PULSE

Supporting GPs since 1960
January 2013 | www.pulsetoday.co.uk

Peverley on cradle-to-grave general practice

CKD or benign kidney decline?

Practices at breaking point

Has the QOF lost its way?

IN THIS ISSUE

3.5 CPD HOURS

LEADER OF A DEFEATED PROFESSION?

'Ultimately, the Government holds all the cards'

Dr Laurence Buckman

NEW LAMA FOR COPD

Eklira® Genuair®▼

aclidinium bromide inhalation powder

18% less initiation cost vs. tiotropium HandiHaler®7*

Around-the-clock COPD symptom control, making a real difference to patients' lives[1,2]

- Comparable efficacy to traditional LAMA treatment with twice daily dosing[3-5†]
- Sustained bronchodilation from day 1[1]
- Improves patients' breathlessness and health status**(vs. control)[1]
- Simple and easy-to-use device[3,5-7]
- 15% annual cost saving vs. tiotropium[7††]

* 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

Eklira® Genuair®▼
322 micrograms inhalation powder aclidinium bromide

Active Ingredient: Each delivered dose contains 375 µg aclidinium bromide equivalent to 322 µg of aclidinium. Each metered dose contains 12.6 mg lactose monohydrate. **Indication:** As a maintenance bronchodilator treatment to relieve symptoms in adult patients with chronic obstructive pulmonary disease (COPD). **Dosage and Administration:** The recommended dose is one inhalation of 322 µg aclidinium twice daily. *Consult SmPC and package leaflet for method of administration.* **Contraindications, Warnings, etc:** *Contraindications:* Hypersensitivity to aclidinium bromide, atropine or its derivatives, including ipratropium, oxitropium or tiotropium, or to the excipient lactose monohydrate. *Precautions:* Should not be used to treat asthma or for relief of acute episodes of bronchospasm, i.e. rescue therapy. May cause paradoxical bronchospasm. Re-evaluation of the treatment regimen should be conducted if there is a change in COPD intensity. Use with caution in patients with a myocardial infarction during the previous 6 months, unstable angina, newly diagnosed arrhythmia within the previous 3 months, or hospitalisation within the previous 12 months for heart failure functional classes III and IV as per the "New York Heart Association". Consistent with its anticholinergic activity, dry mouth has been observed and may in the long term be associated with dental caries. Also, use with caution in patients with symptomatic prostatic hyperplasia or bladder-neck obstruction or with narrow-angle glaucoma. Patients with rare hereditary problems of galactose intolerance, Lapp lactase deficiency or glucose-galactose malabsorption should not take this medicine. *Interactions:* Although co-administration with other anticholinergic-containing medicinal products is not recommended and has not been studied; no clinical evidence of interactions when taking the therapeutic dose has been observed. *Pregnancy and lactation:* Aclidinium bromide should only be used during pregnancy if the expected benefits outweigh the potential risks. It is unknown whether aclidinium bromide and/or its metabolites are excreted in human milk. The benefit for the breast-feeding child and long-term benefit of therapy for the mother should be considered when making a decision whether to discontinue therapy. *Ability to drive and use machines:* The effects on the ability to drive and use machines are negligible. The occurrence of headache or blurred vision may influence the ability to drive or use machinery. **Adverse Effects:** *Common:* sinusitis, nasopharyngitis, headache, cough, diarrhoea. *Consult SmPC in relation to other side-effects.* **Legal Category:** POM **Marketing Authorisation Number(s):** EU/1/12/778/002 – *Carton containing 1 inhaler with 60 unit doses.* **NHS Cost:** £28.60 (excluding VAT) **Marketing Authorisation Holder:** Almirall S.A. General Mitre, 151 08022 Barcelona Spain. **Further information is available from:** Almirall Limited, 1 The Square, Stockley Park, Uxbridge, Middlesex UB11 1TD, UK. Tel: (0) 207 160 2500. Fax: (0) 208 7563 888. Email: almirall@professionalinformation.co.uk

Date of Revision: 09/2012 **Item code:** UKACL1352 Eklira and Genuair are both registered trademarks.

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 Almirall Ltd.

Almirall

Solutions with you in mind

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.

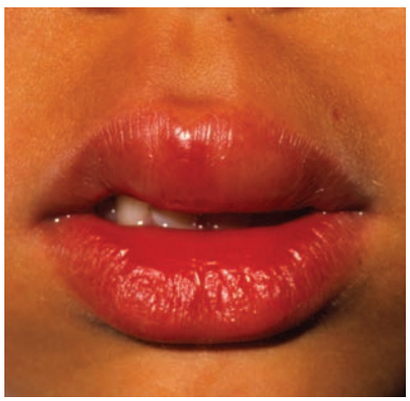
Date of preparation: October 2012

UKACL1332d

JANUARY 2013

Practices at breaking point
Page 6

10 tips to reduce your prescribing spend
Page 38



Key questions on food allergy
Page 48

THIS MONTH

VIEWS

YOUR PRACTICE

CLINICAL

Online-only highlights
pulsetoday.co.uk

The most complicated QOF indicator ever?

Dr Gavin Jamie's analysis of the 2014/15 QOF changes includes a proposed second-generation indicator
pulsetoday.co.uk/2014-qof-analysis

Tricky 10 minutes: how can I stop my constant migraines?

Advice from headache specialists on this difficult presentation
pulsetoday.co.uk/tricky10

Dilemma: renting premises to a complementary therapist

Two GPs and a legal expert offer their advice as our new series gets underway
pulsetoday.co.uk/premises-dilemma

The Big Interview: Professor Mark Baker

Watch a video interview with the director of the Centre for Clinical Practice at NICE
pulsetoday.co.uk/the-big-interview

The information: trigeminal neuralgia

Differential diagnoses, treatment and prognosis
pulsetoday.co.uk/info

Paper of the day

The best of the latest research plus implications for GPs
pulsetoday.co.uk/paper-of-the-day

pulse-learning.co.uk

This month's most popular modules

PulsePlus: childhood infections

2 CPD HOURS
'Superb refresher – highly recommended for all GPs'
Dr Craig Thompson

The information: acne

0.5 CPD HOURS
'Short, sharp and useful'
Dr Keith Souter

These modules are available exclusively to premium members of Pulse Learning Don't miss out – join now at **pulse-learning.co.uk**

Hot topics in iron deficiency anaemia

2 CPD HOURS
'Clear, evidence-based and practical – with a focus on everyday presentations'
Dr Mark Overton

Guideline debrief: psoriasis

2 CPD HOURS
'Very useful and very applicable to GPs – I learned a lot from doing this module'
Dr Leanne Molloy

HELP SMOKERS FIND THE RIGHT QUIT PATH

60% of smokers plan to try and quit smoking in January[1]

But just 20%[1] of smokers recognise that a healthcare professional can help them quit smoking

With your help, they are 4 times more likely to quit successfully than by going it alone[2]

TO ORDER FREE MATERIALS FOR YOUR PRACTICE OR STOP SMOKING SERVICE VISIT

WWW.DGCT.CO.UK

'Don't Go Cold Turkey' is a disease awareness campaign from Pfizer Ltd. to raise awareness of the support available to patients from their healthcare professional to help them quit smoking.

[1] From OnePoll's online survey panel. A total of 6,271 UK adults aged 18+ were asked a filter question to identify smokers who have successfully quit smoking and those who want to quit but are still smoking. Across this overall sample, quota controls were by age, gender, region and by a split of the filter question to ensure a representative profile of the audience. From this 6,271 satisfied the recruitment criteria and took part in an online survey. Fieldwork undertaken in October 2012.

[2] Department of Health. Local stop smoking services – service delivery and monitoring guidance 2011/12. 2011. Available from: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_125939.pdf. Last accessed: 6th November 2012.

DON'T GO COLD TURKEY
QUIT WITH HELP

This initiative is organised and funded by Pfizer Limited
SCE1361a, Date of preparation December 2012

Pfizer

INVESTIGATION

UNP

Case study
Dr Ben Burville

'Existing patients are our priority'
We're open to any new DES, but we can't sign up to one just because it's there; we have to look at the impact new work would have on our patients and the services we provide.

We do a lot of dementia case finding anyway, but as for the other DESs, we just don't have the infrastructure or the time without sacrificing other services. Our priority has to be the patients we've got. We'd love to hire more GPs and nurses and expand our services, but we simply don't have the funding.

I get to work at 7:45am and don't get home till 7:30pm. I enjoy my work but it can be frustrating when you can see the benefits of investing in primary care, yet if anything funding is being reduced while workload is increasing.

In our practice there have already been more and more directives to reduce secondary care admissions and referral management – both to reduce cost. But they all take time. Contrary to popular belief, there isn't an endless amount of time in the day.

Dr Ben Burville is a GP in Amble, Northumberland

Practices at breaking point

As GPs face the biggest practice funding shake-up in the history of the new contract, Madlen Davies and Sarah Holmes look at how practices are planning to cope

In three months' time, practices across the country will face what the GPC has called 'the most significant quantum reduction in the GP contract' since the new contract was introduced.

A Pulse investigation reveals accountants are already advising partners to reduce their drawings by up to 10% and urging practices to urgently re-evaluate the services they provide before April in order to cope with an unprecedented rise in workload.

Coming after several years of pay freezes – or small uplifts that have failed to match rising practice expenses – GP leaders are warning practices to prepare for the worst.

Many are already looking at the services their surgery provides, picking and choosing from the new QOF work and even considering making clinical staff redundant – doing whatever it takes to ensure their business survives.

With even a senior GP adviser at NICE warning of a 'dangerous, unforeseen consequence' from the multitude of changes, coming on top of the new responsibility for commissioning, is this the point of no return for general practice? Or can GPs weather a perfect storm?

The proposals

The exact terms of the contract changes will vary across England and the devolved nations. English GPs face the most stringent deal, with a raft of new QOF targets, plus raised thresholds, the removal of the organisational domain, and funding reallocated to four new directed enhanced services.

GPs in Wales and particularly Scotland face somewhat better deals, while the Northern Ireland Executive has yet to announce its proposed changes.

But GPs in the devolved nations have still been warned they face a huge hike in workload.

The Department of Health insists many of the changes proposed are 'already being delivered' by practices, and that the new deal will improve patient care.

NEIL O'CONNOR

Case study
Dr Rosemary MacRae

'We are worn out'

We planned to take on a new partner this year, but that was based on this year's income. It's getting harder and home life is suffering. It's difficult to plan ahead when the contract changes year after year. We're worn out. We're not going to take any action that will harm the patient, so what can we do?

We thought we'd agreed a contract in 2004 but it's been changed year on year. We've got a choice between suffering financially or taking on everything thrown at us. I have my doubts about the usefulness of some of the work: dementia screening – how useful is that going to be? It takes time to do properly.

We don't feel we can take on more work, but the Government expects us to do more for the same money. Work is just added; nothing is dropped. Not paying us for the organisational work to release money for the additional stuff doesn't mean we can stop doing it. We're doing 11-hour days already and weekends.

Dr Rosemary MacRae is a GP in St Helens, Merseyside

But Pulse's snapshot survey of 229 GPs reveals many are considering drastic measures to preserve services. More than three-quarters (77%) are planning on reducing partner drawings this coming year and 47% plan to cut extra services offered to patients. Almost one-fifth (19%) say they will cut the number of routine appointments.

