

## UK General Practice is the 'best in the world'

Primary care researchers have performed 'outstandingly' in the annual Research Assessment Exercise (RAE), jointly conducted by the four UK higher education funding bodies

The RAE assessment is a competitive cross-disciplinary exercise based on a rising scale from 1\* representing national excellence to 4\* 'world leading'. Of the 12 medical schools submitting evidence to the RAE under the category 'Primary Care and Other Community Based Clinical Subjects', 25 per cent of work submitted achieved the highest recognition, with 90 per cent rated as internationally recognised or excellent. Primary care researchers also submitted work to Health Services Research and Epidemiology panels, where overall more than 50 per cent achieved at least a 3\* rating.

The Universities of Birmingham, Manchester and Oxford, ranked highest overall and were singled out in the RAE report for their groundbreaking work including:

- Research to help GPs spot features that will enable them to make an early diagnosis of meningitis in children. (University of Oxford)
- Research which shows that anticoagulants can safely be used to prevent strokes in very elderly people with irregular heartbeats. (University of Birmingham)
- Research helping GPs decide when to prescribe antibiotics for respiratory infections, helping them keep antibiotic use to situations when it is really needed, thus preventing the development of antibiotic resistance. (Oxford University with University of Southampton)
- Research showing how quality can be measured in general practice, paving the way for the Quality and Outcomes Framework of the GP contract. (University of Manchester)

Outside England, the primary care research carried out by Cardiff, Dundee and Aberdeen Universities also rated highly at the international excellence level.

Professor Amanda Howe, Chair of the Society for Academic Primary Care and Observer on RCGP Council, said: "This shows our research has been judged on a level playing field and been recognised for its academic quality and clinical impact. We already had evidence from an international comparison of UK primary care research that we are highly productive for the costs invested, and it is great to see this confirmed by the RAE. RCGP support for research through the Clinical Innovation and Research Centre and the Scientific Foundation Board really helps the work we do to reach members, and to support people in developing and using the new knowledge produced".

RCGP Chairman Professor Steve Field said he was delighted with the results and that they confirmed what the College already knew.

"The RCGP has always championed academic excellence and academic GPs and researchers in the UK are doing brilliant work that helps all GPs raise the standards of care we provide for our patients.

"The fact that the majority of the work submitted was of high or very high international standard is not surprising as UK academic general practice is already renowned as the best in the world – and this cements our reputation even further.

"GPs are very rarely recognised for their research and innovation and this study not only demonstrates the value of their work but shows how it directly translates into tangible improvements for patients, rather than being consigned to a shelf somewhere to get dusty.

"Quality general practice relies on evidence and is the means by which we continuously improve and move forward. Primary care academics produce and transfer new knowledge to others and they also have a major influence on the way in which we train our doctors of the future to ensure that their learning is relevant and forward-thinking.

"Academic general practice has an expanding role in clinical care, with more of our Members and Fellows active in academic roles than ever before. These results are a major vote of confidence in the work that is going on already and should encourage even more GPs to get involved in future so that we can continue to expand the academic prowess of UK general practice – and continue to show that we have the best primary care research and education in the world.

"UK academic general practice is the best in the world and we have the best general practice primary care units in the world. I am so proud of all the units around the UK that are carrying out groundbreaking and excellent work to improve patient care. This is a brilliant success story for everyone working in primary care in the UK – and for all our patients."

Research Assessment Exercises have been held in the UK in 1986, 1989, 1992, 1996, 2001 and 2008 and are run jointly by the Higher Education Funding Council for England (HEFCE), the Scottish Funding Council (SFC), the Higher Education Funding Council for Wales (HEFCW) and the Department for Employment and Learning, Northern Ireland (DEL).

For RAE2008, quality profiles were produced for each submission of research activity made by higher education institutions. Any HEI in the UK that is eligible to receive research funding from one of the four UK bodies was invited to participate in the exercise – a discipline-based expert review process in which judgements on the quality of research are made by researchers and experts active in that discipline.



Amanda Howe: The RAE report confirms the recognition of our research for its academic quality and clinical impact

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## Warning to GPs to prepare for pandemic

**The RCGP has joined forces with the General Practitioners Committee of the BMA to launch new guidance on how GP practices should prepare for and operate during a flu pandemic.**

Supported by the Department of Health in England, it warns that a pandemic will put the NHS under 'unprecedented pressure' and that general practice will be 'stretched beyond its current limits'.

The guidance predicts that during the pandemic's peak an average GP practice could see an extra 186 cases of flu a week. The guidance says sensible preparation now will make the difference between just 'getting through' a pandemic and maximising the number of lives that can be saved.

There have been three pandemics in the last century which have caused public health emergencies. The worst flu pandemic of last century – the 1918 'Spanish Flu' – caused around 250,000 deaths in the UK. Many experts believe another one is overdue but it is impossible to predict its timing.

The BMA/RCGP guidance is intended as a practical guide for GPs and practice managers. It details how GP surgeries will be expected to adapt from their usual method of working and gives information and guidance on the following:

- Every practice will have to follow 'command and control arrangements' which will be monitored and co-ordinated by Primary Care Trusts to ensure there is a robust, uniform response.
- GP surgeries will be expected to 'buddy up' with neighbouring practices to share resources and exchange staff as necessary. The guidance recommends that practices should ensure these contingency plans are in place by 31 March 2009.

- There will be changes to the death certification process, including bringing in retired doctors to ease the pressure on local services.
- Patients with flu will get access to antiviral medicine via a new National Pandemic Flu Line Service, not via their GP surgery.
- Additional capacity in the health service will be created by prioritising services and patients in a systematic and ethical manner.
- How practices can minimise the spread of infection, for example by setting up separate waiting areas for patients with flu.

While it applies to practices in England only, it is expected that similar guidance will be issued in Scotland, Wales and Northern Ireland.

RCGP Honorary Secretary Dr Maureen Baker said: "We saw at Christmas how seasonal flu puts an added strain on the health service but this was a situation where the NHS and the outside world were otherwise operating normally.

"During a pandemic the NHS would have to work completely differently. General Practice is a critically important service which needs to be able to function as well as possible during a flu pandemic and that's why it's important to plan now while everything is steady state.

"This guidance provides practices with clear instructions on the steps they need to take now and during the pandemic, so that they can look after people with flu, and other emergencies, as well as can be done in very difficult circumstances."

The pandemic guidance is the latest output from the Emergency Planning Group set up nearly three years ago by the College and the GPC with the aim of publishing practical advice, guidance and tools for practices.

### RAE2008 DEFINITIONS OF QUALITY LEVELS

4*	Quality that is world-leading in terms of originality, significance and rigour
3*	Quality that is internationally excellent in terms of originality, significance and rigour but which nonetheless falls short of the highest standards of excellence
2*	Quality that is recognised internationally in terms of originality, significance and rigour
1*	Quality that is recognised nationally in terms of originality, significance and rigour
Unclassified	Quality that falls below the standard of nationally recognised work. Or work which does not meet the published definition of research for the purposes of this assessment

# New support for GPs in training

**e-GP is the new RCGP online e-learning resource to support GP training. It contains a programme of e-learning modules to underpin the GP curriculum and support preparation for the nMRCGP assessments.**

All RCGP Associates in Training (AiTs) are provided with free access to e-GP, along with their account and log-in details. Educational supervisors can visit [www.e-GP.org](http://www.e-GP.org) to register for an account.

Organised into curriculum-based modules, each e-GP module relates to one of the curriculum statements and consists of around two to four hours of e-learning, divided into a variable number of independent e-learning sessions.

As new topics are being created, the amount of e-learning available for each topic will be variable. This is simply a result of the creation process and should not be interpreted as a reflection of the importance of a topic within the RCGP curriculum or the MRCGP assessments.

AiTs can record details of completed e-learning sessions in their ePortfolio as part of the evidence of learning for Workplace-Based Assessment. To facilitate this, a new entry form called 'eLearning Session' has been created in the ePortfolio learning log. They can also generate a certificate for every completed e-learning session and this is automatically recorded in the e-GP system.

The new e-GP Learning Management System (LMS) also has a number of useful functions to help trainee GPs – they can browse the curriculum catalog for e-learning sessions, search for sessions, and create 'personal learning paths'. The programme has been developed jointly by the RCGP and e-Learning for Healthcare (e-LfH).

