAIDs and nevirapine. Fever, malaise and upper respiratory tract symptoms may precede the eruption by a few days. Involvement of the mucous membranes of the eyes, mouth and nose is a prominent early feature. On the skin, dusky red macules appear and become confluent. The skin lesions pass through vesicular and bullous phases before epidermal detachment occurs. Specialist dermatology care is essential.

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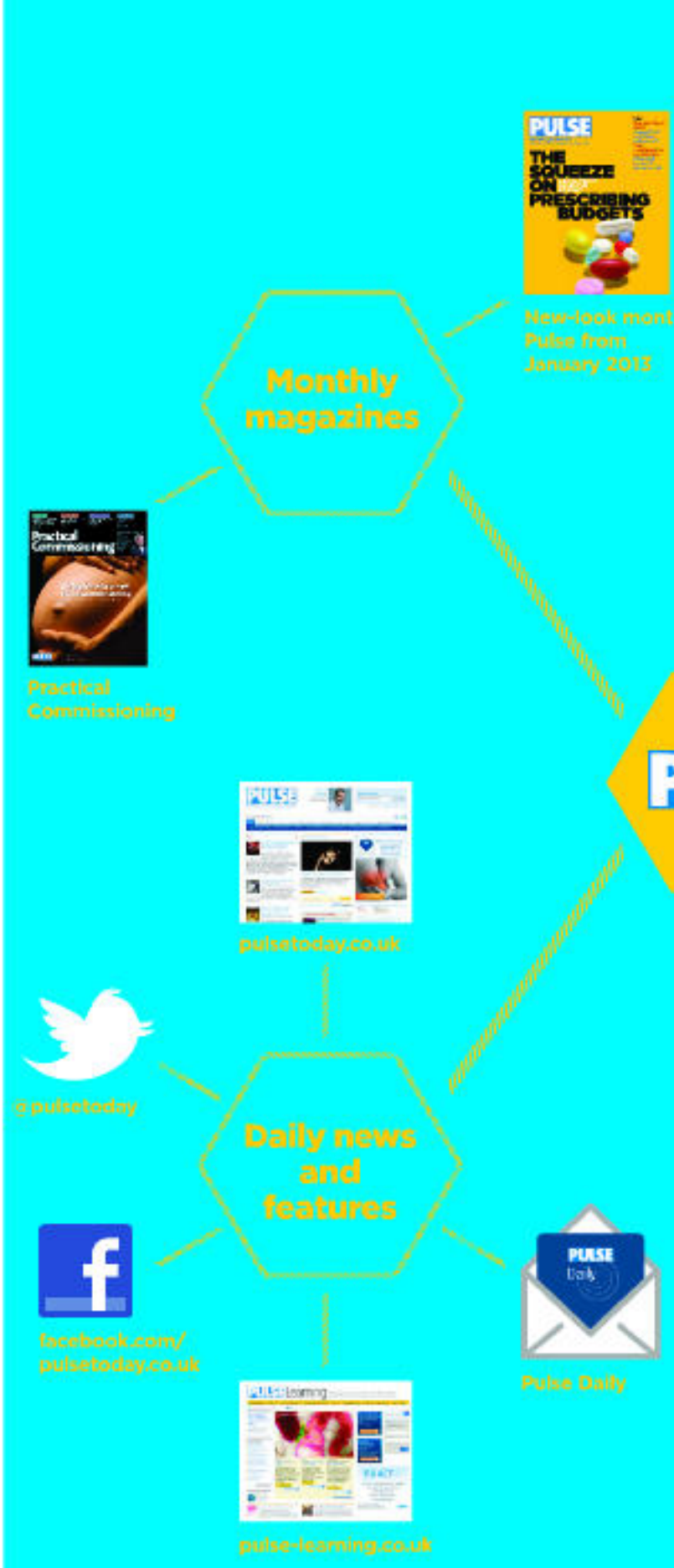

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What I learned from an encounter with an angry patient Dr Shyamala Balendran explains why she's changed her mind about safety in the surgery

How will appraisals change after revalidation? GPC negotiator Dr Dean Marshall offers guidance on 'enhanced appraisals'

How we benefit from a multi-professional partnership Dr Ed Gaynor and Tina Atkins explain how they handle a large patient list at their inner-city practice

How would the funding shake-up affect you?

In his last Finance Diary of the year, accountant **Bob Senior** discusses the potential changes to practice income if the Government's plan to scrap the MPIG and rewrite the Carr-Hill formula goes through

THE GOVERNMENT'S INTENTION to harmonise GP contracts provided the clue that the days of the minimum practice income guarantee (MPIG) in its current form were numbered.