Some practices are also looking at whether they can afford the staff they employ. A tenth (10%) expect to make a salaried GP redundant in 2013/14 and a further 13% expect to make other clinical staff redundant. Almost a quarter (23%)fear they will have to let administrative staff go next year.

> GPs will pick and choose what they do under QOF
> *Professor Helen Lester*

Cutting GP pay

GP partners' own pay packets always take the first hit from any practice funding squeeze, and medical accountants are warning that the reduction next year will be particularly acute.

Rosemary Smith, a senior partner at RS Medical Accountancy, is advising her clients to cut their drawings by 5% to 10%.

She says: 'It is advisable for GPs to cut their drawings after estimating their income for the next year and to make the decision before the start of the year.

'If they over-estimate, they can pay themselves out at the year-end, but it is easier to cut drawings monthly than find themselves having to put larger sums back into the practice.'

But she adds that reducing income may not be enough and practices will also have to trim extra services they offer.

She says: 'Unless they cut overheads as well, they will lose money. GPs will have to spread their income streams so they can cushion new proposals.'

Postcode lottery

Dr Tony Grewal, medical secretary at Londonwide LMCs, says practices simply do not have the capacity to absorb extra work and the proposed contract changes will lead to a 'postcode lottery'.

He says: 'Anything new means you've got to drop something. This applies from the busiest practice to the leafiest suburb.

'CCGs are not looking at primary care provision. They're not borough based, they won't have the information.

'It's unlikely the NHS Commissioning Board will have the capacity or inclination either, so it will lead to a postcode lottery.'

Dr Grewal's practice is planning to reduce diabetes management and health promotion initiatives and stop fitting coils, and has already ceased providing minor surgery.

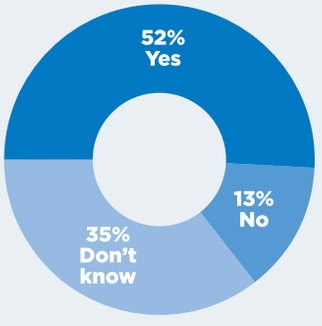
Similarly, Dr Marie-Louise Irvine, a BMA Council member and a GP in Lewisham, south-east London, says her practice will cut some diabetes management work, as well as cease using the PHQ-9 to rate the severity of depression.

'They were not useful to the practice doctors and it was purely a box-ticking exercise,' she says.

Dr John Grenville, medical secretary of Derbyshire LMC, says practices will probably have to move towards greater triaging, with patients seeing nurses and health practitioners for minor ailments.

QOF work

Will you be re-evaluating the QOF work you undertake and considering stopping some QOF work as a result of the planned changes?



Source: Pulse survey of 229 GPs

How practices plan to cope in 2013/14

Source: Pulse survey of 229 GPs

But he warns: 'Occasionally someone will come in seeking assurance for something which they think is a minor problem and it won't be, and it might be missed and they'll suffer. Some patients will slip through the net.'

Dr Paul Conley, a GP in Bordon, Hampshire, says chronic disease care for patients with self-management plans and cosmetic skin surgery are the 'lower-priority services' his practice will look to reduce.

Picking and choosing QOF targets

More than half (52%) of the respondents to Pulse's survey said they will have to re-evaluate which QOF work they take on, with some unlikely to tackle some of the new indicators.

Professor Helen Lester, the clinical QOF indicator development lead for NICE, says the sheer volume of QOF changes may overwhelm GPs.

'GPs will pick and choose what they do under QOF if you make so many changes all in one go,' she says.

'Particularly coinciding with changes to commissioning, I think practices won't have the energy or the capacity to focus in the way they do now. That could be a dangerous, unintended consequence.'

The GPC has already urged practices to consider whether it is financially viable to take on the additional QOF work, and warned that some indicators are 'unworkable'.

Dr Peter Swinyard, chair of the Family Doctor Association, warns the planned hike in QOF upper thresholds will demotivate practices. He says: 'If you set a threshold too high people will say "It's not worth trying for".

'They'll say "We can get blood pressure down to 140/90 but we can't get them down to 120/90".

'Patients won't take enough drugs, because it makes them fall over, and then we'll either get tyrannised for high exception reporting, or our drugs bill will go up and we'll be rapped for over-prescribing. It's lose–lose.'

Political agendas

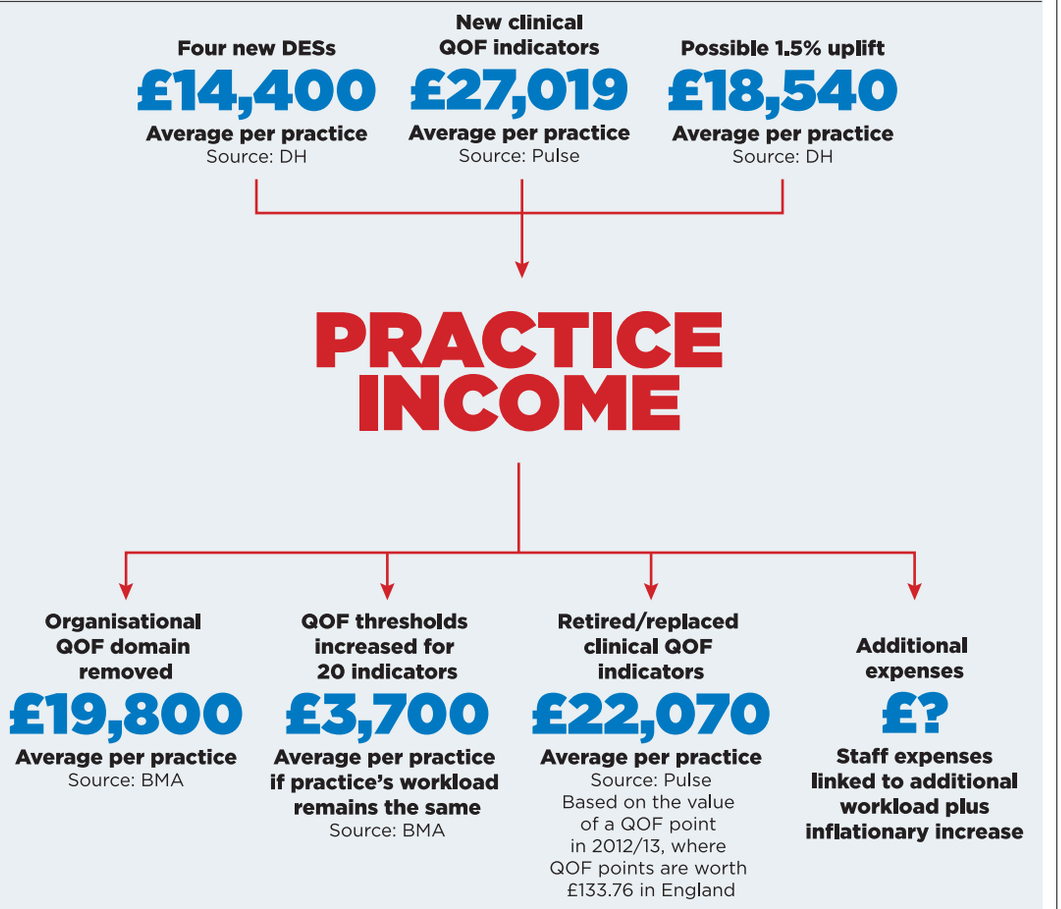
The GPC estimates the average practice will lose £31,000 a year by 2014/15 if the Government imposes its plans to remove funding for the organisational domain of the QOF and hike QOF upper thresholds for 20 indicators.

But they will be able to earn part of the money back by taking on four new DESs worth £3,600 each for the average practice.

However, almost a third of respondents to Pulse's survey said their practice would not take on any of the new DESs proposed, effectively throwing in the towel on a hefty funding cut.

GPC chair Dr Laurence Buckman says: 'I am not sure actually you could take on all four DESs; the workload is very steep. If I am not going to do some of the DESs because I physically can't, then I must be losing money, because the money that funds the DESs is 150 QOF points.'

Practice finances: ins and outs in 2013/14



Key additional changes

- New rotavirus and shingles vaccination programmes, with GP practices to receive £7.63 per vaccine administered.
- DH to increase the face value price of a QOF point in 2013/14 by 16% but reform CPI weighting so that from 2013/14 it is based on the actual average practice list size at the start of the last quarter before the financial year in question so the price of QOF points is 'transparent'.
- DH says this change is cost-neutral but Dr Gavin Jamie, a GP who runs the QOF database website, says the points value per patient will fall in future years.
- DH to remove the current overlap of QOF years by reducing the time period for most indicators from 15 months to 12 months.

Dr Grewal says practices will not take on the new DESs for case-finding in dementia, risk-profiling, telehealth and rolling out online access to GP services unless they can see clear clinical benefits.

He says: 'GPs are fed up with dancing to political agendas rather than clinical ones. The DESs are seen as another vote catcher, not for clinical need.'

Others, however, believe GPs will have no option but to take on the additional work. Michael Ogilvie, client service director at OBC The Accountants, says GP partners are facing a 10% to 20% cut in take-home pay next year, thanks in part to pension tax changes, and they will be forced to take on all the work they can.

EXTRA ONLINE

Analysis
Accountant Ken Craig advises GPs on how they can best survive the contract changes
pulsetoday.co.uk/craig

'Emotionally, doctors are saying they can't do the DESs, but in reality they will have to consider how they can take on the extra work because it's an important source of funding,' he says.

'It won't be pleasant at all, and some may refuse to do it. But I think that young partners, who still have school bills and mortgages to pay, will make more changes than older partners.'

The DH, meanwhile, insists the changes are fair, claiming 'excellent care and improving the health of patients is a priority for everyone in the NHS and we are committed to giving them the tools to make sure this happens'.