➔ Proposals to extend GP training. See page 7



# Children's services: New Laming review

**The tragic death of Baby P has led to a national review of arrangements for safeguarding children. The review is being led by Lord Laming, who previously chaired the public inquiry into the death of Victoria Climbié.**

The RCGP has welcomed the review as an opportunity to do a 'stock take' on the progress made at College level and by general practitioners in implementing consistent and effective arrangements for safeguarding children.

The RCGP submission affirms the unique position of General Practitioners in working with children and their families. It demonstrates how the College has played an active role over the past ten years, both in contributing to national policy and in providing practical guidance including publications and a toolkit launched jointly with the NSPCC to help GPs and their teams to recognise and respond to the needs of the child and other family members.

The submission also highlights the difficulties faced by GPs in recognising and responding to signs which may point towards abuse or neglect – and makes recommendations for further action by Government and national and local agencies.

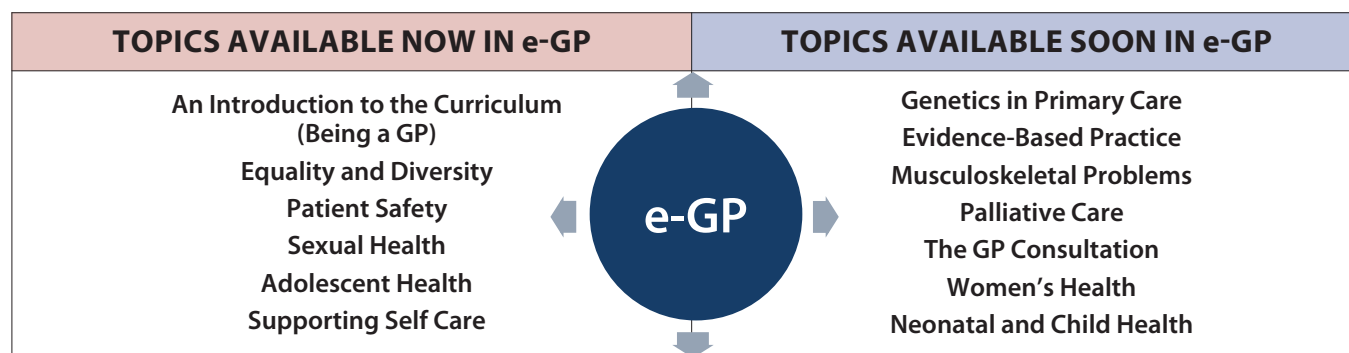
These include provision of free training in Child Protection to all NHS personnel and a call for PCTs to look at the role of GPs with Special Interest in Safeguarding, particularly in representing information and general practice opinion on the processes of Safeguarding, such as Conferences and Reviews.

The College submission also highlights the good practice of individual RCGP members and their teams, including one GP whose practice now has a children's patient registration form which asks for details of the child's school, who is living in the same house, as well as immunisation details, significant health problems and other usual information.

Child in Need meetings happen regularly at the Health Centre or a local school so that GPs can participate and these have made a big difference to collaborative working and patient satisfaction. By having the GPs participating in these meetings, the patients feel supported, even when the plan is difficult or might seem to go against them.

The GP also takes registrars and students to at least one case conference while they are training at the practice, and encourages their reflections afterwards. The practice is planning monthly meetings (similar to the Gold Standard Framework meetings for palliative care) where progress will be discussed.

■ The full College submission can be found on the RCGP website: [www.rcgp.org.uk](http://www.rcgp.org.uk)



Royal College of General Practitioners  
SHEFFIELD FACULTY

Half-day workshop  
for General Practitioners  
and Practice Managers

## HOW TO BE SUCCESSFUL IN A COMPETITIVE TENDER

They did not teach you to write business cases in your VTS yet to service the new world these are vital skills!

Presented by

**Dr Clare Gerada** MBE FRCP FRCGP MRCPsych  
Vice Chairman of the RCGP

**Sandy Gower** CIHM FRCGP (Hon)  
Managing Partner, Bennetts End Surgery

**Caroline Mabbott**  
Associate Director of Healthcare Procurement, NHS Sheffield

**Simon Gilby**  
Managing Director, Provider Services, Sheffield PCT  
[to join us for the Q&A session at the end of the workshop]

**Thursday 12 March 2009**  
**Holiday Inn Royal Victoria, Sheffield**

There will be three workshop sessions through which attendees will circulate followed by a Question and Answer Session.

A GP Perspective • A Practice Manager Perspective • A Political Perspective

Cost

Members and AiTs: £45.00 Non-members: £50.00 General Practitioner attending with Practice Manager: £75.00

If wishing to attend, or for more details, please contact:

Marilyn Lidster, Royal College of General Practitioners, SCHARR, Regent Court, 30 Regent Street, Sheffield S1 4DA  
email: [m.e.lidster@sheffield.ac.uk](mailto:m.e.lidster@sheffield.ac.uk)

Early booking essential as limited places available. There is a NO REFUND cancellation policy on any cancellations received after Tuesday 17 February 2009  
Please make cheques payable to RCGP – Sheffield Faculty and post to Marilyn Lidster at above address.



## Revalidation role for Professor Pringle

**Professor Mike Pringle has been appointed RCGP Medical Director for Revalidation.**

He will be responsible for the development, testing and delivery of the proposed system for GP revalidation, ensuring that it is timely and fit for purpose.

Accountable to the Chair of Council, he will also liaise with organisations including the Department of Health; the General Practitioners Committee of the BMA; the General Medical Council and the Academy of Medical Royal Colleges on issues relating to revalidation.

Professor Pringle is Professor of General Practice at the University of Nottingham and was Chairman of RCGP Council from 1998 to 2001.

# Baby P: The implications for Primary Care

**Dr Janice Allister FRCGP**

Honorary Secretary to the Primary Care  
Child Safeguarding Forum and Member of Council

## 1 Know your procedures

The RCGP/NSPCC toolkit *Safeguarding Children and Young People* (2007) is available via the CIRC section on the RCGP website. It gives guidance in caring for children and young people in general practice, recommending a safeguarding lead within each practice. It contains useful definitions, guidance, templates, a sample practice policy and a self-assessment tool. This can be used in conjunction with the local arrangements.

Many GPs struggle with using systems that don't seem to work very well, even though agreed by the Local Safeguarding Children Boards (LSCBs). Referring to social workers who seem overwhelmed or inexperienced can be seen as a problem. But other professionals, the general public and our patients have high expectations of us and we should not let them down.

## 2 GPs are best placed to pick up a pattern of neglect

It is hard to set thresholds for neglect, in comparison with physical or sexual abuse where there tend to be incidents or disclosures that demand action. Often the diagnosis of neglect is made by recognising a pattern from many different factors over a long period of time. Each factor on its own may be relatively minor, and only worrying when taken in context with other factors. Therefore GPs tend to be the agents best placed to pick up a pattern:

- Medical Neglect – lack of antenatal care, immunisations; failure to keep appointments; late presentations
- Overuse or inappropriate use of the Emergency Department or Out of Hours services
- Other conditions which may contribute to neglect such as the learning disability of parents or mental health, drug or alcohol problems
- Faltering growth

No-one pretends this work is easy. There are difficulties:

- Where GPs are familiar with families there can be conflicting loyalties
- Recent dilution of the GP role
- Reduced priority given by GPs to safeguarding

## 3 The importance of record keeping and of sharing information

As with any other complex medical condition, recognising symptoms and signs, recording the reason for one's concern and taking appropriate action, protects us against allegations of being neglectful ourselves. GPs hesitate to be involved in safeguarding unless there is definite evidence that serious harm is being done. They fear to be perceived as making erroneous judgements.

Sharing information on a need to know basis and attending a case conference is often seen as supportive by patients rather than taking sides against them. Failure on the part of GPs to keep records of concerns they have, or to share information with other appropriate professionals, makes it less likely that abuse will be detected. Keeping records and sharing information appropriately makes detection and prevention more likely.

## 4 GP safeguarding work requires skills of empathy, tolerance, compassion and scepticism

Safeguarding work is a core aspect of our work with children and young people. History taking can be corrupted by disingenuous claims or artificial optimism but this is not new. Empathy, tolerance, compassion and scepticism are core skills for us. It may hurt to act on disbelief, but at this point discussion with other professionals can be helpful. Wider safeguarding responsibilities such as those of a Named GP for a PCT may require more specialist skills.