Some saw the staggered process for PMS funding cuts as an indicator of how the MPIG might be removed. They were therefore caught by surprise by the timescales of proposed changes to the GMS contract announced last month by the Department of Health – changes that ministers have threatened to impose if the BMA does not sign up to them.

Under the plans, GMS contracts would from April 2014 be based on a common capitation price, including a weighting for demographic factors affecting relative patient needs and practice workload. History shows how difficult this weighting calculation will be – witness the infamous Carr-Hill formula, which has never worked as well as it should.

Many GP practices affected by the funding changes would see their income whittled away over seven years as the MPIG is phased out.

While few would argue with the concept of equitable funding, one cannot ignore some of the issues that gave rise to practices needing a correction factor when the allocation formula was last introduced.

Size matters

Probably the most significant of these is that very small practices and practices with split sites are unable to generate the same staffing economies of scale that can be achieved by larger practices operating from a single site. In simple terms, if you compare the staff needed to run a 12,000-patient practice with those needed to run a 3,000-patient practice, you don't just divide the headcount of the larger practice by four.

Although the contract proposals are focused on GMS practices, they point to the aspiration of the NHS Commissioning Board to follow the same approach for PMS agreements. Given the way in which PMS baselines were calculated, the equivalent of a correction factor is locked into many of them.

The past two years have seen some PCTs carrying out quite rigorous PMS reviews, with the intention of levelling the playing field for funding PMS practices. Sometimes, but not always, PCTs have had an eye on what PMS practices might receive under GMS. Interestingly, this process has not happened in all PCTs, with some effectively ignoring it. Perhaps they saw little point in carrying out a time-consuming review when the whole exercise would have to be redone if GMS and PMS contracts were revised in a year or two's time.

£12k
Average annual payment to practices on MPIG

Practice funding changes: the DH plans

- The MPIG would be phased out over seven years from April 2014 in order to achieve 'equitable' core funding, with the Carr-Hill formula also being adjusted
- A common capitation price would be based 'on the number of patients [practices] serve with an appropriate weighting for demographic factors that affect relative patient needs and practice workload'
- The GPC has warned that the proposed changes are 'un-evidenced, unnecessary and destabilising'

The introduction of a weighted capitation funding system would find many small practices and branch surgeries unable to compete on an equal footing with larger practices on bigger sites. Given the number of GPs over 50 already eyeing up retirement, this could be the trigger for many to step down early.

For those left behind in smaller practices, things could prove difficult as they struggle to attract replacement partners.

Some partners could even find themselves in the invidious position of earning less than their salaried GPs and locums. The most obvious option would be to merge with larger practices and close small surgeries, although this is not always possible. Small, owner-occupied practices may be compelled instead to call it a day, hand their contract back, make the staff redundant and sell the surgery for alternative use.

GP partners should talk to their accountants now so that, if this contract proposal does go through, they have a survival plan in place.

Bob Senior is chair of the Association of Independent Specialist Medical Accountants and head of medical services at RSM Tenon

PRACTICE DILEMMA

Should we track our urgent referrals?

Dr Andrew Power looks at what GPs' responsibilities are in following up urgent referrals to hospital

In May, it emerged that hundreds of patients with suspected cancer referred by GPs to Imperial College Healthcare NHS Trust may not have been seen within two weeks because of 'data-collection' issues. London GPs were asked for their help in tracking patients; a report subsequently found that no patients had come to harm. But after this blunder, we're concerned about urgent referrals getting lost. We just don't have the time to chase up every possible cancer case. How much responsibility do we have to make sure urgent referrals go through the system?

At the GP/hospital interface, one of the potential communication risks is that of patient referrals. Although we can be more confident that electronic referrals from general practice are received in secondary care compared to the traditional paper-based standard, the systems are not foolproof. The recent case at Imperial College confirms this concern.

What, therefore, are the GP's responsibilities once the referral has taken place? And what can be done to minimise risk?

Take this case study: a 60-year-old man was referred to a dermatologist for the assessment of an irregular, discoloured skin lesion on his chest. He was seen as an outpatient and listed for a biopsy, which duly took place. A discharge letter was sent to his GP indicating that he would be seen in six weeks at the outpatient appointment when the pathology results would be available. Unfortunately, the outpatient appointment was never organised and any chance of a reminder in the form of histology results was also lost, when these were not reported to the dermatologist.