In a few months we will find out who is correct.

sanofi pasteur MSD
vaccines for life

We've supplied over 2.5 BILLION DOSES of flu vaccine worldwide in the last 60 years[1]...

www.flu-protect.co.uk

Visit www.flu-protect.co.uk for more information about flu and flu vaccination

FLU&YOU
A Sanofi Pasteur MSD initiative

ABRIDGED PRESCRIBING INFORMATION
Inactivated Influenza Vaccine (Split Virion) BP
Refer to Summary of Product Characteristics for full product information. **Presentation:** Inactivated Influenza Vaccine (Split Virion) BP contains 15 micrograms of antigen (per 0.5 millilitre) from each of the three virus strains recommended by the World Health Organization for the present influenza season. It is supplied as single dose prefilled syringes each containing 0.5 millilitre of suspension for injection. The vaccine may contain traces of eggs, such as ovalbumin, neomycin, formaldehyde and octoxinol 9 which are used during the manufacturing process. **Indications:** Prophylaxis of influenza especially in those who run an increased risk of associated complications. Inactivated Influenza Vaccine (Split Virion) BP is indicated in adults and children from 6 months of age. **Dosage and administration:** Adults and children from 36 months should receive one 0.5 millilitre dose. In children aged 6 months to 35 months clinical data are limited and dosages of 0.25 or 0.5 millilitre have been used. Children who have not been previously vaccinated should receive a second dose of vaccine after an interval of at least 4 weeks. Doses should be administered intramuscularly or deep subcutaneously. **Contraindications:** Hypersensitivity to the active substances, to any of the excipients, to eggs, chicken protein, neomycin, formaldehyde, and octoxinol 9. Immunisation should be postponed in patients with febrile illness or acute infection. **Warnings and precautions:** Do not administer intravascularly. Medical treatment should be available in the event of rare anaphylactic reactions following administration of the vaccine. Immunosuppressed subjects may not produce adequate antibodies. Other vaccines may be given at the same time at different sites, however adverse reactions may be intensified. **Pregnancy and lactation:** Inactivated influenza vaccines can be used in all stages of pregnancy. May be administered during lactation. **Undesirable effects:** Common side effects include: injection site reactions (redness, swelling, pain, ecchymosis, induration) and systemic reactions (fever, malaise, shivering, fatigue, headache, sweating, myalgia, arthralgia). These usually disappear within 1 to 2 days. Other serious side effects have been reported and include, allergic reactions (in rare cases leading to shock, angioedema), convulsions, transient thrombocytopenia, vasculitis with transient renal involvement and neurological disorders such as encephalomyelitis, neuritis and Guillain-Barré syndrome.
For a complete list of undesirable effects please refer to the Summary of Product Characteristics. **Package quantities and basic NHS cost:** Single dose prefilled syringes in single packs, basic NHS cost £6.59; packs of 10 single dose prefilled syringes, basic NHS cost £65.90. **Marketing authorisation holder:** Sanofi Pasteur MSD Limited, Mallards Reach, Bridge Avenue, Maidenhead, Berkshire, SL6 1QP. **Marketing authorisation number:** PL 6745/0095
Legal category: POM. Date of last review: April 2012
Reference: 1. Sanofi Pasteur MSD. Data on file 2012 UK15877

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

UK15944 j 07/12

DIGEST

Your essential round-up of all the political, financial and business news relevant to your practice. For full stories and analysis go to pulsetoday.co.uk/news

Care records created without consent

'Human error' was to blame for an NHS IT blunder that saw Summary Care Records (SCRs) created for thousands of patients without them being given an opportunity to opt out, a Department of Health investigation has concluded.

Some 4,201 records were created after a GP practice was incorrectly identified for an SCR upload. Although the records have now been 'withdrawn', meaning they cannot be accessed, the DH said they would not be deleted so that an audit trail would remain.

pulsetoday.co.uk/scr-blunder

CCG conflicts of interest revealed

More than one CCG board member in five has a financial interest in a private healthcare provider, exposing them to possible conflicts of interest when commissioning services from April, a Pulse investigation has revealed.

Analysis of nearly 900 CCG board members' registered interests showed that 23% are directors, owners, partners or shareholders in private healthcare providers, or have a family member with an interest in such a provider.

The majority of the interests related to small businesses providing services such as diagnostics, minor surgery and locums.

pulsetoday.co.uk/ccg-boards

GPC blamed in contract row

Half of GPs think the GPC has done a poor job in negotiations with the Government over the GP contract, but the majority would support the union if it pushed for a boycott of commissioning, a Pulse survey has found.

The snapshot poll of 226 GPs found 51% believed the GPC had done a 'poor' or

A good month for...

Patient choice

The DH revealed that patients will be offered a choice of provider for 20.5 million tests annually by 2015, including endoscopy, audiology assessments, ophthalmology tests and imaging tests such as CT and DEXA scans.

Cardiac physiology tests, respiratory and sleep physiology, urodynamics and vascular physiology tests were also listed as priority areas as the Department of Health released its response to the *Liberating the NHS: no decision about me, without me* consultation.

Dr Gerry Millar

The GP in Moy, County Tyrone, was one of two GPs recognised in the Queen's New Year's honours list.

Dr Millar was recognised with an MBE for his work on palliative care, as the first Macmillan facilitator in cancer and palliative care in Northern Ireland.

Dr David Wood, a GP in Colwyn Bay, Conwy, also received an MBE for his services to education and training in general practice.

Professor Sir Peter Rubin

GMC chair Professor Sir Peter Rubin (pictured below) became the first doctor in the UK to be revalidated after a positive recommendation from his responsible officer.

RCGP chair Professor Clare Gerada and GPC chair Dr Laurence Buckman were also in the first wave to achieve revalidation. By the end of January all doctors will have been informed of their revalidation date.

A bad month for...

QP indicators

Managers have struggled to provide any evidence that QOF indicators designed to cut emergency admissions and A&E attendances have had any impact, according to responses to an NHS Employers survey obtained by Pulse. Only three out of twelve PCT and CCG responses to the survey said the quality and productivity indicators had reduced emergency admissions in 2011/12, while none of the respondents was able to say the A&E QP indicators had led to improved access to primary care in 2012/13.

Obese patients

The obese could face losing their benefits if they fail to use exercise prescriptions given to them by their GP, under controversial proposals from one local council.

A report by the City of Westminster borough council and the Local Government Information Unit suggested local authorities should use council tax and housing benefit to incentivise 'behaviours that promote public health'.

Health secretary Jeremy Hunt

Dr Helen Tattersfield, chair of Lewisham CCG, wrote an angry letter to the health secretary warning that the proposed closure of Lewisham Hospital A&E, decided by a trust special administration without the agreement of local GPs, affected the 'whole ethos of clinical commissioning'. The A&E still looks set to close, but Dr Tattersfield received the backing of two other London CCG chairs, who warned GPs' voices were being 'diluted'.

142 days without a major eczema flare? That's a whole British summer.

Adult patients with moderate-to-severe atopic dermatitis (AD) treated proactively twice-weekly with 0.1% Protopic were free from major flare for a median of 142 days, compared with 15 days for those receiving Protopic flare treatment alone[1,2*]

Exposure of the skin to sunlight should be minimised and patients advised on appropriate sun protection methods, such as minimisation of the time in the sun, use of a sunscreen product and covering of the skin with appropriate clothing[2,3]

astellas

*Protopic is for use in patients with moderate-to-severe AD who have failed to adequately respond to[2,3] or are intolerant of conventional therapies, such as topical corticosteroids[2]

References:

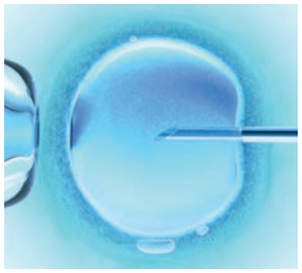
1. Reitamo S and Allsopp R. *J Dermatol Treat* 2010; **21**: 34–44.
2. Protopic 0.1% Summary of Product Characteristics, August 2012.
3. Protopic 0.03% Summary of Product Characteristics, August 2012.

Prescribing information can be found on the adjacent page

PRO12106UK December 2012

Protopic®
tacrolimus 0.03, 0.1% ointment
Help your patients outsmart eczema

DIGEST



'very poor' job in representing the profession in negotiations on the 2013/14 GP contract. Only 14% thought it had done a 'good' or 'very good' job.
pulsetoday.co.uk/gp-contract-2013

CCG risks legal action in rationing test case

CCG leaders are open to legal action after backing controversial age restrictions on fertility treatment that go further than NICE guidelines.

The decision by Slough CCG to retain the PCT's policy of limiting access to IVF treatment to women aged 35 years and under has left it open to being named in pending legal action.

The CCG's board met after a couple from Slough launched legal action against health secretary Jeremy Hunt and NHS Berkshire under age-discrimination legislation after the health authority refused IVF treatment because the woman was over 35. The case will be the first to challenge NHS rationing decisions on the basis of age and could set a precedent.
pulsetoday.co.uk/slough-ccg

GPs should sidestep family disputes

The Medical Protection Society has warned GPs not to get embroiled in family disputes, after receiving a record number of phone calls from GPs asking for advice on how to deal with 'warring parents' and children's medical records.

The defence body said it received 179 calls on the matter last year – and that it expected the number to grow.
pulsetoday.co.uk/family-disputes

Success claim on boundaries pilots

The coalition Government has cited pilots abolishing practice boundaries for commuters in certain cities as a major success in its mid-term progress report, despite the project's late start and disappointing numbers of participants.

Quote of the month

'If you think you would be slightly embarrassed explaining it to Jeremy Paxman, you must look to change your arrangements'

Dr Dennis Cox on potential conflicts of interest in CCGs
pulsetoday.co.uk/ccg-boards

Controversy of the month

Is the CSA exam fair to overseas trainees?

What's the row about?
The British Association of Physicians of Indian Origin (BAPIO) is threatening to take legal action against the RCGP unless it makes changes to reduce the failure rate of international GP trainees in the MRCGP's clinical skills assessment exam, which is six times higher than that of UK trainees.

What's the latest?
The RCGP is considering extending the number of chances trainees are given to pass the exam from four to six, and providing more support for international trainees. But a study by the college has found the exam is fair and there are 'no substantial effects of gender or ethnicity on examiner/candidate interactions'.

What happens next?
As Pulse went to press, the RCGP was set to meet with BAPIO and the British International Doctors' Association, while the newly formed British Pakistani Doctors Forum was planning a protest outside the RCGP's headquarters. No date has been set for publication of either the 2011/12 exam statistics or research into the differentials being conducted by the RCGP and King's College London.
Follow the latest developments at pulsetoday.co.uk/education

The Government also cited the formation of CCGs and 'real terms' increases in the health budget as ways it has 'improved the NHS' since taking power in 2010.
pulsetoday.co.uk/coalition-success

'Friends and family test' for GPs

The NHS Commissioning Board is to explore how the Government's 'friends and family test' can be extended to GP practices over the next 18 months.

The plans could include asking patients to state on the internet how likely they would be to recommend a practice to friends or family, but the GPC said the test would not reflect the reality of GP care.
pulsetoday.co.uk/ff-test

Welsh GPs reject QOF concessions

GPC Wales has rejected the final offer on the 2013/14 GP contract from the Welsh Government, despite concessions on the additional QOF workload planned in England and support for practices hit by the MPIG phase-out.

The Welsh Government's final proposals are now likely to be imposed on practices from 1 April.

The news came as the BMA unveiled the full details of the QOF concessions obtained in a separate deal in Scotland, which include less substantial threshold hikes and funding removed from the organisational domain being reused elsewhere within the QOF rather than shifted to new DESs. Talks in Northern Ireland continued as Pulse went to press.
pulsetoday.co.uk/wales-contract

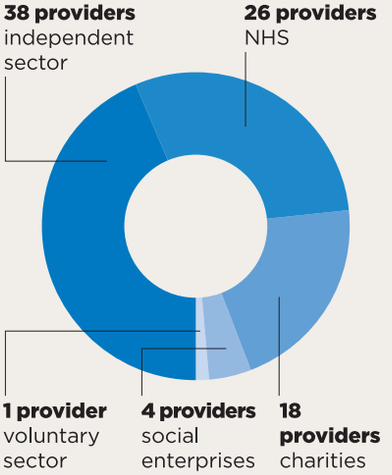
LMC reminds GPs not to test own bloods

Wessex LMC has given a 'gentle reminder' to GPs not to investigate themselves or a family member not registered at their practice, after a hospital found names accompanying blood samples sent in for testing did not match those on GP practice lists.