## 5 Noticing tell-tale signs of physical abuse

How many times have we skipped examination of a miserable or crying child? Signs such as unexplained bruises and lacerations, a torn ear lobe or frenulum, animal bite marks, blackened finger and toenails, all of which Baby P suffered before he died, should sound alarm bells. The local procedure must be followed. Responsibility to parents, including the duty of confidentiality, needs to be overridden when the welfare of the child may be at stake.

*Never again:  
the toddler  
whose story  
shocked the  
nation – and  
sparked a  
widespread  
review*



## 6 Implementing a Gold Standard review meeting

This would be a team meeting with (for example) GPs, practice nurses, school nurses, health visitors and midwives, reviewing those subject to child in need or child protection plans. Practices who have done this have found it very valuable in sharing insights and updated information.

## 7 Serious Case Reviews have added significance for all of us, not just Named GPs

Most of us will be asked at some time in our professional lives, by the coroner or paediatrician leading the review, for details of a child who has died and the family. Again the welfare of other children may be at stake, and confidentiality rules are overridden. If in doubt, the defence societies will advise. For Named GPs, their duty is in gathering information. No one envies them this task and we owe them our support. *Working Together 2006*<sup>1</sup> [Chapter 7] lays a statutory duty on doctors in England to contribute to Child Death Review processes. The GMC offers guidance<sup>2</sup> on sharing information about children. In particular, it instructs doctors to maintain confidentiality unless disclosure would be in the public interest, or on the order of a court, and offers the following examples of situations in which disclosure would be justified:

- Child/young person at risk of neglect or sexual, physical or emotional abuse
- Information would help in the prevention, detection or prosecution of serious crime, usually crime against the person
- Child/young person is involved in behaviour that might put them or others at risk of serious harm, such as serious addiction, self-harm or joy-riding.

GPs should:

- Consider the information relating to
  - Health, development and treatment of the child
  - Significant medical history of parents, siblings and others
- Consider how best to provide this information to the Review Team, taking into consideration:
  - Risk to others in household
  - Whether or not child has capacity to consent
  - Whether or not parent/carer has capacity to consent [Mental Capacity Act]
  - Public interest [see GMC guidance above]
  - Proportionality of disclosure

## 8 Support

Police report that safeguarding children is one of the few issues where communities wholeheartedly support police work. It is costly work, especially emotionally, because there may be many points at which we feel that we have failed our patients and our communities.

Working with other professionals, following agreed procedures, and participating in case conferences help share the burden of care and responsibility which can otherwise weigh heavily. The Primary Care Child Safeguarding Forum ([www.pccsf.co.uk](http://www.pccsf.co.uk)) aims to provide support and opportunities for discussion as well as an annual conference. It is affiliated to the College.

## References

- 1) Fleming et al 2004. *Sudden Unexpected Death in Infancy: a multi-agency protocol for care and investigation. The report of a working party convened by the Royal Colleges of Pathologists and the Royal College of Paediatrics and Child Health.* London RCPPath.
- 2) General Medical Council. *0-18 years: guidance for all doctors.* GMC London 2008. [www.gmc-uk.org/guidance/ethical\\_guidance/children\\_guidance/index.asp](http://www.gmc-uk.org/guidance/ethical_guidance/children_guidance/index.asp) [accessed 29.7.08]

## Countdown to a tragedy

**September 2006:**

Mother tells GP 'child bruises easily'

**October 2006:**

Mother explains to GP baby had fallen down stairs previous day

**11 December 2006:**

GP notices more bruising which mother could not explain

- immediately referred to paediatrician at Whittington Hospital
- Social Services notified
- Child on Protection Register [Neglect, Physical Abuse]

**19 December 2006:**

Mother and partner arrested and bailed

- CPS decided no reasonable prospect of successful prosecution
- [Police closed investigation into abuse 2 August 2007]

**January 2007:**

Returned to family home by Social Services

• **Case Conferences**

- Paediatrician unable to attend but 'made report available'; says she 'would not have supported return to family home'
- Mother 'working well' with Social Services
- Illusion fabricated that mother living alone
- Mother completed parenting course

**February-April 2007:**

Boyfriend frequently left in charge

- Injuries coincided with his increasing involvement in household

**April 2007:**

Taken to hospital: 'unexplained cuts & bruises'

**June 2007:**

Taken to hospital: 'unexplained cuts & bruises'

**25 July 2007:**

Mother telephoned GP to ask

help 'getting Social Services off her back'

**26 July 2007:**

Saw GP, noticed child 'withdrawn'

**1 August 2007:**

Saw paediatrician, St Anne's Hospital

- child development clinic
- child not examined because 'cranky and miserable'
- with her for an hour

**2 August 2007**

Police announce they are closing investigation

**3 August 2007**

Mother called 999

- Baby P 'blue, cold and stiff'
- Formally pronounced dead at North Middlesex Hospital shortly after midday

# STEPS raises awareness with Baby Hip Health Week

National charity STEPS is holding its Baby Hip Health Week from 23-28 February to coincide with the publication of its survey of hospitals and Primary Care Trust policies and guidelines for the screening and diagnosis of Developmental Dysplasia of the hip (DDH).

Initial findings from the research indicate that many PCTs do not have a hip examination policy which is an important part of the newborn and six- to eight-week physical baby health check. This has implications for service delivery resources and training for GP practices.

Every year, up to 2,000 babies and children are diagnosed with DDH which describes a range of conditions from mild instability and immaturity to total dislocation of the hip. Treatment can vary depending on the severity of the hip condition and how early it is detected but full body plaster casts (hip spicas) and even surgery can be required. Late diagnoses can lead to early hip replacement and osteoarthritis, for which there is no cure.

Even if the hips appear to be normal it is important to be aware of signs that might mean there is a problem. Typical signs that parents report to GPs include one leg appearing shorter than the other; an extra deep crease on the inside of the thigh; crawling with one leg dragging; or walking with a limp or a waddle. While these signs are not conclusive, they may indicate the need for further investigation.

STEPS has produced an award winning parent leaflet (*Baby Hip Health*) on the screening procedure for detecting DDH. To obtain the leaflet or find out more about the Baby Hip Health Campaign, contact the STEPS helpline on 0871 717 0044 or email [info@steps-charity.org](mailto:info@steps-charity.org)



Baby has a 'bath' in her hip spica

When a child is diagnosed with a lower limb condition, such as hip dysplasia, parents can often feel confused and isolated. STEPS, a small national charity, provides a dedicated information and support service to parents which help them become effective carers of their children and to make confident and informed decisions at what can be a confusing and difficult time.

■ STEPS website: [www.steps-charity.org.uk](http://www.steps-charity.org.uk)

# New report on services for patients with epilepsy

The latest report published by national charity Epilepsy Action shows that current service provision is still poor – despite the condition affecting nearly 400,000 people in England.

The report highlights the negative consequences this is having on patients before setting out some realistic solutions to help bring about positive change.

The report, *Epilepsy in England: time for change*, was launched at the House of Commons last month and was attended by a host of key stakeholders in epilepsy services including MPs and peers, health professionals, health trust chief executives and people affected by epilepsy.

The charity now hopes that those charged with health service provision will act to ensure adequate epilepsy services for all people living with the condition.

The report draws on the results of surveys carried out among primary care trusts and acute trusts across England, as well as people with epilepsy. It reveals how, in many parts of England, epilepsy services are significantly failing people with the condition. In particular, they fall well short of guidelines for epilepsy services, as set out by the National Institute for Health and Clinical Excellence (NICE).

## The headlines

The majority of trusts lack even the most basic information needed to design adequate services. The survey uncovered significant discrepancies in the way trusts currently gather and collate information on epilepsy. They show that many trusts do not hold basic data on the prevalence and population of people with epilepsy in their region. In particular, only 18 per cent of PCTs provided figures on the number of children with epilepsy. The report underlines that, without this vital information, trusts are unlikely to be able to plan and provide services that meet the NICE guidelines and those of people with epilepsy.

## The report also claims that:

- Despite NICE guidelines that all people with suspected epilepsy should be seen by an epilepsy specialist, half (49 per cent) of acute trusts do not employ one and only 12 per cent of PCTs employ a GP with a Special Interest in epilepsy
- Despite NICE guidelines stating that all people with suspected epilepsy should be seen urgently (within two weeks), more than 90 per cent of trusts have longer waiting lists

## A call to action:

The report calls on the government and policy makers to show leadership by driving improvement in epilepsy services. It sets out a ten-point plan of how this can be achieved, addressing the specifics of adequate service provision for all epilepsy patients in England.