More than a year later the patient presented again to his GP with dyspnoea and metastatic malignant melanoma was subsequently diagnosed. The patient died four months later and his wife understandably questioned his management. The dermatologist, GP and pathologist were all criticised for what was identified as a systems error and a payment was made.

This case illustrates that there are pitfalls beyond the stage of the referral being made and received. It describes a delayed diagnosis of cancer, which may lead to substantial damages, depending on the harm done and the specific circumstances of the claimant.

Reducing risk

There are no easy solutions and it would be counterproductive to suggest a system that is unduly work-intensive for GPs. To implement a belt-and-braces system for all referrals would be a retrograde step.

Nevertheless GPs can be vulnerable, should the referral system fail, and the stakes are of course high with cancer referrals.

There are some commonsense options, that can be used to proactively track urgent referrals for suspected cancer.

GPs could, for example, consider advising patients: 'If you don't receive an appointment within two weeks, get back in touch with me.' Recording this in the notes at the time of the consultation would be beneficial.

Some practices keep a log of urgent cancer referrals and if they are not able to tie up the referral with a response, they check with the patient that an appointment has taken place. Where this can work well is in the form of a spreadsheet, where urgent cancer referrals are logged once sent. GPs may delegate responsibility to a receptionist to check on a weekly basis whether these have been actioned.

Referrals, particularly urgent referrals, have been streamlined by electronic transmission. Unfortunately the system is not foolproof and additional checks are recommended for suspected cancer referrals.

Dr Andrew Power is a medicolegal adviser for the Medical Protection Society

Commissioning for better mental health outcomes

Dr Caroline Dollery outlines three ways in which GP commissioners can improve care for patients with mental health problems

GPs ARE IN A STRONG POSITION to improve the commissioning of mental health care. We see the impact on individuals, their families and carers, and on the community as a whole.

We see whoever walks through the practice door, and taking a holistic approach allows us to target general health measures, as well as address specific issues, for example the risks of being on atypical antipsychotics.

This article outlines three main ways in which GP commissioners can improve mental health outcomes in their area.

Use the NHS Outcomes Framework

The first NHS Outcomes Framework sets out the outcomes and corresponding indicators that will be used to hold the NHS Commissioning Board to account for the outcomes it delivers through commissioning health services from 2012/13.

The main domains within the NHS Outcomes Framework are:

- Preventing people from dying prematurely
- Enhancing quality of life for people with long-term conditions
- Helping people recover from periods of ill health or following injury
- Ensuring people have a positive experience of care
- Treating and caring for people in a safe environment and protecting them from avoidable harm.

These goals are all relevant to mental health, and can be used as a starting point for discussion on how they might be applied to that area of care. Long-term conditions are of particular interest, with the known incidence of depression in diabetes, COPD, rheumatological and neurological conditions. Detailed guidance on each domain is available on the Information Centre website, including packages of the indicators for each domain.[1]

Draw up outcomes-based measures

Commissioning is currently based on block contracts, and is activity-based – for instance numbers seen, or admissions prevented. Local commissioners may have built in some approaches that focus on patients' recovery within service specifications, but it varies widely. Some areas operate user-centred recovery-based models, as recommended in NICE guidance on patient experience.[2]

Opportunities will emerge to unpick existing block contracts and develop outcomes-based measures with shadow Payment by Results (PbR). This is not the same as acute hospital PbR, but allows patients to be placed within a cluster, where appropriate interventions, based on NICE guidance, can be linked to care plans.

This is still being worked through in pilot sites, and is in shadow form in most of England. We can start to address cluster diagnoses and build recovery measures and outcomes: users can set targets or goals at outset with support, interventions

Opportunities will emerge to unpick existing block contracts

can be evidence-based and agreed measurable outcomes can be agreed. Links to personalisation of health and social care budgets can have a positive impact on improving recovery, including that of people with personality disorder.

Here in Mid-Essex CCG, we decided to take a proactive approach to outcomes, despite the uncertainty of how organisations would be set up in the new world. We formed a joint working group with the local authority, who led an exercise with all the stakeholders to build a consensus on how, in our area, we will use outcomes within contracts.

We ran a productive two-day workshop with stakeholders, and developed a report outlining high-level performance indicators and outcomes that would be meaningful and measurable. These can then be taken by commissioners and put into more detail if this needs to be specified within a contract. An example might be showing the number of people successfully changing their lifestyle, an 'outcome' that could be broken into smoking cessation, participation in an exercise programme and reducing obesity levels, for instance (A few examples of our outcomes-based measures are in the box, below).