On further investigation it was found that a GP and a hospital doctor had requested tests to be carried out on their own bloods, supplying a false name. It was also found that GPs had requested blood testing for family members who were not on their practice lists.
pulsetoday.co.uk/blood-tests

Stats snapshot

How non-NHS providers are dominating Any Qualified Provider



(Out of 87 providers in total)

Source: Department of Health figures for providers approved under AQP to provide community services

CLINICAL ROUND-UP

All the new guidelines, journal papers and clinical policy developments with practice-changing implications

Second-generation QOF indicators loom

GPs would earn QOF points for assessing the needs of carers of dementia patients, confirming new hypertension diagnoses with ambulatory blood pressure monitoring and controlling blood pressure in patients with peripheral arterial disease, under NICE proposals.

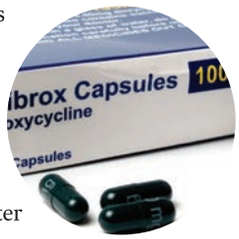
The three are among 14 new QOF indicators proposed for 2014/15 under a consultation that runs until 4 February.

The list also includes a 'second-generation' QOF indicator combining processes and outcomes in a single target – termed 'tightly linked measures' by NICE – for diabetes lipid management.

The indicator would award QOF points for the percentage of type 2 diabetes patients aged 40 or over with 'successful lipid management' – defined as any one of: last recorded cholesterol in the past year of 4mmol/l or below; last recorded cholesterol above that target but moderate-dose generic statin commenced or dose increased; or last recorded cholesterol above 4 but switched to a different statin or other cholesterol-lowering medication.

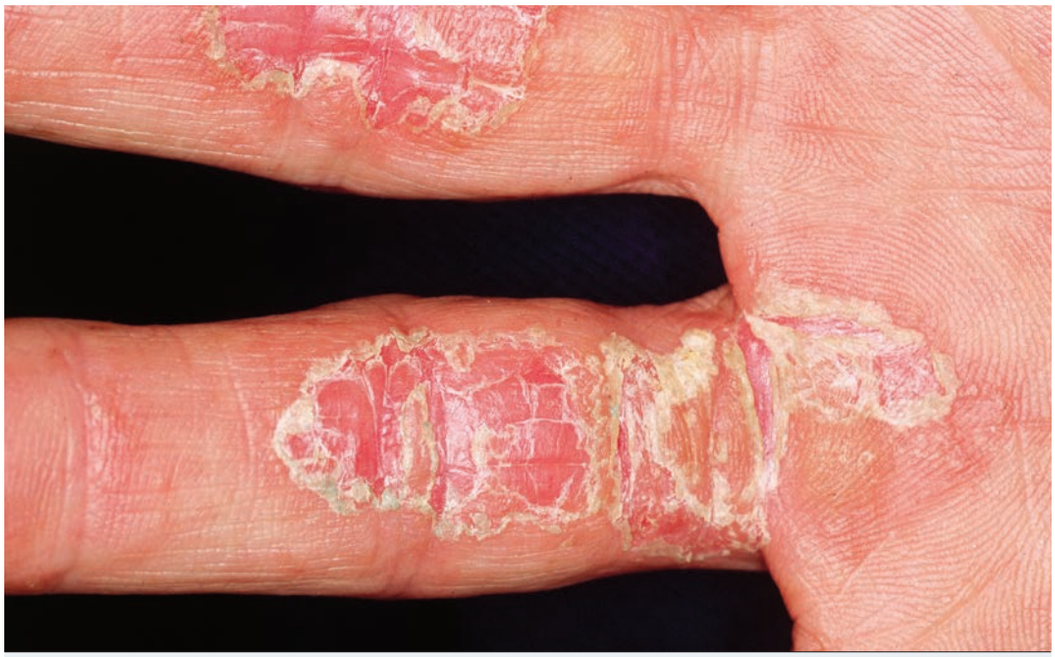
To see the proposed 2014 indicators in full, go to pulsetoday.co.uk/QOF2014

Antibiotics cut from pharmacy scheme



Pharmacy leaders have rowed back from plans to include trimethoprim, doxycycline and ciprofloxacin in a pharmacy access scheme after talks with the Department of Health.

The three antibiotics will now be removed from the scheme to offer prescription-only medicines under patient group directions without an individual prescription – though azithromycin will still be included, alongside a list of other drugs that includes salbutamol and sildenafil. The scheme is due to be rolled out to up to 12,500 pharmacies from this month.



Guideline of the month

NICE: psoriasis

Scope of the guideline

Psoriasis is believed to affect up to 2.2% of the UK population – over 1.3 million people – with most cases seen in young people and adults under the age of 35. This guideline advises on assessment, treatment and referral as well as spotting and managing comorbidities.

Key points for GPs

- Refer: severe and extensive cases (over 10% of body area); children; acute guttate psoriasis; and any case – including nail disease – where there is a major impact on the patient's wellbeing
- Immediate referral for generalised pustular psoriasis or erythroderma
- Initial treatment of trunk and limb psoriasis with a potent corticosteroid plus vitamin D or a vitamin D analogue, each applied once daily (one in the morning, the other in the evening)
- Topical monotherapy is ineffective for nail disease
- Initial treatment for scalp psoriasis is a potent corticosteroid applied once daily for up to 4 weeks
- All psoriasis patients should have a cardiovascular risk assessment at least five-yearly.

Expert comment

Dr John Edwards, a dermatology GPSI in Glasgow: 'There is a definite emphasis on earlier, more intensive treatment. Coal tar shampoo is no longer an option for scalp disease and topical treatments should not be used for nail disease. The algorithm for treatment of the trunk and limbs is the clearest we've had yet.'

EXTRA ONLINE

Guideline debrief: psoriasis
2 CPD HOURS
pulse-learning.co.uk

Practical issues

- More research is needed on the sequence of topical therapies and whether some patients would benefit from earlier use of systemic treatments
- The guideline recommends GPs use the Physician's Global Assessment (which ranks from 'clear' to 'severe') but admits no psoriasis assessment tool is validated for primary care
- New research suggests psoriasis puts patients at higher risk of liver problems which could be exacerbated by methotrexate – a low-cost, effective systemic treatment for many.

The guideline

CG153 *Psoriasis: the assessment and management of psoriasis*. NICE 2012

- To get up to speed with the guideline, complete our Pulse Learning CPD module *Guideline debrief: psoriasis*, where GP Dr Andy Jordan – a hospital practitioner in dermatology – uses five case histories to outline the primary care implications of the new guidance.

'Very helpful as it's based on typical patients we see every day in general practice' *Dr Anna Malone*
pulse-learning.co.uk

The talks between the National Pharmacy Association and DH came after GP leaders raised concerns over antibiotic resistance.
See the full list of drugs and GP reaction at pulsetoday.co.uk/pharmacy-access

Amoxicillin no help in simple LRTIs

Amoxicillin does not significantly reduce duration of symptoms in patients with uncomplicated lower respiratory tract infections, a new study shows.

Patients prescribed amoxicillin were only 6% more likely than those on placebo to experience a resolution of their major symptoms within seven days – a difference that failed to reach statistical significance.

The UK researchers randomised 2,061 adults presenting to their GP with acute cough to either amoxicillin or placebo three times daily for seven days.

They concluded: 'Amoxicillin provides little symptomatic benefit in clinically uncomplicated LRTIs.'
Lancet 2012, online 19 Dec

Let pharmacies fit IUDs, say MPs

CCGs should consider commissioning pharmacies to provide a wider range of contraception, including the fitting of IUDs, says a cross-party panel of MPs convened by thinktank 2020health.

Their inquiry into the problem of unplanned pregnancies said improving access to contraception and increasing the number of health professionals trained to provide long-acting reversible contraception would reduce the rising number of terminations.

The report concluded: 'Pharmacies have been developed as a valuable resource in terms of emergency contraception, but they also need to be promoted as a resouce for better provision of regular and longer-term contraceptive methods. For instance, increasing capacity to provide emergency IUD fitting when women present for emergency contraception should be prioritised.'
To read the full story, and join the debate, go to pulsetoday.co.uk/pharmacy-larcs

Core stability exercise 'better for back pain'

Core stabilisation exercises are more effective than general exercise in treating chronic low back pain short-term, but the benefits fade after three months, finds a new analysis.

The meta-analysis of five randomised controlled trials found patients treated with core stability exercise experienced significantly greater reduction in pain intensity over the first three months than those treated with general exercise. But there was no difference after a year.

Dr Majid Artus, Arthritis Research UK research fellow at Keele University, said: 'A large number of systematic reviews of a wide range of treatments for non-specific low back pain show the same pattern of at best moderate effectiveness short term, with no long-term benefit.'
PLOS One 2012, online 17 December

Omega-3 after MI cuts mortality by a third

Prescribing omega-3 supplements within two weeks of a myocardial infarction reduces the risk of death by almost a third, a UK study suggests.

The finding comes as a Department of Health consultation closes on a proposed new QIPP indicator aimed at reducing prescribing spend on omega-3 compounds.

The researchers looked at 2,466 UK patients prescribed a 1g daily dose of omega-3 fatty acids for secondary prevention of an MI. Patients had a significant 21% reduction in the risk of death – compared with controls – if the medication was prescribed within 90 days of a heart attack, but this increased to 32% if prescribed within 14 days.
Clin Ther, online 17 December

Lower death risk among overweight

Individuals who are overweight have a lower all-cause mortality than those with a normal BMI, research has found.

Overweight patients, with a BMI between 25 and 30, had a 6% lower mortality rate than those with a normal BMI of 18.5 to 25, according to the systematic review of 97 studies.

Obesity (BMI of 30 or above) was associated with a 29% higher death risk than normal weight, but grade 1 obesity – a BMI of 30 to 35 – carried no significantly increased risk of death.
JAMA 2013, online 2 January

Paper of the month

NSAID plus two or more BP drugs linked to kidney damage

The study
In the first large-scale trial of its kind, researchers studied data from 487,372 antihypertensive users on the UK Clinical Practice Research Datalink (formally the General Practice Research Database) to look at a possible association between concurrent NSAID use and kidney damage. The study was set up in response to case reports suggesting use of two or more antihypertensives may further increase the risk of kidney damage associated with NSAID use.

The findings
Use of an NSAID plus a single antihypertensive was not associated with any increased risk of kidney damage compared to those just on the antihypertensive. But triple therapy – two antihypertensives plus an NSAID – increased the risk of acute kidney damage by 31% compared to taking the two antihypertensives alone, with the highest increased risk of 82% seen in the first 30 days of use. A total of 2,215 cases of acute kidney injury occurred over six years' follow-up.

What does it mean for GPs?
The study leaders said although overall there was no increased risk of kidney damage associated with a single antihypertensive plus NSAID, there was a non-significant trend towards increased risk among those on a diuretic plus NSAID. This was not seen with an NSAID plus either an ACE inhibitor or an ARB. They urged extra vigilance, particularly in the first month of treatment, if a patient requires two or more antihypertensives alongside an NSAID.

Expert comment
Dr Matt Hughes, a cardiology GPSI in Cardiff: 'Patients with CKD were excluded so this study gives us our best picture yet of the effect of antihypertensives plus NSAIDs on kidney function.