These include recommendations to ensure all patients receive an annual review of their epilepsy and that NHS workforce planning focuses on the recruitment and training of sufficient epilepsy specialist consultants and epilepsy specialist nurses. This would better position PCTs and ATs to deliver NICE guidelines.

*Epilepsy in England: time for change* is the latest in a long line of reports, all highlighting the critical need for improvement in epilepsy services. Most recently the All Party Parliamentary Group (APPG) on epilepsy's report, *Wasted Money, Wasted Lives*, published in 2007, highlighted key failings in epilepsy services. It also showed that 400 avoidable deaths happen each year due to a lack of adequate services.

Earl Howe, Chair of the APPG on epilepsy, said: "Uncontrolled epilepsy can have a devastating impact on the quality of life of people with epilepsy. Every seizure brings the risk of injury and even death, and early treatment means that seizures may be reduced. The results in this report are deeply concerning."

■ To view a full version of the report, visit [www.epilepsy.org.uk/timeforchange](http://www.epilepsy.org.uk/timeforchange) or call 0113 210 8800. Patients seeking non-medical advice and information on epilepsy can visit [www.epilepsy.org.uk](http://www.epilepsy.org.uk) or call the Epilepsy Helpline freephone: 0808 800 5050.

Epilepsy Action is a registered charity. As well as campaigning to improve epilepsy services and raise awareness of the condition, the organisation supports people with epilepsy in a variety of ways, including a national network of branches, accredited volunteers, regular regional conferences and an Epilepsy Helpline.

## MEDICAL DIRECTOR (Four sessions)

### Clinical Innovation and Research Centre (CIRC)

Developing Clinical Excellence through Clinical Audit and Effectiveness, Service Development and Research Projects

The role of the Medical Director (CIRC) is to be established to support the Chair of the Clinical Innovation and Research Centre and the expanding portfolio of work. The role is for four sessions per week, expected initially for one year.

The role is to be offered on a Contract for Services/Secondment from an employer basis and is not an employed post within the RCGP. Contract for Services offered on a sessional rate based on the GP05 Educator Scale (£9,832 per four-hour session).

As the Medical Director for the Centre, you will be responsible for leading clinical and some academic operations in conjunction with the Head of Clinical and Research/CIRC manager as directed by the Chair of the CIRC. Responsibilities include:

- Leading the clinical and research development programmes within CIRC, providing support to the CIRC team and the programme.
- Liaising with and supporting the work programmes of the Clinical Champions and other clinical projects in conjunction with the CIRC team.
- Identifying and submitting applications to funding opportunities for clinical audit service development and research projects with the support of the CIRC team.
- Liaising with and contributing to 'Essential Knowledge Updates' and other workstreams of the Education directorate.

For an informal discussion please contact:

<b>Professor Nigel Mathers</b> Chair of CIRC Tel: 0114 271 5922 Email: <a href="mailto:n.mathers@sheffield.ac.uk">n.mathers@sheffield.ac.uk</a>	<b>Colette Marshall</b> Head of Clinical Innovation and Research Tel: 020 3170 8248 Email: <a href="mailto:Cmarshall@rcgp.org.uk">Cmarshall@rcgp.org.uk</a>
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- Further information about the work of CIRC is available at [www.rcgp.org.uk/clinical\\_and\\_research/circ.aspx](http://www.rcgp.org.uk/clinical_and_research/circ.aspx)

To apply for this post, please send your CV with full career details, plus supporting statement outlining why you believe you are suitable for this role, to:

**Colette Marshall**  
RCGP Clinical Innovation and Research Centre  
31 Southampton Row London WC1B 5HJ

Closing date: 9 February 2009 Expected interview date: 19 February 2009

Interviews to be held at: The Royal College of General Practitioners, Princes Gate, London SW7



## Packed programme at Essex in March

Essex Faculty will be hosting its Annual Conference in Braintree on 11 March.

The conference is open to all primary care physicians in Essex and beyond, with presentations on the educational role of the RCGP, Women in Medicine and Medical Regulation as well as workshops on how to prepare for iMAP and relicensing/revalidation.

Speakers include Dr Bill Reith, Chair of the RCGP Postgraduate Training Board; Professor Elizabeth Paice, Director of the London Postgraduate Deanery; and Paul Phillips, Deputy CEO of the General Medical Council.

Chair of Essex Faculty Dr Sati Ariyanayagam – who is pictured at last year's event with RCGP Chairman Professor Steve Field – said: "Last year's event was a real success which we are hoping to emulate this time around. We have worked hard to put together a packed programme so that every GP working in Essex and



the surrounding areas will find something to suit them."

■ For details please contact Gerald Walsh at the Faculty Office on 020 7173 6076; e-mail [gwalsh@rcgp.org.uk](mailto:gwalsh@rcgp.org.uk) Details are also on the Faculty's web page [www.rcgp.org.uk](http://www.rcgp.org.uk)

# Devolution: An opportunity for Gold Standard primary care mental health services in Wales?

**Dr Huw Lloyd**

GP in Wales and Chair of WaMH in PC

DEVOLUTION HAS not been received with universal enthusiasm within Wales and some are still sceptical about its ability to make any significant difference. However the current coalition government between the Labour Party Wales and Plaid Cymru did believe it could make real changes and in their joint agreement *One Wales: A progressive agenda for Wales*, they set out their aspirations:

## Welsh Assembly Government

We aspire to a world-class health service that is available to everyone, irrespective of whom they are or where they live in Wales, and at the time when they need it. Our health services must inspire confidence in the people of Wales that they will receive the best care available.

*One Wales: A progressive agenda for Wales*

If you do not live or work in Wales, it is possible that the significant differences that are developing between the health services in England and Wales might have escaped your attention. There are very big changes that are occurring, and it is more than just the fact that there are free prescriptions for everyone in Wales. There are basic differences in policy.

For example, *One Wales* also states:

*'We will move purposefully to end the internal market.'*

and:

*'We firmly reject the privatisation of NHS services or the organisation of such services on market models. We will guarantee public ownership, public funding and public control of this vital public service.'*

But most importantly for those with an interest in mental health and well-being, the government stated in *One Wales*:

*'We will place a new priority on providing for mental health, including child and adolescent mental health services.'*

This has been demonstrated by the support given by the Minister for Health and Social Care, Edwina Hart, for the Gold Standards programme initiated by The Wales Mental Health in Primary Care Network (WaMH in PC).

## The Wales Mental Health in Primary Care Network

Welsh Council of the Royal College of General Practitioners set up a primary care mental health network for Wales (WaMH in PC) in 2003 to enable those with an interest in primary care mental health in Wales to share ideas and for there to be a conduit 'to encourage, foster and maintain the highest possible standards in general medical practice' in the field of mental health.

It is clear that mental health promotion, social inclusion and the management of mental disorders are of huge importance to all in primary care as they form a major part of the day-to-day work of all general practitioners.

## The Gold Standards programme

There is always scope for improvement in the quality of patient care in this aspect of every day clinical practice and many individuals, practices and organisations are working at innovative ways of providing better care for users and carers in the primary care setting. Unfortunately many of these good ideas are not passed on to others and the enthusiasts' drive and initiative fails to reach further than their own team or locality. WaMH in PC wants to capture this good work and pass on these examples high quality practice, and this desire to disseminate good practice led to the beginning of the Gold Standards programme.

## The Welsh Declaration for Mental Health and Well-being

One of the first products of the Gold Standards programme was The Welsh Declaration for Mental Health and Well-being (February 2007) in which WaMH in PC recognised the importance of

these issues to all the people of Wales and also the responsibilities not only of government and the health service, but also industry, local government, the voluntary sector, business communities, educational institutions and, of course, individuals to play their part in establishing mental health and well-being in Wales.

As individuals in Wales we all:

- Have a responsibility for our own and others' mental health and wellbeing.
- Need to be able to develop the understanding and gain the skills so that we can recognise signs of mental ill-health in others and ourselves.
- Need to be able to access services easily that will support recovery and empowerment, leading to the promotion of independence and to the facilitation of self-management and maintenance of mental health and wellbeing.

*The Welsh Declaration for Mental Health and Well-being*

The Declaration was used to state the next part of the project:

We call upon others to work with us (WaMH in PC) to promote:

- The mental health and general wellbeing of all the people of Wales
- Recovery through services that have the appropriate values and evidence base.
- Research and development that will be directed towards providing the evidence base for mental health and wellbeing.
- Good practice by engaging with individuals and their carers, as they are central to the relationship between service providers and themselves in setting and shaping the services they require. This will be achieved through partnership, empowerment and personal responsibility.
- Person-centred approaches that acknowledge and value individuals as people and give proper recognition to the therapeutic potential of these interactions and relationships.