We will pilot the use of each outcomes-based measure within an agreed area, and review it next year. We will also feed it into our work on the PbR programme, and this will allow us to have a better understanding on whether PbR will generate more effective commissioning by CCGs and the local authority.

Better information is going to be critical – from coding through to performance monitoring. Users' views need to be central to evaluation, as well as families and carers.

Our intention is to establish a partnership board with the local authority, to have a joint strategy and work programme for mental health and learning disability commissioning, and use similar methods in developing our commissioning intentions in the future.

Involve key stakeholders

A major challenge in mental health commissioning is the impact of social care as a determinant of recovery, especially as regards housing, personal finance, education and training and employment. As a consequence, integrated approaches to commissioning outcomes are the preferred approach.

There are many ways this can be done, including:

- Running fully integrated pooled budgets – a legally binding contract with the local authority to share resource in developing and implementing strategy
- Joining national pilots of community budgets, of which there are currently four (one being within Essex, where I work)
- Setting up partnership boards with the local authority to develop joint commissioning approaches, falling short of full pooled budgets.

Which model a CCG uses will depend on local culture, experiences of joint working and its appetite for risk sharing.

In addition to local authorities, a number of other stakeholders need to be worked with to develop improved outcomes.

It is vital that you include the third sector, as they allow greater choice and flexibility for users of services, and can often contribute to developing solutions with their wide experience in mental health, for instance through delivering advocacy services. Other stakeholders include local acute trusts, community trusts and services, schools, educational institutions, adult learning, job centres and Citizens Advice Bureaux.

Measuring outcomes

- We have given our Improving Access to Psychological Therapies (IAPT) service a CQIN aimed at improving access for the elderly population, with three linked outcomes (Patient Health Questionnaire 9, Generalised Anxiety Disorder 7 Recovery, and reduction in crisis referrals).
- We have asked for the 'recovery star' model to be used in all pathways in secondary care, with an outcome of assessing success of treatment programmes, and compliance with evidence-based treatments. It will also inform us of any gaps in service provision, and the need to make stepping up or stepping down a patient's treatment more effective.
- Our main provider has agreed to use a Core Assessment and Outcomes Package across all pathways and to train doctors to use it.
- We have specified the need to improve physical health for mental health patients which will be achieved through primary care.
- We have asked to improve access for patients by developing more local care – linked outcomes for this will be reducing DNAs, improving completion of treatment and improving recovery outcomes. It will also be linked to medication outcomes – planned to be improving consistency in prescribing and reducing antipsychotics in the elderly and in patients with a learning disability.
- We are linking the accommodation strategy of the local authority with mental health services to encourage earlier discharge to appropriate supported housing. We hope this will make it easier to implement patient-held health and social care budgets.
- We have developed a learning disability outcomes framework to be used in contract negotiations with providers.

Dr Caroline Dollery is the director of Mid Essex CCG and a GP in Danbury

References

1 NHS Outcomes Framework. ic.nhs.uk/statistics-and-data-collections/audits-and-performance/nhs-outcomes-framework-indicators

2 NICE. *Patient experience in adult NHS services: Improving the experience of care for people using adult NHS services*. nice.org.uk/cg138

PULSE LIVE 2013

YOUR PRACTICE
YOUR PATIENTS
YOUR FUTURE

THE NATIONAL CONFERENCE FOR GENERAL PRACTICE | 30 APRIL – 1 MAY

PULSE IS GOING LIVE

Pulse has reached a key moment in its 52 year history. Your magazine will be going live with a two-day conference for GPs and practice managers. The event will be taking place on 30 April – 1 May 2013.

Pulse Live is the exciting new initiative from Pulse magazine brought to life with a two day national event for GPs and practice managers

The Pulse Live agenda will offer a stimulating mix of plenary and keynote sessions and three conference streams tailored to the learning needs of GPs and practice managers. For more information visit the website.

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DOCTORS/GPS REQUIRED

Atherton and Tyldesley Medical Practices

General Practitioner Required
Full & Part-time

We are seeking enthusiastic GP to work in our established Medical Practice at our Atherton and Tyldesley Medical Centre's within Ashton Wigan and Leigh PCT.

- The Practice list size is 4000 patients and growing.
- The Practice is based over 2 sites (Atherton and Tyldesley)
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- High QoF achievers
- The Practice is KPI driven and delivers high results.
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Our aim is to provide an excellent standard of primary care whilst supporting personal and professional development.

For an informal discussion, please contact Dr Stephen Cullen, Local Medical Director, Tel: 01942 481680.

Informal enquiries and visits by appointment please.