'So can we definitively state that the combination of an antihypertensive and an NSAID is "safe"? Probably not – especially with the suggestion of a signal of harm with diuretic plus NSAID. But we should be especially vigilant when we add a second antihypertensive.'

Don't miss out on the key journal papers with GP implications – go to pulsetoday.co.uk/paper-of-the-day

INVESTIGATION

ALAMY

Revealed: how GPs are split on migrant health provision

Practices remain confused over the rules for registering migrants, with some going much further than current rules allow, finds Michael Woodhead

It's been a decade since Birmingham GP Dr Vijay Abrol was castigated for refusing to treat asylum seekers at his Edgbaston practice. In 2002, Dr Abrol put up a sign in the window of the City Road Medical Centre saying he would not register any more asylum seekers until he received more support and funding.

The chair of his local PCT described Dr Abrol's actions as 'smacking of xenophobia' – but, 10 years on, it seems many GPs still share some of Dr Abrol's concerns.

According to a survey conducted by Pulse of 229 GPs, 52% believe NHS provision for migrants is too generous and only 7% believe it should be better.

Ten years on, Dr Abrol says his workload has continued to rise with migrants now arriving from Eastern Europe and hospitals becoming like 'border posts'.

He says: 'If I send a patient, they ask to see their passport. It has created a situation where they are suspecting all non-white patients of being illegal.'

It's a subject many GPs are still reluctant to speak openly about.

When asked to comment on the findings of the Pulse survey, one leading GP asked not to be named to avoid appearing a 'ranting racist'.

He said: 'I treat a lot of migrants and asylum seekers, quite happily, but I think there needs to be a public debate. It's going to become an increasing issue as we get people from countries like Bulgaria and Romania becoming eligible for NHS treatment in 2014.

'The problem is that everyone tiptoes around the issue. There is an increasing burden of patients coming to the UK who are entitled to treatment – but whether we can afford an open-ended system in the future is a matter for debate. The UK has got to decide what it can and can't afford and who is eligible.'

What the rules say

- Overseas visitors, 'whether lawfully in the UK or not', are eligible to register with a GP practice.
- There is no formal requirement for patients to prove identity or immigration status. Practices can ask patients for documentation but, if they do so, must ask every patient.
- GPs can only refuse an application if their list is closed or if they have other reasonable grounds, for instance if a patient is violent or lives outside the practice area.
- Asylum seekers and refugees are entitled to register. GP practices 'have the discretion to accept failed asylum seekers' as NHS patients, although the BMA advises this discretion applies only as it would for any other patient.
- If a patient is turned down, a GP must nonetheless provide 'immediately necessary' treatment for up to 14 days.

Source: NHS PCC 2012, Access to primary medical services for overseas visitors and BMA 2011, Overseas visitors: who do you treat?

Relax, Urgency controlled

Vesicare®
solifenacin

ABBREVIATED PRESCRIBING INFORMATION

Presentation: Vesicare® film-coated tablets containing 5 mg or 10 mg solifenacin succinate. **Indication:** Symptomatic treatment of urge incontinence and/or increased urinary frequency and urgency as may occur in patients with overactive bladder syndrome. **Dosage:** *Adults:* Recommended dose: 5 mg once daily. If needed, the dose may be increased to 10 mg once daily. *Children and adolescents:* Should not be used. **Contraindications:** Urinary retention, severe gastrointestinal condition (including toxic megacolon), myasthenia gravis or narrow-angle glaucoma and in patients at risk for these conditions. Patients hypersensitive to the active substance or to any of the excipients, or undergoing haemodialysis, or with severe hepatic impairment, or with severe renal or moderate hepatic impairment and on treatment with a potent CYP3A4 inhibitor. **Warnings and Precautions:** No clinical data are available from women who became pregnant while taking solifenacin. Caution should be exercised when prescribing to pregnant women. The use of Vesicare® should be avoided during breast-feeding. Assess other causes of frequent urination before prescribing. Use with caution in patients with clinically significant bladder outflow obstruction at risk of urinary retention, gastrointestinal obstructive disorders, risk of decreased gastrointestinal motility, autonomic neuropathy, severe renal or moderate hepatic impairment (doses not to exceed 5 mg), concomitant use of a potent CYP3A4 inhibitor, hiatus hernia/gastroesophageal reflux and/or patients currently taking medicines that can cause or exacerbate oesophagitis. Angioedema with airway obstruction has been reported with some patients on Vesicare®. Patients with rare hereditary problems of galactose intolerance, the Lapp lactase deficiency or glucose-galactose malabsorption should not take this medicinal product. **Interactions**: Concomitant medication with other medicinal products with anticholinergic properties may result in more pronounced therapeutic effects and undesirable effects. Allow one week after stopping Vesicare® before commencing other anticholinergic therapy. Therapeutic effect may be reduced by concomitant administration of cholinergic receptor agonists. Can reduce effects of stimulators of gastrointestinal tract motility. If used concomitantly with ketoconazole or other CYP3A4 potent inhibitor, maximum dose should be 5 mg due to 2-3 fold increase in AUC of Vesicare®. Pharmacokinetic interactions are possible with other CYP3A4 substrates with higher affinity and CYP3A4 inducers. **Adverse Effects**: Dry mouth, blurred vision, constipation, nausea, dyspepsia, abdominal pain, urinary tract infection, peripheral oedema, colonic obstruction, rash, urinary retention, hallucinations, confusional state, angioedema. In worldwide postmarketing experience, QT prolongation and Torsade de Pointes have been reported in association with Vesicare® use, but the frequency of events and the role of Vesicare® in their causation cannot be reliably determined. *Prescribers should consult the Summary of Product Characteristics in relation to other side effects.* **Basic NHS Cost:** Vesicare® 5 mg blister packs of 30 tablets £27.62; Vesicare® 10 mg blister packs of 30 tablets £35.91. **Legal Category:** POM. **Product Licence Number:** Vesicare® 5 mg PL 00166/0197; Vesicare® 10 mg PL 00166/0198. **Date of Revision:** September 2012. **Further information available from:** Astellas Pharma Ltd, 2000 Hillswood Drive, Chertsey, KT16 0RS. Vesicare® is a Registered Trademark. For full prescribing information please refer to the Summary of Product Characteristics. **For medical information phone 0800 783 5018.**

Adverse events should be reported.
Reporting forms and information can be found at www.mhra.gov.uk/yellowcard
Adverse events should also be reported to Astellas Pharma Ltd. Please contact 0800 783 5018.

Date of preparation: November 2012
VES12484UK

astellas
Leading Light for Life

INVESTIGATION

GETTY

Practices 'can't cope'

Few GPs who responded to the Pulse survey said they would knowingly register someone in the UK illegally – even though they are not allowed to discriminate according to a patient's legal status. Only 17% said they would register a patient they believed to be an illegal immigrant, whereas 36% of GPs said they would not.

The findings come as no surprise to Dr Les Goldman (pictured), a Bradford GP who runs a primary care service that he says 'looks after the patients that most GPs don't like to accept'.

In 2011 he helped set up Bevan Healthcare, a social enterprise organisation dedicated to providing primary care services to asylum seekers, refugees and homeless people on behalf of the NHS.

Dr Goldman says GP practices are not prejudiced, but there are barriers that make it difficult for asylum seekers.

He says: 'You might have 20 asylum seekers register in a fortnight, and a GP just can't cope. It isn't malice or prejudice. It's just that your capacity to deal with it is limited.'

Ambiguous rules

There is considerable uncertainty over current regulations (see box, page 16), with our survey showing more than three-quarters (77%) of GPs are confused about the rules for treating and registering migrants, overseas visitors and illegal immigrants.

Practices are split on the approach they take, with 58% routinely asking new patients for proof of identification when registering, but more than a quarter not asking for any proof of residency or identity. Nearly 15% break the current rules by only asking patients 'sometimes' for proof of identity.

Dr Nick Simpson, Loughborough GP and chair of Leicestershire and Rutland LMC, says the rules on treating migrants are incredibly complex. His practice has drawn up a summary of eligibility rules for people from countries seen most often in the practice.

He says: 'Our practice manager compiled a list, which the receptionist keeps, so when the person turns up requesting medical care, we can say "you're from such-and-such country that can have medical care", or "there will be a charge for it" – that's appropriate, but obviously not if it's a dire emergency.'

Caught in the crossfire

Dr Paul Roblin, chair of Berkshire, Buckinghamshire and Oxfordshire LMC, says the lack of clarity is a major source of frustration for GPs.

He says: 'The Department of Health has abrogated its responsibility. It has failed for decades to provide a rule book that is understandable to all.'

According to Dr Roblin, practices and PCTs are wrongly led to believe by NHS counter-fraud authorities that they have an obligation to conduct identity and proof-of-residency checks on patients.

He says: 'GPs are not obliged to do that. The bottom line is there is only an obligation for GPs to accept a request for registration and to provide immediately necessary medical treatment.'

This lack of clarity has seen GPs caught in the crossfire. In 2011, a GP practice in Essex found itself facing legal action if it did not register failed asylum seekers from Nigeria, even though the practice had been advised by the UK Border Agency that they were not eligible for NHS treatment.

At the same time, some primary care organisations have warned practices they may be investigated by the NHS Counter Fraud Service if they have 'knowingly registered ineligible patients'.

GPC deputy chair Dr Richard Vautrey says there can be no threat of action against GPs from the NHS for registering patients without checking whether they are eligible for NHS services. He says: 'Nothing within GMS regulations obliges GPs to take on that role.

'We have spoken directly to the NHS Counter Fraud Service about this and it has amended its guidance. If you look at its guidance there are procedures that could apply, but you would need to do that for everybody.

'If GPs ask for evidence of immigration status or residency from one patient, but not every other patient, they could be deemed to be applying discrimination and that's something that they should not be doing – so they either need to do it for every patient or do it for none.

'I think it's better to accept that it's a role for other bodies in the health service to assess whether someone is eligible for NHS care or not – not for GPs.'

EXTRA ONLINE

Migrant registration
Read how Dr Nick Simpson copes with the rules around registering migrants
pulsetoday.co.uk/migrants

Government review

The most recent Government review of migrant and visitor access to NHS services took place in 2010. It noted that free NHS hospital treatment was a right of all current, lawful residents of the UK.

Non-residents and visitors are required to pay for hospital treatment, but this does not extend to primary care – yet. GPs have a contractual duty to provide free emergency treatment and immediate necessary treatment for up to 14 days to any person within their practice area. Practices can – at their discretion – accept overseas visitors for inclusion in their patient list if the person is staying more than three months, but cannot discriminate on grounds of race.

The review concluded no major changes were needed in the rules of NHS entitlement for migrants, but it did flag up areas of concern where eligibility criteria should be tightened up. 'Medical tourism' was highlighted, with claims that some people were travelling to the UK with the specific intention of receiving medical treatment or to use maternity services.

It proposed foreign visitors who incurred significant debts to the NHS be denied the right to re-enter the UK and urged an investigation into ways of making health insurance compulsory for visitors who do not qualify for reciprocal healthcare.

GP charges

No changes were proposed in access rules for foreign nationals to primary care, but this is now being reconsidered. An 'ongoing' Government review is considering extending the system of charging for NHS treatment from hospitals to primary care. A spokesperson says: 'The review is looking at whether we could introduce [charges] into primary care and how that would work.'