*The Welsh Declaration for Mental Health and Well-being*

## The Three Hallmarks

Underpinning all the work in the Gold Standards programme are three hallmarks that must be found in any part of the programme:

- Person centredness
- Trust
- Communication

So whatever the programme is dealing with, such as the individual consultation, mental health promotion, the primary care/secondary care interface etc, these qualities must be present.

## Current areas of activity

The potential scope of the programme is huge and so obviously it cannot be tackled all at once but at the moment amongst other things we are looking at:

- Mental health promotion
- Suicide, self harm and risk mitigation
- Evaluation and accreditation
- Communities projects
- Mental health in the work place
- The primary care/secondary care interface

We are very aware of the size of the task that we have set ourselves. Indeed it is a task that will never really end but we are sure it is worth the effort. Comments, criticism but, above all, help would be welcomed. We hope that through the Mental Health Forum we shall be able to share good ideas and practice. At the time of writing our website is being changed but please Google WaMH in PC and you will find us.

# Crossing the boundaries

**A Mental Health Forum has been established by the RCGP and the Royal College of Psychiatrists to promote good practice in mental health care across generalist and specialist services.**

The Forum, co-chaired by RCGP Clinical Champion for Mental Health Dr Carolyn Chew-Graham and Roger Banks, Vice President of the RCPsych, will build on the strong working alliances already established between the RCGP Mental Health Task Group and other organisations in primary care.

It will act as a source of expert advice to organisations with an interest in mental health, building and supporting collaborative activities and influencing national policy and strategy through the respective Colleges.

Another of the aims of the Forum will be to support the work of mental health practitioners at all levels, particularly those at the frontline of service delivery.

The specific anticipated outputs of the Forum will include:

- Policy development and comment on relevant consultations
- Production of joint publications
- Guideline development
- Input into the Curriculae for General Practice and Psychiatry
- Hosting joint conferences, workshops and events

To encourage cohesion and avoid fragmentation or duplication, clinical aspects covered by the Forum will be reported to the RCGP Clinical Innovation and Research Centre (CIRC), with policy issues reported to RCGP Honorary Secretary and education issues fed back to the RCGP Professional Development Board.

Co-Chair Dr Chew-Graham said: "The two Royal Colleges and other leading mental health organisations have worked together on a wide range of initiatives in the past including education, training, and research but the establishment of the Forum takes this work onto another level.

"We hope that by formalising our combined strengths and influence, we can ensure that policies and services are well thought through and properly joined up so that patients with mental health problems get a better deal."

# RCGP joins bid to beat Britain's number one killer

**The College has joined a national coalition of voluntary organisations promoting and protecting cardiovascular health in England.**

The Cardio and Vascular Coalition is concerned that with the current National Service Frameworks for Coronary Heart Disease due to conclude in 2009-10, a new plan is needed for the next decade to ensure appropriate planning and resources for cardiovascular disease.

Based at the British Heart Foundation, it has seven main aims including the introduction of a ten-year Cardiovascular Health Strategy starting in 2010 that will join up prevention, diagnosis and care from birth to end of life. It wants to ensure that patients living with cardiovascular disease are at the centre of policy and services and will be working to influence central and local government, health and social care commissioners, service planners and policy makers to ensure that cardiovascular health is high on their agendas.

The RCGP has contributed to the Green Paper consultation on the strategy, highlighting the need for more research into the prevention of the disease in some black and minority ethnic populations who are at high risk and calling for more information on the use of biomarkers in early detection. Responses will inform the White Paper which is due for completion in the Spring.

# The Pain in Spain...

**The first International Course on Pain Medicine, supported by the RCGP, will be held at the Granada Congress and Exhibition Center, Granada, Spain, from 28-31 May, 2009.**

The ICPM will offer the latest clinical information on the most prevalent chronic pain conditions and will be of interest and value to all GPs managing regularly chronic pain patients. Topics include: neck and low back pain; osteoarthritis; headaches; neuropathic pain; cancer pain; fibromyalgia; urogenital and pelvic pain; pain in the elderly.

RCGP Members booking before 15 February will be eligible for a discounted rate of €300; Feb 16-Mar 31: €350; after Mar 31: €400. Accompanying guest – until Feb 15: €100; Feb 16-Mar 31: €150; after Mar 31: €200

■ **Further information and registration options at [www.icpm.net](http://www.icpm.net)**

# Tackling Health Inequalities

Last chance to book for the RCGP conference *Addressing Health Inequalities through Primary Care: Taking action through learning, planning and providing* on Thursday 5 February 2009 at Princes Gate

Esteemed GP and founder of the inverse care law Dr Julian Tudor Hart heads a line-up of speakers that includes RCGP Chairman Professor Steve Field, Dr Iona Heath and Dr Steve Feast, Senior Health and Wellbeing advisor at the Department of Health.

■ **Further information at:** <https://integra.rcgp.org.uk/membersarea/multievents/displayEvent.asp?Type=Full&Code=AHIPC1>

# Is your research outstanding?

**Only a few more weeks to submit your entry for the RCGP Discovery Prize – a prestigious international award recognising outstanding research in general practice.**

Important discoveries in general practice have transformed health care – the Discovery Prize recognises achievement which has continuing major importance for primary care in the UK and abroad. The terms 'discovery' and 'research' can be interpreted broadly, and may include qualitative and innovative work. Deadline is 27 February 2009.

■ **Find out more at:** [www.rcgp.org.uk/news\\_events/prizes\\_and\\_awards/prizes\\_awards\\_details/discovery\\_prize.aspx](http://www.rcgp.org.uk/news_events/prizes_and_awards/prizes_awards_details/discovery_prize.aspx)

# Combined antiplatelet and anticoagulant therapy

**A frequently asked question in general practice is if and when it is appropriate to combine an antiplatelet (aspirin/clopidogrel) with warfarin.**

A recently published retrospective, longitudinal, pharmacoepidemiologic analysis estimated and compared the incidence of adverse and coronary event rates between patients receiving warfarin monotherapy (for any indication) or warfarin and antiplatelet combination therapy<sup>1</sup>. There were 2,560 patients in the monotherapy cohort and 1,623 patients in the combination therapy cohort. Patients in the combination group were more likely to have had anticoagulation-related haemorrhages (4.2 per cent vs 2.0 per cent; unadjusted  $p < 0.001$ ) and coronary events (0.9 per cent vs 0.3 per cent  $p = 0.009$ ). This is an NNH of 45 for haemorrhage after six months treatment. With adjustment, combined warfarin and antiplatelet use was independently associated with haemorrhagic events (OR 2.75; 95 per cent CI 1.44 to 5.28), but not with coronary events (OR 0.99; 0.37 to 2.62).

The authors concluded that at the population level, the haemorrhagic risk associated with warfarin combined with antiplatelet therapy appears to outweigh the benefits and clinicians should carefully consider the risks and benefits when recommending combined antiplatelet therapy for patients receiving warfarin who do not meet evidence-based criteria for such therapy.

## Atrial fibrillation

An article in the *BMJ*<sup>2</sup> recommends: 'Don't add aspirin for associated stable vascular disease in a patient with atrial fibrillation

**PETER BURRILL**

*Specialist Pharmaceutical Adviser for Public Health  
Derbyshire County PCT*

receiving anticoagulation'. The risk of major bleeding with warfarin plus aspirin compared with warfarin alone is quoted as 3.9 per cent and 2.3 per cent a year respectively ( $p < 0.01$ ). This is an NNH of 63.

The author concludes 'clinicians should be aware that in patients with atrial fibrillation and stable vascular disease, adding aspirin to warfarin does not seem to prevent stroke and vascular events and increases bleeding risk. If a patient taking aspirin for atrial fibrillation is diagnosed with vascular disease and requires warfarin, the aspirin should be stopped once warfarin is started and therapeutic range (INR 2.0 - 3.0) achieved.

Aspirin plus clopidogrel (without warfarin) is not an alternative in patients with atrial fibrillation at high risk of stroke. The message to stop prescribing aspirin alongside warfarin in such patients needs much greater emphasis in prescribing guidelines'.