Applications by letter and full CV to:

Lesley Auston, Executive Assistant,
IntraHealth
William Brown Centre
Manor Way,
Peterlee,
County Durham
SR8 5TW,
Tel: 0191 5181564 or by email to: lesley.auston@intrahealth.co.uk

Closing date for applications: 17th December 2012
To find out more about us please visit our website at www.intrahealth.co.uk.

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Claughton Medical Centre

Dr B W Taylor, Dr G P Arthur, Dr A Cullumbine, Dr L Antanaj, Dr M Gaia
And Dr K Edwards
Claughton Medical Centre
161 Park Road North
Birkenhead
CH41 0DB

Tel No: 0151 652 1688
Fax No: 0151 670 0565

FIXED SHARE GP PARTNER REQUIRED

We are looking for expressions of interest from those who might be interested in joining our practice as a fixed share partner GP for six sessions per week.

We are GMS practice with approx 9500 patients.

We are a friendly, supportive and well established practice which achieves excellent QOF results. We currently have 6 established partners and are looking to invite the right person to join our team. We have a very capable nursing team in place and all clinicians are supported by an established, efficient and friendly admin / reception team. We believe we offer high quality patient centred care and are interested in speaking to GP's who would be keen to join our team.
We use Front Desk and Synergy.
For more details or for an informal discussion please contact Sue Ugow, Practice Manager.

Email: susan.ugow@nhs.net

Please note: Claughton Medical Centre is an Equal Opportunities Employer

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with earnings potential £135K + NHS Pension, Bristol location

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- **Locations:** We will have bases across our service area and welcome flexibility from applicants in order to build an extensive knowledge of local populations and care pathways.
- **Role commencement:** March 2013

You will be professionally supported with educational sessions and feedback for your Appraisal and Revalidation, and a full induction package will be provided before you start. Support with relocation expenses also available.

To apply: Please download an application pack from www.brisdoc.co.uk and return to cath.browne@brisdoc.org.

Closing date: 17th December 2012
(Interviews to be held on 3rd January 2013)

For more information, contact Cath Browne, HR Manager, on 0117 9370901.

BARWELL & HOLLYCROFT MEDICAL CENTRE

Leicestershire www.barwellmedicalcentre.co.uk

GP PARTNER (6 Sessions)

We have a vacancy for a partner in our well established PMS practice, working over two sites. Applicants must have an interest in becoming a GP Trainer.

- List size 10,500
- Current team of 4 partners, 5 Salaried GP's, 3 Nurses and 3 HCAs.
- Specialist Nurses clinics in COPD, Heart Failure and Mental Health.
- Teaching and Training Practice
- High QOF points achievers
- Systmone Practice

Informal enquiries, visits and applications (with CV) :
Mrs. Yvonne Glover, Practice Manager, Barwell & Hollycroft Medical Centre, Clifton Way, Hinckley, Leics. LE10 0XN. Tel 01455 234414.
Email yvonne.glover@gp-c82061.nhs.uk

Closing date: 14th December 2012.

NHS Sefton

Salaried GP • £85,264 pa pro rata • Ref: 778-99107

To start immediately - Ideally 8 Sessions per week (flexible) (12 months contract with a possibility of extension)

An exciting opportunity has arisen for a Salaried General Practitioner to provide cover for the Clinical Leaders in South Sefton CCG. We are seeking to recruit a flexible, proactive Salaried GP to work closely with the clinical leads and local management team to support the development and delivery of the CCGs and surgeries operational plan. You are expected to work as part of a cohesive team and, when necessary, take lead responsibility for issues outside their immediate sphere of responsibility. Come and join us to be part of the positive changes taking place!

Informal enquiries or visits by arrangement with the Chair, please email: clive.shaw@sefton.nhs.uk

For further details and to apply online please go to www.jobs.nhs.uk

Closing Date: 12 December 2012.

www.seftonpct.nhs.uk

MATERNITY LOCUM

Dynamic teaching practice seeks maternity locum cover to start asap for 5-8 sessions per week in the SW17 area. We also need up to 4 sessions per week cover, initially as a locum, at our Clapham surgery in SW4.

Please send CV to penelope.smith@nhs.net or Tel: Fiona Hughes on 020-8254-8036

PARTNER REQUIRED
Withnell - Rural Chorley

We are seeking to replace our long serving retiring senior partner commencing beginning of June 2013.

Our three partner practice is based in a picturesque rural location on the edge of West Pennine Moors only five minutes from Chorley and the motorway network.