But Dr Vautrey says practices might come to be seen as an arm of the immigration service. He says: 'This would create a heavy workload, would place general practice in a difficult position and would be almost impossible to put into practice. The GP role is to treat the patient as best as they are able.'

He adds: 'The reality is the vast majority of people who are asking to see a GP are doing so appropriately.'

Others disagree. Dr Roblin says: 'GPs are expected to practise with limited funding, and if we are using that for treating visitors, the taxpayer loses out. It may be more appropriate to have a system where we say that if you can't provide proof of residence, you have to pay for treatment.'

A PATIENT SUPPORT PROGRAMME YOU CAN COUNT ON TO CARE

A FREE SERVICE TO HELP PATIENTS MAKE THE MOST OF THEIR VESICARE (SOLIFENACIN)

- Easy to join
- VIP nurse helpline
- A range of support materials
- Access to VIP website: www.astellas-vip.co.uk
- Improves patient adherence[1,2]
- Helps the patient, which can help you

ViP
Vesicare Information Programme

You can also find further information about the free Vesicare Information Programme at **www.astellas-vip.co.uk/HCP**

PRESCRIBING INFORMATION

Presentation: Vesicare® film-coated tablets containing 5 mg or 10 mg solifenacin succinate. **Indication:** Symptomatic treatment of urge incontinence and/or increased urinary frequency and urgency as may occur in patients with overactive bladder syndrome. **Dosage:** *Adults:* Recommended dose: 5 mg once daily. If needed, the dose may be increased to 10 mg once daily. *Children and adolescents:* Should not be used. **Contraindications:** Urinary retention, severe gastrointestinal condition (including toxic megacolon), myasthenia gravis or narrow-angle glaucoma and in patients at risk for these conditions. Patients hypersensitive to the active substance or to any of the excipients, or undergoing haemodialysis, or with severe hepatic impairment, or with severe renal or moderate hepatic impairment and on treatment with a potent CYP3A4 inhibitor. **Warnings and Precautions:** No clinical data are available from women who became pregnant while taking solifenacin. Caution should be exercised when prescribing to pregnant women. The use of Vesicare® should be avoided during breast-feeding. Assess other causes of frequent urination before prescribing. Use with caution in patients with clinically significant bladder outflow obstruction at risk of urinary retention, gastrointestinal obstructive disorders, risk of decreased gastrointestinal motility, autonomic neuropathy, severe renal or moderate hepatic impairment (doses not to exceed 5 mg), concomitant use of a potent CYP3A4 inhibitor, hiatus hernia/gastroesophageal reflux and/or patients currently taking medicines that can cause or exacerbate oesophagitis. Angioedema with airway obstruction has been reported with some patients on Vesicare®. Patients with rare hereditary problems of galactose intolerance, the Lapp lactase deficiency or glucose-galactose malabsorption should not take this medicinal product. **Interactions:** Concomitant medication with other medicinal products with anticholinergic properties may result in more pronounced therapeutic effects and undesirable effects. Allow one week after stopping Vesicare® before commencing other anticholinergic therapy. Therapeutic effect may be reduced by concomitant administration of cholinergic receptor agonists. Can reduce effects of stimulators of gastrointestinal tract motility. If used concomitantly with ketoconazole or other CYP3A4 potent inhibitor, maximum dose should be 5 mg due to 2-3 fold increase in AUC of Vesicare®. Pharmacokinetic interactions are possible with other CYP3A4 substrates with higher affinity and CYP3A4 inducers. **Adverse Effects:** Dry mouth, blurred vision, constipation, nausea, dyspepsia, abdominal pain, urinary tract infection, peripheral oedema, colonic obstruction, rash, urinary retention, hallucinations, confusional state, angioedema. In worldwide postmarketing experience, QT prolongation and Torsade de Pointes have been reported in association with Vesicare® use, but the frequency of events and the role of Vesicare® in their causation cannot be reliably determined. *Prescribers should consult the Summary of Product Characteristics in relation to other side effects.* **Basic NHS Cost:** Vesicare® 5 mg blister packs of 30 tablets £27.62; Vesicare® 10 mg blister packs of 30 tablets £35.91. **Legal Category:** POM. **Product Licence Number:** Vesicare® 5 mg PL 00166/0197; Vesicare® 10 mg PL 00166/0198. **Date of Revision:** September 2012. **Further information available from:** Astellas Pharma Ltd, 2000 Hillswood Drive, Chertsey, KT16 0RS. Vesicare® is a Registered Trademark. For full prescribing information please refer to the Summary of Product Characteristics. **For medical information phone 0800 783 5018.**

1. Data on File, 313515, Astellas Pharma Ltd.
2. Data on File, 313515. VIP Patient Compliance Survey 2008

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 Astellas Pharma Ltd.
Please contact **0800 783 5018**

VES12431UK / Oct 2012

astellas
Leading Light for Life

ANALYSIS

ALAMY

Has the QOF lost its way?

As the profession gears up for the biggest changes to the QOF since it was first introduced, Sofia Lind asks what the framework is for and where its future lies

Once a great success story, some leading GPs are now starting to question the direction the QOF is heading in.

Even the chair of the RCGP said last November that she thinks the framework is 'out of control',[1] while NICE's QOF development lead is questioning whether it has moved too far from its roots as a tool to improve the quality of care and become more of a payment lever for ministers.

There is no prospect of any stability in the framework any time soon, with the Department of Health planning the most wide-ranging shake-up of the QOF from April since it was first introduced. But has it strayed too far from its original purpose?

Bright beginnings

It was all so different in 2004: for the first time, GP pay was linked to the quality of care that practices provided and the profession more than rose to the challenge, reaching 90% achievement in the first year the QOF was introduced.

Achievement levels have remained high ever since, but only at the cost of increased workload. Media criticism that GPs were getting a '20% pay rise for doing their jobs' stung[1] and resulted in pressure from the Government for practices to do more under the framework.

Evidence also began to emerge that although performance under the QOF had increased in the years before and just after the framework was introduced, this ran out of steam in subsequent years.[2]

The DH pledged to overhaul the QOF in 2009, refocusing it on outcomes rather than process-based targets. This led to NICE taking control of the process of developing indicators and a step change in the micro-management of the framework.

Since then, GPs have had to cope with increasing numbers of changes to the QOF every year, culminating with this

ONLINE

The QOF in 2014/15

Read the full list of indicators NICE is consulting on **pulsetoday.co.uk/qof2014**

Expert view
Professor Martin Roland

Improving quality or saving money?

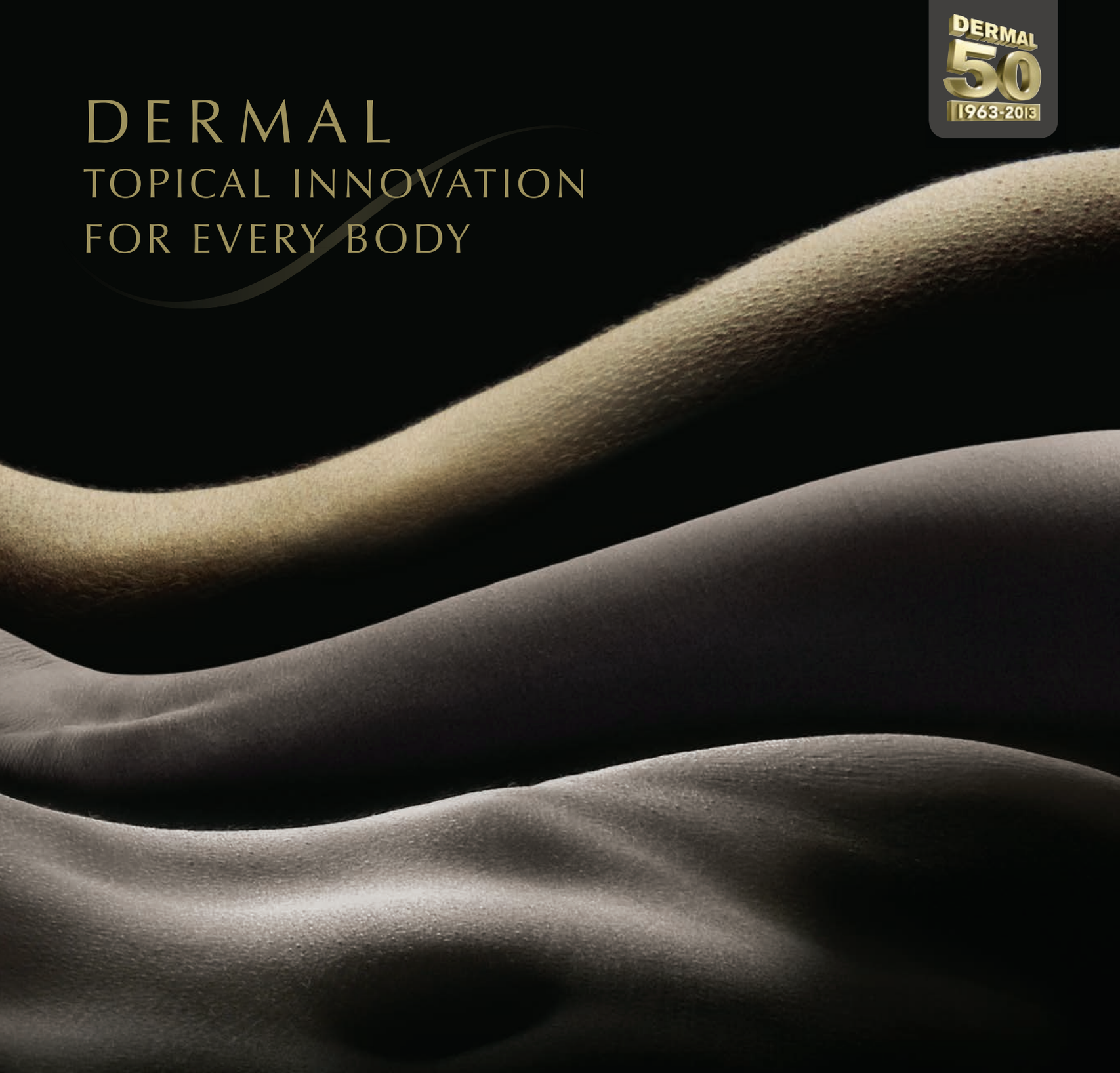
For the original QOF, there was relatively little dissent about the indicators that were selected. They were the low-hanging fruit; things that on the whole GPs probably felt they should be doing anyway. But indicators that have been introduced since then have been much more controversial.

Firstly, we have indicators such as the PHQ9 questionnaire for depression. These indicators were prompting GPs to change something, rather than incentivising what they did already, so they were more controversial.

Secondly, those related to productivity are a long way from the original QOF. They are an incentive to get GPs to reduce secondary care utilisation, for example by reviewing referrals. Incentivising GPs to take a look at their own work is fine, but the QOF has a different feel to it if it becomes about saving money rather than improving quality.

My view is that it is best suited to being a framework that focuses on clinical quality. The more it deviates from that, the more ambiguous and potentially problematic its role becomes.