## After coronary intervention

A specific group of patients where triple therapy might seem logical is those with atrial fibrillation who undergo PCI with stent implantation (PCI-S). The AF is likely to require warfarin therapy and stent implantation mandates a course of dual antiplatelet therapy. A study has addressed this issue<sup>3</sup>. Consecutive AF patients

(104) with indication for oral anticoagulation who underwent PCI-S were followed up and those receiving triple therapy (TT) were compared with those receiving other regimes (non-TT). The primary endpoint was occurrence of major bleeding complications, split into early major bleeding (EMB) [ $\leq 48$  hours] or late major bleeding (LMB) [ $>48$  hours]. There was no difference in EMB but TT was associated with a higher incidence of LMB (21.6 per cent vs 3.8 per cent;  $p = 0.006$ ). This is an NNH of 6. No differences in major cardiovascular events were observed in patients treated with TT vs non-TT (25.5 per cent vs 21.0 per cent;  $p = 0.53$ ). The results of this study clearly do not support a triple therapy approach.

A recent *BMJ* article<sup>4</sup> addresses the issue of an anticoagulated AF patient at high risk of stroke who needs coronary intervention. No systematic review or randomised trial has dealt with this question. The author suggests that triple therapy with warfarin, clopidogrel and aspirin may increase the relative risk of life threatening bleed around ten-fold in vulnerable patients with multiple comorbidities and risk factors for bleeding.

The article offers the advice in the table below.

## Conclusion

The author suggests that because dual antiplatelet therapy needs to be used for longer with drug eluting stents, interventional cardiologists should avoid using such stents in patients with AF, who require long term anticoagulation.

If a patient is discharged on warfarin and antiplatelet therapy the reasoning behind this should be provided. Record this in the patient's notes and make sure that any stop date provided for the clopidogrel is acted upon.

SUGGESTED MANAGEMENT STRATEGY FOR PATIENTS WITH NON-VALVULAR ATRIAL FIBRILLATION REQUIRING ANTICOAGULATION AND PERCUTANEOUS CORONARY INTERVENTION WITH STENTING				Management after percutaneous coronary interventions*	
STROKE RISK CATEGORY	'Usual' strategy recommended	Perceived potential bleeding risk	Acute coronary syndrome at presentation	If patient has bare metal stent	If patient has drug eluting stent
LOW	ASPIRIN	NOT RELEVANT	NOT RELEVANT	Aspirin plus clopidogrel for 4 weeks, then aspirin	Aspirin plus clopidogrel for 6-12 months, then aspirin
HIGH	WARFARIN	LOW	NO	Use bare metal stent if possible; triple therapy with warfarin, aspirin, and clopidogrel for 2-4 weeks; then warfarin and clopidogrel for up to month 12; then warfarin alone	Triple therapy with warfarin, aspirin, and clopidogrel for 3-6 (or more) months; then warfarin and clopidogrel for up to month 12; then warfarin alone
			YES	Triple therapy with warfarin, aspirin, and clopidogrel for 3-6 (or more) months; then warfarin and clopidogrel for up to month 12, then warfarin alone	Triple therapy with warfarin, aspirin, and clopidogrel for 3-6 (or more) months; then warfarin and clopidogrel for up to month 12; then warfarin alone
HIGH	WARFARIN	HIGH†	NO	Use bare metal stent if possible; triple therapy with warfarin, aspirin and clopidogrel for 4 weeks; then warfarin alone	Triple therapy with warfarin, aspirin and clopidogrel for 4 weeks, then warfarin and clopidogrel for up to month 12; then warfarin alone
			YES	Triple therapy with warfarin, aspirin, and clopidogrel for 4 weeks; then warfarin and clopidogrel for up to month 12; then warfarin alone	Triple therapy with warfarin, aspirin, and clopidogrel for 4 weeks; then warfarin and clopidogrel for up to month 12; then warfarin alone

*These recommendations are based on extrapolation from diverse studies in different populations, given the lack of evidence on the optimal management for such patients. Also, although coronary stents are usually used these days, optimal balloon-only angioplasty with bail-out stenting may be used in highly selected patients or lesions. These recommendations are for post-percutaneous coronary intervention (or stenting). If surgery is needed, triple (or dual) antithrombotic therapy is associated with excess bleeding, and many surgeons request that antiplatelet therapy be stopped before surgery.*

\*Aspirin 75 mg/day; clopidogrel 75 mg/day. Warfarin dose adjusted to target INR 2.0 - 2.5.

†Pay particular attention to the following risk factors: age over 75; taking antiplatelet drugs or non-steroidal anti-inflammatory drugs; taking multiple other drugs (polypharmacy); uncontrolled hypertension; a history of bleeding (for example, peptic ulcer or cerebral haemorrhage) or poorly controlled anticoagulation therapy.

## References

- 1) Johnson SG et al. *Chest* 2008; 133: 948-54
- 2) Lip GYH. *BMJ* 2008; 336: 614-5
- 3) Manzano-Fernandez S et al. *Chest* 2008; 134: 559-67
- 4) Lip GYH. *BMJ* 2008; 337: 1110-12

## DIARY DATES

Here's a taster of RCGP courses, conferences and events taking place over the next couple of months. A full listing can be found on the RCGP Courses and Events web page

### FEBRUARY

**17 RCGP Masterclass: Consulting Skills**  
Refresh and enhance your consulting skills under the guidance of former RCGP President and consulting skills expert, Dr Roger Neighbour. RCGP, 14 Princes Gate London SW7 1PU. 09:30-16:30 Members: £175 Non-Members: £220

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**Sexual Health in the Surgery**  
The fifth National Conference on sexual health and contraception in general practice, with practical workshops covering a variety of topics. The Palace Hotel, Manchester. 09:30-16:30 Members: £140 Non-Members: £170 Joint GP/Nurse Ticket: £250

### MARCH

**7**

**Locum GPs 'Survival Guide'**  
Drs Shanker Vijaydeva and Muhammed Ali explore ways in which GPs looking to become a locum or currently working as a locum can maximise their work. RCGP, 14 Princes Gate London SW7 1PU. 09:30-16:30 Members: £175 Non-Members: £220

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**Business Skills for GPs**  
Explore a range of relevant business issues, business tools and frameworks to help you look at your practice (and career) from a strategic perspective. RCGP, 14 Princes Gate London SW7 1PU. 09:30-16:30 Members: £125 Non-Members: £175

### APRIL

**14/15**

**Consulting Skills for GP Registrars**  
Specifically tailored for GP registrars. Enhance your consulting skills under the guidance of consulting skills expert, Dr Roger Neighbour. RCGP Assessment Centre, Croydon CR0 0XT. 09:30-16:00 Members: £275 Non-Members: £350

# Supporting medicines adherence

DR NORMA O'FLYNN MRCPG PhD

Clinical Director

National Collaborating Centre for Primary Care

## NICE has just published a guideline, *Medicines Adherence: involving patients in decisions about prescribed medicines and supporting adherence*.

Evidence from many disease areas and from different health systems suggest that between 30-50 per cent of medicines for long-term conditions are not taken as prescribed<sup>1</sup>. The guideline was developed by the National Collaborating Centre for Primary Care which is hosted by the RCGP. The principles underpinning the guideline are likely to be familiar to those holding MRCPG but the guideline is directed to all healthcare professionals who are involved in prescribing, dispensing or reviewing medicines.

The guideline does not use the word 'concordance': a term that was developed to describe the consultation process by which agreement about therapeutic decisions was reached by prescribers and patients. 'Concordance' presumes an exploration of patients' views and their incorporation into the decision made. The full version of the guideline<sup>2</sup> (available on the NICE website: [www.nice.org.uk/CG76](http://www.nice.org.uk/CG76)) outlines the difficulties in clearly defining and measuring what concordance is and points out that the follow-up and support that a decision may require are not necessarily part of the usual understanding of concordance. The guideline developers prefer the term 'adherence'.

Adherence is defined as 'the extent to which the patient's behaviour matches agreed recommendations from the prescriber'. This definition presumes an agreement between prescriber and patient about the prescriber's recommendation. Non-adherence is not seen as the patient's 'fault' but can occur because of a failure to achieve informed agreement to the prescription in the first place or to identify and provide the support that the patient needs later on. Informed adherence is the outcome of choice – an informed choice in decision to take medicines and supported adherence<sup>3</sup>.