We are proud to continue to practice traditional family medicine out of a Health Centre so little capital outlay is required. The health centre has a full compliment of practice staff with two practice nurses and district nurses, health visitors and parenting team on site.

An ideal candidate would value the traditional doctor patient relationship and continuity of care and ideally would have an interest in female medicine, family planning and child health. There is scope for further development of the practice, and a desire to drive the practice forward would also be welcomed.

The practice is highly valued within the local community and offers a partner the opportunity to obtain an adequate remuneration with a good work life balance.

Enquiries to Nicola Phillipson/Ethel Vickers 01772 777770
Applications to Mrs Nicola Phillipson by 30th November
Withnell Health Centre
Railway Road
Withnell
Chorley
PR6 8UA.
Interviews January 2013

2 Salaried GP(s) required for Minster Medical Group
Minster Medical Centre, Minster on Sea, Sheerness, Kent, ME12 3LT

We are a 4 partner APMS practice based in a modern community hospital looking for two enthusiastic GPs to join our busy multidisciplinary team on the Isle of Sheppey, Kent.

The two full time salaried GP roles will include interesting work within local prisons and general practice.

Experience of EMIS PCS and SystmOne desirable

Salary negotiable according to experience

If you are interested in joining our team please submit your cv to the Practice Manager elaine.rosenthall@nhs.net or for more information please call 01795 877714

We are a friendly, rural 3 partner practice seeking a well motivated experienced doctor who is willing to be involved in medical student training.

- 3730 Patients
- GMS; High QOF achievers
- Dispensing
- GP Training practice to year 4 students
- Emis LV (Emis Web from February 2013)
- No extended hours

Salaried position 2-4 sessions from January 2013 with the prospect of increase of hours at the end of 2013 when one of our GP Partners retires. Family planning training desirable. Job share applications will also be considered.

Applications by CV with a covering handwritten letter to:
Mrs Susan Mellor-Palmer
Practice Manager
Craven Arms Medical Practice
Craven Arms
Shropshire SY7 9PY

01588 672309 or cravenarms.practicemanager@nhs.net
Closing date 22nd November 2012

Salaried GP required with view to partnership
Abbey Medical Centre

Single Handed Practice • Excellent admin support
EMIS LV system • High QOF points achieved
List size 2400

For informal discussion and further details please contact Practice Manager Smita Nirgude 07799678894 Smita.nirgude@nhs.net Closing date 15/12/12

DOCTORS/GPS REQUIRED

The NHS is changing. Medway Community Healthcare is one of the new health social enterprises delivering a range of community services

NHS

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Salaried GPs - opportunities for you

£73,580 pa

About you

Looking for a change? Join our team of salaried GPs working at our practice at the Sunlight Centre in Gillingham and for our Medway On Call Care (MedOCC) urgent care service at bases in Chatham, Rochester and Gillingham.

About us

- Medway Community Healthcare CIC is a social enterprise that is co-owned by its employees.
- The Sunlight Surgery team serves a population of around 5200 patients and works closely with colleagues from the wide range of community health services we also provide.
- The MedOCC GP and nursing team provides a 24 hour unplanned care service across Medway.
- Medway Community Healthcare is a multi-million pound business with around 1100 staff, which provides a wide range of both planned and unscheduled care. Visit www.medwaycommunityhealthcare.nhs.uk to find out more.

Join our team and be part of this exciting time.

Interested? For an informal chat about the role please call Dr Simon Collins (medical director and clinical lead) on 01634 792086.

To apply, please send your CV and a covering letter to Darshana Malhotra at mchrecruitment@nhs.net or 7-8 Ambley Green, Bailey Drive, Gillingham, Kent ME8 0NJ, quoting reference: 813-175-1012-TB or visit www.jobs.nhs.uk/cgi-bin/vacdetails.cgi?selection=912978545

Closing date: 11 December 2012

www.medwaycommunityhealthcare.nhs.uk

We are looking for an enthusiastic & committed GP to work up to 9 sessions a week.

We are a busy, semi-rural dispensing practice in Manningtree, Essex, looking to replace a retiring partner.

4850 patients and rising – 40% dispensing

Purpose built premises agreed planning for extension May 2014.

Substantial private income from local secure hospital.

High QOF achievers. Low staff turnover. Emis Web.

2 practice nurses & 1 nurse practitioner.

Informal enquiries/visits are welcomed.

Riverside Health Centre, Station Road, Manningtree CO11 1AA
Practice Manager: melanie.lodge@nhs.net

Thirsk, North Yorkshire

Market town dispensing practice requires full time or 2 part time **Salaried GP's** commencing 1st February 2013.