Professor Martin Roland is professor of health services research at the University of Cambridge, and was a key adviser to the Government on implementing the QOF in 2004



DERMAL

TOPICAL INNOVATION FOR EVERY BODY

2013 sees Dermal celebrate 50 years of successful topical innovation.
This extensive experience in developing highly effective, yet cosmetically elegant treatments for application to the skin, has benefited millions of people for half a century.
Dermal remains committed to building on that success for the benefit of future generations.

Dermal Laboratories Limited, Tatmore Place, Gosmore, Hitchin, Herts, SG4 7QR
www.dermal.co.uk

DERMAL™
TOPICAL INNOVATION

ANALYSIS

year's contract changes that will see a record number of indicators replaced in the framework, a hike in the upper thresholds for 20 indicators, a new 'public health' QOF domain and a radical change to the way the value of QOF points is calculated.

A problem of definition?

The Government is clear that it has always defined the QOF as a voluntary incentive scheme that aims to 'reward practices for systematically improving the quality of care given to patients'. It claims that the changes it is seeking for the QOF support this aim.

But NICE QOF lead and original architect of the framework Professor Helen Lester says there is now an urgent need to define what it is for. She says: 'It is one of the big problems with the QOF. Is it a payment mechanism for GPs or is it a quality improvement tool?

'I think it would be very useful if there was an agreement that said "the primary purpose of the QOF is..." even though it is nine years later. I think it is quality improvement and have argued this for many years and I continue to argue it.'

The removal of the organisational domain from the QOF from April means practices will no longer be paid for medicines management and keeping patient records up to date. But the GPC says one of the major roles of the QOF is to provide the funding to support practice services and this is being put in danger by the planned changes.

GPC deputy chair Dr Richard Vautrey says: 'It is unfortunate that the focus has moved to the incentive scheme as opposed to the recognition of the resources necessary to provide staff to deliver quality in general practice.

'Policymakers have forgotten that in order to deliver good-quality care you need a stable resource to be able to employ staff to deliver the results.'

The inclusion of 'quality and productivity' indicators has also been cited by experts as a major source of concern.

Professor Martin Roland, professor of health services research at the University of Cambridge and another of the GP academics originally behind the development of the QOF in 2004, says the QP indicators were a 'long way' from the original remit (see box, page 20). Responses to a recent NHS Employers survey showed PCT and health board managers struggled to find evidence that some QP indicators have had an impact.

Future of the QOF

All this has led to calls from RCGP chair Professor Clare Gerada for a root-and-branch review of practices' incentives.

Professor Gerada says the QOF represents too much of GPs' pay – around 15% according to the DH – and is leading to a 'distortion' in the doctor-patient relationship.

She says: 'The QOF has gone from the sublime to the ridiculous – it is deprofessionalising GPs.

'We need a rethink of incentives for GPs and must stop this misguided shift towards diseases and metrics.

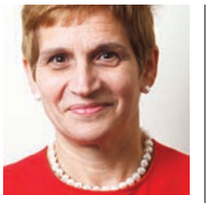
'It's not just that it is a tick-box exercise, it is that it shifts the agenda from what is in front of us to what the computer wants us to do and the QOF has dictated. It has gone from being a reasonably good idea to a tail that is wagging the dog and distorting the doctor-patient relationship.'

NICE says it is continuing to plan new indicators, with a fresh emphasis on public health, and driving the framework towards improving outcomes.

Dr Gillian Leng, deputy chief executive at NICE, says: 'The QOF from next year will have a public health domain that we have been asked to specifically liaise with Public Health England to work on priority areas for.

'We want to work with public health priorities, which is to emphasise that we do need an evidence base before we can put them in there.'

NICE advisers have recently decided to pilot alcohol screening indicators and pursue the development of 'next-generation' QOF indicators to improve outcomes. So-called 'tightly linked measures' (TLMs) are aimed at encouraging GPs to improve the outcomes of selected groups of patients identified through the QOF by combining processes and outcomes into a single indicator.



'The QOF is now the tail wagging the dog – and it is distorting the doctor–patient relationship'
Professor Clare Gerada

A TLM indicator for lipid control in patients with diabetes has been put out to consultation this month for the 2014/15 QOF, alongside others incentivising health checks in dementia carers, and points for controlling blood pressure in peripheral arterial disease and using ambulatory blood pressure monitoring to diagnose hypertension.

Professor Lester says: 'There will definitely be a bigger focus on public health. There also may be more of a focus on patient-suited indicators – for example, asking the patients on the receiving end what it was like to have a review of their rheumatoid arthritis, and feeding that back to the advisory committee so that they could see whether patients thought it was a step too far or was in fact a welcome addition to their usual treatment.'

A victim of its own success?

NICE advisers have also backed a DH plan to 'bundle' diabetes indicators to ensure that practices only get their points if they carry out nine checks on one patient.

Dr Leng says this may extend to other areas in time: 'If you don't bundle them there is a potential for more challenging ones just not to be delivered. Although there are always critics, on balance, the evidence supports that approach.'

What is certain is that the QOF will continue to evolve over time, but whether most practices will continue to attain high levels of achievement is debatable.

Dr Vautrey says this may be a blessing in disguise: 'It is a victim of its own success. Practices have stepped up and delivered far higher levels of achievement than were originally envisaged.

'That is one of the reasons why the Government has continued to focus on the QOF.'

References

1 Do GPs deserve their recent pay rise? *BMJ* 2005, online 6 Oct tinyurl.com/b9zylpu

2 Campbell et al. *NEJM* 2009; 361: 368-378 tinyurl.com/b5hnyo2

Where is the QOF going?

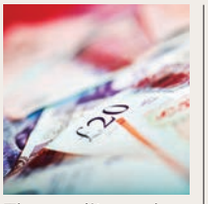
More emphasis on public health and tackling lifestyle issues, such as alcohol misuse, smoking and exercise

Moving towards more outcomes-based targets in specific patients for instance, 'tightly linked' indicators for lipids in diabetes

Bundling indicators to ensure several checks are done in one patient before points are awarded, beginning with diabetes

Including measures of patient satisfaction in the development of QOF indicators

Greater divergence between England and the devolved nations; for example, less stringent rises in upper thresholds in Scotland



The quality and productivity indicators will be reviewed, and perhaps extended if found to be successful at reducing hospital activity

In England, QOF thresholds are set to rise – some to 100%. In Wales, they will rise to the median while in Scotland, no threshold will rise above 90%

ALAMY X3

This year, give your patients more ways to quit or reduce the harm from smoking

The New Year can be a time when smokers make that decision to either quit smoking or look for safer alternatives – in fact up to 2 million smoking cessation products are prescribed in the first three months of the year.[1]

The clear majority of smokers who attempt to give up this New Year will relapse within the first week,[2] and fewer than 3% may be smoke-free after one year using willpower alone.[3] However, smokers are more likely to quit successfully with help from their doctor.[4] Data show that in practice, people trying to quit smoking often do not receive enough support and do not use sufficient NRT.[5]

To help smokers be successful, it is vital they get the right support as early as possible. Not all smokers will want to quit immediately and may need support in cutting down on the number of cigarettes they smoke or switching to a safer alternative.

New draft guidance published by NICE recommends that NRT products offer an effective way of reducing the harm from cigarettes and that where possible, one or more NRT products should be prescribed to help patients cut down to quit or smoke less.[5]

Abstinence in the first week of a quit attempt is a key indicator of long-term success:[3,6]

- ✓ When smokers abstain in the first week, 1 in 4 will be abstinent at 52 weeks[3]
- ✓ People who abstain during week 1 are 9x more likely to still be abstinent at 52 weeks than those who smoke during the first week ($p<0.001$)[3]

Consider NICORETTE® INVISI 25mg PATCH™ as your first-line NRT prescription nicotine choice to help give smokers a positive start to their quit attempt.

For those unwilling or unable to quit, NRT such as NICORETTE® INVISI 25mg PATCH™ can also be used as a safer alternative to smoking.

4 Reasons why NICORETTE® INVISI 25mg PATCH™ makes sense for smokers:

1. **It helps set smokers up for short-term abstinence and long-term quitting success**
   Over half of all smokers using NICORETTE® INVISI 25mg PATCH™ abstain during the first week[6]
2. **It enables 1 in 2 smokers who were abstinent during week 1 to remain smoke-free at 12 weeks[6]**
   At 12 weeks, NICORETTE® INVISI 25mg PATCH™ is 90% more effective at helping smokers quit compared with placebo (34% quit on NICORETTE® INVISI 25mg PATCH™ vs. 17.5% on placebo; $p<0.001$)[7]
3. **The safety profile of NRT is recognised and well established[8]**
   NICORETTE® INVISI 25mg PATCH™ is well tolerated with a good safety profile.[3] The new draft guidance published by NICE states, "all licensed nicotine-containing products are a safe and effective way of reducing the harm from cigarettes"[5]
4. **16-hour NICORETTE® INVISIPATCH™ is the only patch specifically designed to mimic your smokers' regular smoking pattern by avoiding nocturnal nicotine dosing**
   Sleep disturbance is a recognised symptom of nicotine withdrawal.[9] Nocturnal nicotine provided by 24-hour patches is proven to increase sleep disturbance over placebo levels.[10,11] 16-hour NICORETTE® INVISIPATCH™ does not add to the insomnia which occurs as a result of nicotine withdrawal[3,12,13]