The guideline therefore makes recommendations both about involving patients in decisions about medicines and about assessing and supporting adherence. Recommendations also cover reviewing medicines and communication between healthcare professionals. The guideline draws extensively on sociological and psychological literature which examines patients' experience of medicine-taking and uses this to provide professionals with information on how patients' actually use medicines.

### Involving patients in decisions

Good communication skills are needed for involving patients in decisions and healthcare professionals are recommended to adapt their consultation style to the needs of patients, to consider factors such as physical or learning disabilities, language problems and consider the most effective way of communicating with each patient. Encouraging patients to ask questions about their condition and treatment and using open ended questions are recommended. The guideline reminds healthcare practitioners of the Disability Discrimination Act 2005 which requires that reasonable adjustments are made for patients with disabilities.

The psychological and sociological literature makes clear that patients make an assessment of medicines based on their own understandings of their problem and the treatments. Patients' evaluations of medicines may depend on the effect of a medicine on the symptom they find most troubling rather than on a disease process and patients may take a different view from healthcare professionals on risks, benefits and side effects. Healthcare professionals are therefore advised to explain clearly to the patient both the disease or condition and how the medicine influences this and also to clarify what the patient expects from the treatment.

The right of patients to decide not to use a medicine or to stop using a medicine is expressly recognised in the guideline. Healthcare professionals are advised that they have a duty to help patients make decisions about medicines based on an understanding of likely risks and benefits rather than misconceptions. If healthcare professionals are concerned that a patient's decision could have an adverse effect, they are recommended to record the decision and the information provided to the patient. Capacity to make a decision, if in doubt, should be assessed using the principles of the Mental Capacity Act (2005).

Healthcare professionals are recommended to ask patients what they know, believe and understand about medicines, both when initiating new prescriptions and when reviewing medicines. Patients may have general concerns about medicines or concerns about specific medicines. The research evidence indicates that common concerns of patients are about becoming dependent on medicines and whether patients think that they personally need the medicine. Patients may wish to minimise how much medicine they take and may wish to discuss with healthcare professionals what will happen if they do not take the medicine; non-pharmacological alternatives to medicines; how to reduce and stop medicines they have been taking for some time; or how to fit taking the medicine into their daily routine.

Patients cannot be involved in decisions about medicines unless they have adequate information. The guideline makes recommendations about timing and content of information provided to patients. The guideline recommends that information is offered to patients before medicines are prescribed and when medicines are dispensed. Information should be relevant to the patients' condition and treatment and jargon-free, and patients should be directed to other sources of information.

Healthcare professionals are advised not to presume that Pa-

tient Information Leaflets (PILs)\* will meet patients' information needs and to address concerns that patients may have after reading PILs. While the guideline recommends that information for patients needs to be individualised, it is suggested that information provided to patients in all settings might include:

- What the medicine is
- How the medicine is likely to affect their condition (that is, its benefits)
- Likely or significant adverse effects and what to do if they think they are experiencing them
- How to use the medicine
- What to do if they miss a dose
- Whether further courses of the medicine will be needed after the first prescription
- How to get further supplies of medicines

### Supporting adherence

The guideline emphasises the importance of continued support beyond the decision to prescribe. Most healthcare professionals will be using patient self-report as the initial basis for their assessment of adherence and the guideline has considered the advantages and disadvantages of self report and recommends how 'self-report' should be used. The recommendations remind healthcare professionals that some level of non-adherence is common; that the aim of assessing non-adherence is to identify patients who need support; and that adherence needs to be evaluated in a non-judgemental way.

Healthcare professionals should:

- Ask about non-adherence in a way that does not apportion blame
- Explain why the question is being asked
- Ask about adherence in a specific time period eg, in the past week; and
- Enquire about practices such as stopping and starting medicines and altering doses

If patients are non-adherent, the guideline recommends exploring whether this is because of concerns or beliefs the patient has about medicines: ie, they intend not to use the medicine; or whether they are non-adherent because of practical difficulties such as remembering or difficulties with packaging. Concerns and beliefs should be addressed and other support decided on by healthcare professional and patient. The full guideline provides an extensive review of interventions to increase adherence.

The evidence base for many common interventions is very inconclusive and the guideline recommends care when deciding on interventions and targeting these to specific need. These include use of multi-compartment medicines systems (eg, dosset boxes); simplification of dosing regimes; the use of alternative packaging for medicines; and encouraging patients to monitor their condition. Although a large proportion of patients in the UK do not pay a prescription charge, healthcare professionals are recommended to ask patient if prescription charges are a problem for them and explore options for reducing costs.

### Reviewing medicines

The guideline conceptualises medicine taking as a dynamic process where the initial prescription and use of a medicine generates concerns and experiences which will influence further decisions and taking of medicines. A review of medicines – either as part of the monitoring of a long-term condition or carried out by a healthcare professional other than the prescriber – needs to use the principles of involving patients in decisions about medicines and supporting adherence. Patient knowledge, understanding, concerns and perception of need for medicines are likely to change over time and review may be especially important when patients are taking multiple medications.

### Communication between professionals

The guideline recognises the complexity of modern medical care and makes a number of recommendations about communication between professionals. Healthcare professionals are recommended to have robust processes in place to ensure communication with other healthcare professionals involved in the patient's care. Healthcare professionals involved in reviewing medicines should inform the prescriber of the review and its outcome and, on transfer between services, the patient and subsequent healthcare providers should receive written information.

The guideline recommends that patients are encouraged and supported to keep an up-to-date list of all medicines they are taking. The list should include the names and dosages of prescription and non-prescription medicines, supplements taken by the patient and any allergic or adverse reactions to medicines.

- Material supporting the guideline is available from the NICE website and from the National Prescribing Centre at [www.npci.org.uk](http://www.npci.org.uk).

\*Patient information leaflets (PILs) contain information for patients on how medicines should be used. It is a legal requirement that this information is included on the label or within the packaging of a medicine.

### References

- 1) *Adherence to long term therapies* WHO (2003)
- 2) *Medicines Adherence: Involving patients in decisions about prescribed medicines and supporting adherence*. [www.nice.org.uk/CG76](http://www.nice.org.uk/CG76)
- 3) Horne R, Weinman J. *Concordance, A Partnership in Medicine Taking*. 2004. The Pharmaceutical Press

# On the road to extended GP Training

Dr Bill Reith

Chair

RCGP Postgraduate Training Board

IN SUMMER 2008, the Department of Health in England commissioned the College to investigate the business case for extending GP specialty training as recommended in the Tooke report (*Aspiring to Excellence: Final report of the Independent Inquiry into Modernising Medical Careers*). The DH had cautiously welcomed the Tooke recommendation, but had pointed out in its response to Tooke that there were several unresolved questions over costs and the consequences for the NHS. However, the DH did indicate that implementation of the Tooke recommendation – 'on whatever basis' – should begin in 2011.

It was encouraging that the Secretary of State's response to Tooke was generally positive, and that the profession is being given such a key role in its implementation – particularly extending GP training to five years. There is a strong evidence base that the RCGP GP curriculum can be best delivered over a five-year period. We believe that such extended training of generalists is in the best interest of patients.

Although the work has been commissioned by the DH in England, the relevant regulations derived from the European Directive are UK-wide, and this means that change cannot be introduced in any of the four countries of the UK without all agreeing to change.

The Department of Health in England wants the case for extending training to be made on the benefits to patients, the profession, and the NHS set against the costs and consequences of the changes. Based on the responses to Tooke, the RCGP already knew that there would be considerable support in principle for the proposals – but that solving the practical issues for the profession and the NHS would be critical in getting DH endorsement. The BMA's response to Tooke had already highlighted the need to ensure that extension should focus on the GP curriculum throughout and be relevant to the future GP's career.

The College set up a small team to take the work forward and this is supported by a steering group of stakeholders. The first step was an information-gathering exercise across the UK, to establish the views of stakeholders, including patients, the profession, governments and the NHS. With the full business case due for the DH in May 2009, the College aimed to produce an interim report for the Department to summarise progress on the project to date. The Interim Report was sent to the DH at the end of November.

Our thoughts as set out in the Report are that an extended training period cannot simply be 'more of the same'. We need to ensure that we are training not only to meet 'today's needs' but to provide the GPs who will make up the backbone of the NHS in 2020 and beyond are properly equipped. This means not only training competent GPs but also producing practitioners who are confident in their own abilities.

There must in an extended period be a focus on preparing the future GP for the challenges of dealing with an aging population with increasing co-morbidity, and an NHS where a greater share of leadership and responsibility for the direction and planning of care will fall on the shoulders of the GP. We believe that the cost of extending training, including capacity, will be small set against the savings to be made from better prescribing, referral, and team and case management across a professional lifetime.