High achieving teaching practice with EMIS system and purpose built premises, 8100 patients and 4 partners.

For further information please contact:

Practice Manager

Lambert Medical Centre, 2 Chapel Street, Thirsk, YO7 1LU

Email: David.Dodsworth@GP-B82042.nhs.uk

Closing date: 17th December 2012

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Buchanan Road Surgery

We are looking for a **Salaried GP** from April 2013

Due to a partner moving on we are looking for a GP who would like to join our friendly and dynamic team.

We are offering 6 sessions and possibility of partnership. We are looking for someone who would be able to assist us / has an interest in training and education and who is willing to maintain/develop our QOF and enhanced services.

The practice is located in a socially deprived area of the city and although the work is challenging it is also extremely rewarding.

- 5200patients
- SystmOne
- Excellent QOF achievement
- Member of North Sheffield CCG
- Excellent nursing and admin teams
- Substance misuse management (a training opportunity if interested)
- Enhanced services ; Warfarin, Minor ops, Nursing Home care
- Training practice - GP Registrar
- Medical students

Informal enquiries and visits welcome

Please apply in writing with your CV and cover letter explaining why you would like to consider working with us to Michelle Richards Practice Manager at michelle.richards1@nhs.net
Or at Buchanan Road Surgery 72 Buchanan Road Parson Cross Sheffield S5 8AL
Telephone 0114 2454834

Closing date Friday 31 December 2012

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We are a values driven primary care provider with full and part time GP salaried positions within our 2 Bradford based practices.
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For more information and to apply send a copy of your CV with a covering letter to lydiafairman@onemedicare.co.uk or call Lydia on 0113 284 3158.

http://www.onemedicare.co.uk/careers.php

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- **Just outside M25, excellent transport links to both London and Surrey**
- **Closing date: 15th December 2012**

Contact: Dr. Hamed Khan, Partner. Email: hamedkhan88@hotmail.co.uk
Go to http://www.oxtedhealthcentre.co.uk/ for further details of the practice

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SALARIED GP/LONG TERM LOCUM REQUIRED

MOSELEY MEDICAL CENTRE, SOUTH BIRMINGHAM

- High QOF Achievement
- No Investment Required, Leased at Notional Rent
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- Emis/Paperlight
- 4-5 Sessions per week
- Salary Negotiable
- Enquires/Visits Welcome

Please send Application with CV and a handwritten covering letter to Manager
Moseley Medical Centre, 21 Salisbury Road, Moseley, Birmingham B13 8JS
Telephone: 0121 449 0122/07770756274 Email: drrajab@hotmail.com

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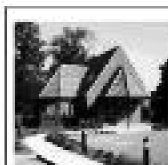

Toftwood Medical Centre

Telephone [illegible] Fax [illegible]

Dr A Walker MRCGP DRCOG FP Cert

Dr A Gregory MB BCH BAO(Hons) DRCOG MRCGP

2 Chapel Lane,
Toftwood,
Dereham,
Norfolk,
NR19 1LD.

GP partner in GMS practice wanted

Due to a retirement we are seeking a new partner to join our happy team. Are you the one? Six to eight sessions preferred. Six months mutual assessment.

This vacancy may also lead to the opportunity to become the senior partner in the medium term.

3500 generally appreciative patients in expanding mid Norfolk market town. Twenty minutes to the beautiful city of Norwich and forty minutes from the coast.

No premises buy in required.

PCT leased premises, recently refurbished with possible plans to extend.

Excellent working relationships in a friendly & well integrated team of part time salaried GPs, Nurse Practitioner, Practice Nurse and Healthcare assistants, administrative team & practice manager.

Visiting CPN, counsellor & midwife.

Good relationships with neighbouring practices and representation on South Norfolk CCG.

Fully computerised using Isoft synergy computer system. Switching to TPP system one in March 2013.

Good QOF achievement & patient survey results.

Patient participation group.

Informal visits or enquiries welcome, or submit CV and covering e-mail or letter to:- Mrs Eve Barrett, evebarrett@nhs.net.

The Rosegarth Practice Halifax

Full Time Salaried GP

We are looking to recruit an enthusiastic salaried GP to replace a retiring partner at our well established practice.

We are a Training Practice (GP, FY2 and medical students) providing care for 10000 patients across 2 sites in central Halifax.