Nicorette Invisi Patch Prescribing Information:
Presentation: Transdermal delivery system available in 3 sizes (22.5, 13.5 and 9cm²) releasing 25mg, 15mg and 10mg of nicotine respectively over 16 hours. **Uses**: Nicorette Invisi Patch relieves and/or prevents craving and nicotine withdrawal symptoms associated with tobacco dependence. It is indicated to aid smokers wishing to quit or reduce prior to quitting, to assist smokers who are unwilling or unable to smoke, and as a safer alternative to smoking for smokers and those around them. Nicorette Invisi Patch is indicated in pregnant and lactating women making a quit attempt. If possible, Nicorette Invisi Patch should be used in conjunction with a behavioural support programme. **Dosage:** It is intended that the patch is worn through the waking hours (approximately 16 hours) being applied on waking and removed at bedtime. ***Smoking Cessation: Adults (over 18 years of age):*** For best results, most smokers are recommended to start on 25 mg / 16 hours patch (Step 1) and use one patch daily for 8 weeks. Gradual weaning from the patch should then be initiated. One 15 mg/16 hours patch (Step 2) should be used daily for 2 weeks followed by one 10 mg/16 hours patch (Step 3) daily for 2 weeks. Lighter smokers (i.e. those who smoke less than 10 cigarettes per day) are recommended to start at Step 2 (15 mg) for 8 weeks and decrease the dose to 10 mg for the final 4 weeks. Those who experience excessive side effects with the 25 mg patch (Step 1), which do not resolve within a few days, should change to a 15 mg patch (Step 2). This should be continued for the remainder of the 8 week course, before stepping down to the 10 mg patch (Step 3) for 4 weeks. If symptoms persist the advice of a healthcare professional should be sought. ***Adolescents (12 to 18 years):*** Dose and method of use are as for adults however, recommended treatment duration is 12 weeks. If longer treatment is required, advice from a healthcare professional should be sought. ***Smoking Reduction/Pre-Quit:*** Smokers are recommended to use the patch to prolong smoke-free intervals and with the intention to reduce smoking as much as possible. Starting dose should follow the smoking cessation instructions above i.e. 25mg (Step 1) is suitable for those who smoke 10 or more cigarettes per day and for lighter smokers are recommended to start at Step 2 (15 mg). Smokers starting on 25mg patch should transfer to 15mg patch as soon as cigarette consumption reduces to less than 10 cigarettes per day. A quit attempt should be made as soon as the smoker feels ready. When making a quit attempt smokers who have reduced to less than 10 cigarettes per day are recommended to continue at Step 2 (15 mg) for 8 weeks and decrease the dose to 10 mg (Step 3) for the final 4 weeks. ***Temporary Abstinence:*** Use a Nicorette Invisi Patch in those situations when you can't or do not want to smoke for prolonged periods (greater than 16 hours). For shorter periods then an alternative intermittent dose form would be more suitable (e.g. Nicorette inhalator or gum). Smokers of 10 or more cigarettes per day are recommended to use 25mg patch and lighter smokers are recommended to use 15mg patch. **Contraindications:** Hypersensitivity. **Precautions:** Unstable cardiovascular disease, diabetes mellitus, renal or hepatic impairment, phaeochromocytoma or uncontrolled hyperthyroidism, generalised dermatological disorders. Angioedema and urticaria have been reported. Erythema may occur. If severe or persistent, discontinue treatment. Stopping smoking may alter the metabolism of certain drugs. Transferred dependence is rare and less harmful and easier to break than smoking dependence. May enhance the haemodynamic effects of, and pain response, to adenosine. Keep out of reach and sight of children and dispose of with care. **Pregnancy and lactation:** Only after consulting a healthcare professional. **Side effects:** *Very common:* itching. *Common:* headache, dizziness, nausea, vomiting, GI discomfort; Erythema. *Uncommon:* palpitations, urticaria. *Very rare:* reversible atrial fibrillation. See SPC for further details. **NHS Cost:** 25mg packs of 7: (£9.97); 25mg packs of 14: (£16.35); 15mg packs of 7: (£9.97); 10mg packs of 7: (£9.97). **Legal category:** GSL. **PL holder:** McNeil Products Ltd, Roxborough Way, Maidenhead, Berkshire, SL6 3UG. **PL numbers:** 15513/0161; 15513/0160; 15513/0159. **Date of preparation:** Feb 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 McNeil Products Limited on 01344 864 042.

References:
1. IMS Unit Data January-March 2011. **2.** Hughes JR *et al.* Smoking cessation among self-quitters. *Health Psychol* 1992; **11**: 331–334. **3.** Tønnesen P *et al. Eur Resp J* 1999; **13**: 238–246. **4.** Hughes JR. New Treatments for Smoking Cessation. *CA Cancer J Clin*. 2000; **50**: 143–151. **5.** NICE Public Health Draft Guidance, October 2012. **6.** Data on file – CEASE 2. **7.** Data on file – CEASE 4. **8.** Stapleton JA *et al. Addiction* 2008; **103**: 146–154. **9.** Nicotine addiction in Britain: A report of the Tobacco Advisory Group of the Royal College of Physicians. London: Royal College of Physicians, 2000. **10.** Imperial Cancer Research Fund General Practice Research Group. *BMJ* 1993; **306**: 1304–1308. **11.** Richmond R *et al. Med J Aust* 1994; **161**: 130–135. **12.** Sachs et al. *Arch Intern Med* 1993; **153**: 1881–1890. **13.** Russell MA *et al. Br Med J* 1993; **306**: 1308–1312.

Date of preparation: November 2012 UK/NI/12-0996a

McNeil Products Ltd.

nicorette®

www.nicorette.co.uk

For every cigarette, there's a nicorette®

PREVIEW

What does 2013 hold for GPs?

After the maelstrom of 2012, Pulse looks into its crystal ball and, with the assistance of some leading GPs, predicts the big themes for the coming year

GPs take on commissioning

1 April 2013 will mark the beginning of the great CCG experiment in the NHS. Led by GPs, these groups will be responsible for spending up to £65bn of the NHS budget.

Balanced precariously on their shoulders is the whole NHS reorganisation project, and the success of the biggest efficiency drive in the history of the NHS. CCGs have a lot to prove.

Dr James Kingsland, a GP in the Wirral and special adviser to the Department of Health on commissioning, warned that CCGs have to tackle the 'them and us' feeling that is developing among grassroots GPs.

He said: 'The priority has to be the engagement of the wider clinical community. CCGs must realise that the constituent practices are its members – not just the governing body.

'I am still hearing too many practices saying "us and them" rather than the inclusive "we". If CCGs get that right, everything else will follow; if they get that wrong, they'll fall into the same trap as PCTs.'

A huge ramp-up of QOF workload

A Government imposition of the most wide-ranging QOF changes since the framework was introduced looms large.

> 'We're at burn-out. The wheels really are squeaking'
> *Dr Peter Swinyard*

EXTRA ONLINE

More 2013 predictions
Read more future-gazing from leading GPs
pulsetoday.co.uk/2013preview

The changes, in England at least, will see funding for the organisational domain removed, a raft of new work introduced, upper thresholds hiked to reflect the performance of the top 25% of practices – to 100% in some cases – and a change in the way QOF payments are calculated.

Dr Peter Swinyard, chair of the Family Doctor Association, predicted the changes would be 'extremely difficult for GPs to cope with'.

He said: 'Tightening of targets and incorporation of new QOF work will be difficult at a time when we're at burn-out. The wheels really are squeaking.'

Practices battle with online appointments and remote monitoring

One of the new health secretary's four top priorities is to bring 'the technological revolution to the NHS', and GP practices are at the forefront of his plans.

The Department of Health has proposed two new DESs – each worth £3,600 of former QOF funding for the average practice – to come into effect from next year.

The first will require practices to offer patients the ability to book appointments, order prescriptions and receive test results online. From 2014/15, GPs will also have to provide secure

Hopes and fears for 2013

Dr Paul Cundy
GPC IT subcommittee chair
Hope That they don't muck around with my pension any more
Fear Not surviving the year

Dr Kailash Chand
BMA deputy chair
Hope Good sense prevails in Government and it realises how low GP morale is
Fear The political classes won't listen and carry on pushing their own agenda

Dr Maureen Baker
Former RCGP honorary secretary
Hope GPs can find ways of working to cope better with the pressures we face
Fear A flu epidemic or some outbreak that puts a lot of pressure on GPs

Dr Peter Swinyard
Family Doctor Association chair
Hope For the Government to come back to the table and really talk to us and engage with us
Fear That it won't

Dr Charles Alessi
NAPC chair
Hope We discover quite how valuable primary care is
Fear Behaviours of old around top-down direction will persist in the NHS

Dr Michael Ingram
GPC member in Hertfordshire
Hope GPs will unite to deal with the issues we face
Fear A stressful 2013. I am not sure how we can handle it

Dr Barry Moyse
Assistant medical secretary of Somerset LMC
Hope People going through revalidation will find it just a next step
Fear The lack of clarity about remediation

Dr Alan McDevitt
Scottish GPC chair
Hope The UK Government will listen to our argument that GP workload is saturated
Fear The UK model of general practice starts to come apart

electronic communication with the practice and offer online access to medical records.

Under the second DES, practices will also be incentivised to carry out 'remote monitoring' of patients from April, a major push on behalf of the Government's cherished '3millionlives' telehealth initiative.

Dr Paul Cundy, chair of the GPC's IT subcommittee, predicted GPs would experience a 'tsunami of irrelevant electronic communications' that would prove difficult for practices to cope with.

He said: 'GPs will receive communications from the sharply elbowed, worried-well e-Twitterati at the first sign of a snivel, any ache or minimal disturbance of their physiology.'

Screening for signs of dementia

Dementia care is a major clinical priority at the DH, after the Prime Minister issued his 'challenge on dementia' last year. Progress has been patchy so far, but this is likely to change in 2013 with the Government planning to fund a new DES for case finding early signs of dementia in at-risk patients.

The move has kick-started a petition against the plans. Proposer Dr John Cosgrove, a GP in Birmingham, said the DES was not evidence based and risked distracting GPs from other work.

He said: 'We need a political solution on how to meet the needs of our elderly population and this is just a distraction. Instead of focusing on diagnosis, we should be offering on the basis of need.'

The squeeze on GP take-home pay continues

GPs have endured several years of pay freezes and rising expenses, but 2013 will be the year where practice finances will be hit harder than ever.

GPs face additional expenses from revalidation and CQC registration, rising pension contributions, cuts to local enhanced services and increasing work imposed on them from secondary care – bringing the unwelcome prospect of working harder than ever just to stand still.

Dr Ivan Camphor, medical secretary of Mid-Mersey LMC, said: 'It is just terrible and cannot be sustained in its present form.

'How are we going to do this? With what resources? And people want us to be open on Saturdays and Sundays. We may as well give up. It is not the end of general practice, it is the end of the NHS.'

Widening divide between the UK nations

2013 is set to be the year the UK-wide GP contract starts to splinter.

The Scottish GPC has negotiated a contract deal for GPs in Scotland that will safeguard practices from a number of QOF changes facing GPs in England.

Welsh GPs have also been offered significant concessions on the QOF changes and safeguards over the phasing-out of the MPIG, although GPC Wales has formally rejected the offer. The GPC in Northern Ireland is still in talks.

Dr David Bailey, chair of GPC Wales, said: 'Regrettably from April we will have a wider difference between the four countries than we have had.

'General practice in the UK should be the same whether you are in John O'Groats or Land's End and it is unfortunate that the UK Government is acting to split things up.'

More regulation and scrutiny

GPs will face the introduction of revalidation and CQC registration this year.

Dr Tim Morton, chair of Norfolk and Waveney LMC, said revalidation and CQC inspections might be a good idea in principle, but would add an unwelcome additional burden on top of all the other pressures on GPs.

He said: 'By themselves they are OK. The problem is we have them both coming at the same time.'

Public outcry over the payment of the quality premium to GPs

You do not have to be Nostradamus to predict controversy over the payment of the quality premium to GPs in 2013.

The first shots have already been fired by the *Daily Mail*, suggesting that practices will receive £30,000 – the average payment based on the expected figure of £5 per patient – for 'doing their job'.

The NHS Commissioning Board has yet to confirm how much the premium will be worth, or what restrictions it will place on its allocation to practices, but it has said CCGs will have to meet targets on mortality rates, reduce avoidable hospital admissions and pass the 'friends and family test' to receive the payment.

GPC deputy chair Dr Richard Vautrey said: 'The *Daily Mail* article is the start of it. Our fear is that CCGs will put pressure on local practices to achieve targets and stay within budget in order to get the premium. This could lead to patients feeling they are not being referred or prescribed medication just so that the practice can receive payments.'

Increased rationing of services

The QIPP challenge is only half way through, and more financial pain is set to be visited on the NHS in 2013.

A survey by Pulse last autumn found that GPs were already feeling the effects of rationed services. Two-thirds of respondents said rationing had adversely affected primary care while three-quarters said it had damaged their relationship with some of their patients.

Dr Michael Ingram, a GP in Hertfordshire, said: 'Next year will have the excitement of disinvestment in general practice, high workloads, and an unwanted and complex reorganisation. It contains all the elements of a perfect storm.'