If the case for extending training is accepted, implementation would involve a number of regulatory and financial changes, particularly changing the legal minimum length of training from the present three to five years. If the first statutory 'five-year courses' begin in August 2011, the first 'five year' qualified GPs would be leaving training at the earliest in 2011.

Trainees entering training before 2011 – before the change to the minimum length becomes effective – could not be compelled to extend their training. It may however be possible, as it is at present, to voluntarily extend training beyond the legally required three-year minimum. Many deaneries currently offer some four-year training programmes at present.

Extension would lead to a large increase in the numbers of GP trainees working in practices at any given time. We have highlighted the need for government to invest in an expansion of training places and in training infrastructure. Trainers, and the network of College and Deanery staff supporting training, must be properly supported.

Meanwhile, the College is continuing to work on the extending GP training project. It's exciting work and I believe the project's success will improve healthcare for all NHS patients and improve the professionalism of GPs. We have always supported improvements to training for GPs so that patients can receive better health care.

Although we're finding substantial support from all stakeholders, we do recognise that the government's decision on whether training will be extended or not will depend on the strength of the business case we can make for doing so. I'm confident that the College team will deliver the outcome we all are looking for.



The future's bright: RCGP President Professor David Haslam with the Award winners

## Awards aplenty for GPs in training

**Bespoke websites for GPs, the out of hours experience and the e-portfolio put GPs in training on the road to success in the 2008 RCGP Registrar Awards.**

The awards are made annually to celebrate original and innovative work undertaken during the course of vocational training and eight prizes were awarded.

### First prize winners:

**Carsten Grimm:** *From search engine to find engine* (design of a website with custom search engines for general practitioners)

**Jane Kirby:** *E-portfolio Pearls – making of the e-portfolio*

**Kupa Khistriya:** *NHS Direct OOH Experience for GP Registrars – a qualitative evaluation*  
Each received £1,000 together with a bound copy of their project

### Runners up:

**Mbang Ana:** *Discussion paper – Is there a place for religion/spirituality in medicine?*

**Veronica Grant:** *To allow Medication in Possession for residents of approved premises*

**Lucy Hillman:** *What are the sexual health needs of our patients and what are their opinions on STI screening in general practice?*

**Sarah McKelvie:** *An audit on the prevention of steroid induced osteoporosis in patients aged over 65*

**Greta Rafter:** *All children younger than five years of age, with feverish illness, should have temperature, heart rate, respiratory rate and capillary refill time measured and recorded, in keeping with NICE guidelines 2007.*

Each received £400.

RCGP President Professor David Haslam, who presented the awards said: "The awards always attract a high level of entries but we were blown away by the calibre of this year's submissions. We can be assured that the future of general practice is in very safe hands."

The awards have been running for the past 27 years and are supported by an educational grant from Roche Products Ltd.

## Diagnosing depression: Put your expertise to the test

**How good do you think you are at diagnosing depression in your older patients? This is a question that the RCGP and Age Concern are asking you as part of their new joint initiative called Take the Challenge – an online interactive test for GPs and other primary care professionals.**

You will follow the journey of 84-year-old Arthur Tanner who visits his GP Dr Shah about leg pain. You will be asked to spot the clues that he may be depressed and the barriers that might stand in the way of his depression being effectively diagnosed and treated. The test is anonymous and a score will be given out of 100.

In August last year, Age Concern, with the support of the RCGP, launched a campaign called *Down, but not out* to improve the diagnosis and treatment of older people with depression.

The campaign highlighted the fact that depression affects one in four (or two million) older people over the age of 65 in the UK, yet many slip through the net.

One of the reasons for this is that two-thirds of older people with depression never discuss it with their GP. They don't see depression as a real illness that is worth 'bothering' their doctor about. Of those who do raise it, only half are diagnosed and receive treatment.

Gordon Lishman, Director General of Age Concern England said: "GPs and other primary care professionals are crucial to older people getting the treatment they need for depression. *Take the Challenge* is an innovative way of testing current knowledge and assumptions about depression in later life, with the aim being to improve detection and treatment."



Take the Challenge and test your knowledge

Carolyn Chew-Graham RCGP Clinical Champion Mental Health says: "We are encouraging GPs to 'take the challenge' as part of their self-directed CPD. We would also like to see collaboration between primary care staff completing the quiz and learning more about depression in older people as part of a practice learning activity."

- Be among the first to Take the Challenge: [www.takethechallenge.org.uk](http://www.takethechallenge.org.uk)
- For more information about Age Concern's campaign *Down, but not out*, visit the website [www.ageconcern.org.uk/downbutnotout](http://www.ageconcern.org.uk/downbutnotout) or email [campaigns@ace.org.uk](mailto:campaigns@ace.org.uk)

## Federations in action: the St Helens experience

**Four general practices in St Helens are showing how the federated model can work to improve GP training.**

Aspect Health Ltd is made up of four training practices who decided to pool their resources last summer following the RCGP's publication of *Primary Care Federations: Putting Patients First* and amid the backdrop of Lord Darzi's review of the NHS.

An innovative teaching programme covering key areas of the nMRCGP curriculum has allowed trainers from the practices to hold monthly tutorials with subjects covering their particular area of interest. Tutorials are co-ordinated through the federation teaching website and have been well received by GP trainees.

According to Dr Greg Irving, one of the federation trainees, working together has been a great success.

"It has gone down very well – trainees get to see different practices and work with a wider range of people. It gives us wider exposure and access to tutors with different specialties and distinct experiences.

"The St Helens experience is an example of how working more closely to share local knowledge and expertise can build on the strengths of each individual practice."

At the same time, each practice has retained its autonomy, independence and unique identity by continuing to use existing buildings.

Working together means the four practices are well placed to bid for PCT contracts. The

federation has been successful in its bid for two Darzi equitable access schemes in the area, with the training of GPs seen as a key strength.

Federation also means better access and different ways of accessing the service (some booked, some walk-in appointments) with extended hours being more practicable. Economies of scale also mean that one practice manager can now do payroll for all four practices.

It has been a busy six months for Aspect Health:

- A limited company has been formed, along with a Board, an executive team and a website. Accountants and solicitors were consulted to help set up the business model
- Exploratory meetings have been held with the Chief Executive of the local Acute Trust, the Director of Social Services, the Carers Centre, local third sector organisations and the local Chamber of Commerce, as well as our host PCT

- The federation is working with the local Rotary Club to run a two-day event promoting health awareness in the town centre

Aspect Health has already been approached by a number of other groups looking to follow a similar teaching model, and in the future will aim to use their federated model to deliver revalidation.

■ [www.aspecthealth.net](http://www.aspecthealth.net)



A different Aspect: Chief executive Dr Simon Hargreaves (left) with Dr Greg Irving

## The RCGP Diary Project needs YOU!

March 2008 saw the beginning of the RCGP Diary Project – an initiative designed to capture snapshots of the new GP curriculum 'on the ground', gathered through the diary entries of GP trainers and trainees. What does the curriculum look like in real life? What does it mean to people to be working with this curriculum? What are the tasks, challenges, rewards?

Building on the back of 2008's notable success, the Diary Project is reopening in February 2009 to a wider cohort: we would like to invite all parties working with the GP curriculum to submit diary entries describing your experiences during one day of working with the curriculum. This includes the experiences of general practice staff, programme directors, educational and clinical supervisors, in hospital and general practice, trainers, trainees and all others whose lives are impacted by the GP curriculum.

It is not taxing to submit your diary entry: simply visit [www.rcgp-curriculum.org.uk/](http://www.rcgp-curriculum.org.uk/) and click on the Diary Project tab for more information and the diary entry form.

Pick a day which you would like to reflect upon (February 23 – March 1 2009), write your diary entry and hit 'submit' to anonymously add your diary to the archive.

The diary entries we receive provide a rich resource for future researchers to understand the experiences of working with the GP curriculum at this point in history, and right now provide key insights for the teams working at implementing and developing the curriculum. We hope you will take this opportunity to share a glimpse of the GP curriculum at work in 2009 – we really do need you.

To get involved visit [www.rcgp-curriculum.org.uk](http://www.rcgp-curriculum.org.uk) or email [diaryproject@rcgp.org.uk](mailto:diaryproject@rcgp.org.uk)

RCGP News invites your comments or letters...

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