The Practice:

- GMS
- High QOF achievement
- Large range of Enhanced Services
- Full complement of supportive and dedicated nursing and administrative teams
- Active involvement with Local Commissioning Consortium
- SystmOne/paper light
- Encouragement to develop specialist interests and skills

Applications are invited in writing with CV to our Practice Manager, Sue de Lacy at Rosegarth Surgery, Rothwell Mount, Halifax. HX1 2HB. Sue would also be happy to deal with informal enquiries or arrange a visit (contact 01422 353450).

Closing Date for Applications: 10th December 2012

DRS N & S K NAGPAL

THE SURGERY, WILLIAM HOPWOOD STREET, BLACKBURN, BB1 1LX

VACANCY:	Salaried GP
SALARY:	Negotiable
HOURS:	9 sessions per week
RESPONSIBLE TO:	Lead GP

We are looking for an enthusiastic GP to join our friendly patient centred team. A combination of outstanding clinical skills with a forward thinking and innovative approach to patient care are essential:

- PMS Practice providing a wide rang of NHS services.
- Approximately 5855 patients
- Enthusiastic and supportive team
- High QoF achievement
- Excellent administration and support teams
- Extended Hours provider
- EMIS WEB System

Job Description available on request

All applications in writing please enclosing Curriculum Vitae and the names of two referees to: Dr N Nagpal at the above address or by email: nirmala.nagpal@nhs.net

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

EDITOR'S CHOICE

Restoring health in the slums

Dr Miriam Dolan describes her rewarding experience volunteering for Slumdoctor in northern India

Last year I volunteered for the first time with the Slumdoctor (UK) project that sets up an annual three-day medical camp in a northern Indian village.

This set a contrasting scene from my rural Northern Irish practice in County Fermanagh. India struggles not only with communicable diseases, but also the non-communicable ones such as diabetes, hypertension and heart disease, which are often untreated and lead to high mortality and disability rates.

The 2012 team consisted of more than 100 healthcare volunteers from across Europe and the local region. We worked up to 12 hours a day, providing treatment to more than 8,000 people. Patients were triaged and further investigations were organised locally. Patients were referred to the local hospital if treatment was needed. This was funded by the charity and we provided necessary medication.

Many patients were started on treatment for diabetes, cardiovascular disease or risk factors, COPD, severe menorrhagia or third-degree uterine prolapse. Hundreds of people were fitted with hearing aids or glasses and many people regained sight due to cataract surgery.

Dr Miriam Dolan

The medical camp is in its eighth year, having grown from two volunteers to 30 oversees and 120 local volunteers. As the camp is growing, Slumdoctor is looking for volunteers for next year's camp which will run from 8–11 March 2013.

It was rewarding to work with such an inspiring team in challenging circumstances. My GP skills proved a huge benefit. The patients were grateful that you took the time to listen (through a translator), to discuss their condition and offer treatment.

The project ticks all those boxes we had as ideological medical students.

Dr Miriam Dolan is a GP in Co Fermanagh, Northern Ireland

MORE ONLINE
Read more from Dr Dolan and another Slumdoctor volunteer
pulsetoday.co.uk/off-duty

BIG INTERVIEW

In this week's Big Interview we talk to Dr Iona Heath, outgoing president of the RCGP, about the challenges facing her successor, out-of-hours services and falling GP morale.

▶ pulsetoday.co.uk/the-big-interview

WHAT YOU'VE BEEN SAYING

▶ pulsetoday.co.uk/forum

"When GPs are seen as rationers rather than advocates of healthcare, patients bypass them"

... on the surge in non-elective hospital activity that has hit CCG budgets

"If the BMA thinks this is worth spinning as a victory, then it sounds truly hollow"

... on the BMA hailing a concession from the Government in patient talks

"Maybe we should just be saying "no" more often"

... on health secretary Jeremy Hunt's admission that GPs are doing more work despite flat budgets

OPINION

Taking a stand for abortion

Dr Anne Livingstone, a GP in Tower Hamlets, east London, explains why she and several colleagues joined a counter-demonstration in support of a British Pregnancy Advisory Service clinic.

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

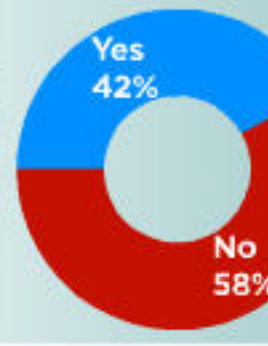
THIS WEEK'S POLL

Is 48 hours enough notice for CQC inspections?

Vote at ▶ pulsetoday.co.uk/polls

Last week's poll

Should pharmacists be allowed to give out prescription-only medicines?



Turn inside for this week's shot of the world according to Copperfield
▶ page 21