

# Sheffield says no to polyclinics

**A 'one size fits all' approach to healthcare will result in patients having to travel further, the loss of continuity of care and an unnecessary duplication of existing primary care services.**

That was the resounding verdict of patient groups and healthcare professionals at a public meeting organised by Sheffield Faculty to debate Lord Darzi's review of the NHS.

Led by Dr Janet Hall – Sheffield Faculty representative on RCGP Council – and Ailsa Donnelly, Chair of the College Patient Partnership Group (PPG), around 30 people attended the meeting to hear about the proposed changes to the NHS and the potential implications for patients and general practice.

Dr Hall and colleague Dr Louise Moss introduced the meeting with a short history of the NHS review, the related concerns and the concept of polyclinics.

Although 'super surgeries' could offer more choice, a wider range of services and a solution for some deprived areas, they expressed their unease about a 'one size fits all' approach.

GPs would naturally welcome NHS reform and investment and there was massive potential to change primary care services for the better, they said.

Implementation should, however, be GP-led, following the

recommendations outlined in the RCGP *Roadmap* document, with patient needs always the top priority and the strengths and values of general practice, such as personal registration and a multidisciplinary team approach, being safeguarded at all costs.

Contributions followed from Ailsa Donnelly, RCGP Vice-Chair Dr Clare Gerada and the Head of Primary Care at Sheffield PCT Karen Curran.

PPG Chair Ailsa Donnelly offered examples of how fictional patients such as a healthy commuter, a patient with mental health problems and a pregnant mother would experience a typical polyclinic – with varying results and degrees of patient satisfaction.

Karen Curran from Sheffield PCT, a former practice manager, said she understood the need for change while appreciating the concerns of GPs. She agreed that any changes to primary care in Sheffield needed to be GP-led and explained how her team was already working with local GPs and stakeholders to "find something that fits in Sheffield".

Ms Curran outlined the Trust's plans for a 'walk-in clinic' in the city centre close to a development of new flats to accommodate the needs of the younger workers, but insisted there would be no changes enforced on existing high-quality practices. She did, however, admit that although existing practices



could offer 'Darzi services', they would have to compete with private providers.

Dr Clare Gerada expressed the view that an underlying privatisation agenda was at the heart of the review process and said she was concerned about regular references to the 'American model of good practice'. She claimed that future healthcare services could evolve into a mixed economy, similar to the organisation of university top-up fees, and that this gradual privatisation was already under way with GP practices co-locating with private services.

Dr Gerada concluded with a plea for a louder patient voice in the future of the NHS: "We understand we shouldn't stop progress. Every politician wants to make a difference but it is crucial that general practice is preserved for future generations. As GPs living in our com-

munities, we have a vested interest in providing the best possible care to our patients otherwise they'll come knocking on our doors!"

"The majority of the time, today's general practice works really well but GPs need patients' help in understanding and responding to government plans. You, your family, your friends and future generations risk losing cost-effective, community-based healthcare. The NHS works because of general practice and general practice works because of general practitioners."

A concluding feedback session reinforced the view that general practice should continue to be locally accessible, personal, and the source of a wide range of services to provide effective continuity of care.

Following the meeting, RCGP Chairman Steve Field said: "I

must acknowledge the incredible leadership some of our members have shown in engaging with the Darzi agenda locally.

"The Sheffield Faculty public meeting was an excellent example. I can't emphasise enough how important it is that we do things like this – polyclinics will mean the end of family medicine as we know it and I'm not sure that our patients fully realise this."

The RCGP will be launching a follow-up document to the *Roadmap* this month. Based on a workshop attended by around 25 GPs from around the UK who have a strong interest in federations or who have successfully set up their own federated models, it will provide information on how to implement a federated model whatever the location, size of practice or patient population.

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## Le Delegation Français at Princes Gate



RCGP country Chairs Professor Steve Field, Dr Ken Lawton, Dr Helen Herbert and Dr David Johnston, along with Professor Nigel Sparrow, Chair of the RCGP Professional Development Board, met with a

delegation of French healthcare professionals to discuss the Quality and Outcomes Framework, and outline the College's ideas for a system of revalidation.

## Prestigious international award for former RCGP President

Professor Dame Lesley Southgate, DBE, has been presented with the prestigious 2008 John P. Hubbard Award by the National Board of Medical Examiners (NBME) in Philadelphia.

Dame Lesley secured the award for her innovative approaches to teaching and assessing doctors' communication and clinical skills.

In presenting the award, Bennett L. Levanthal MD, Chairman of the 2008 Hubbard Award Committee, said: "A central theme in Dame Lesley's accomplishments is the development of authentic, high-fidelity and rigorous assessment methods that can be directly applied



in work-based settings.

"Her work in this area has had a huge impact on the organisation of assessment in medicine, particularly of practising physicians in the United Kingdom and internationally."

The John P. Hubbard Award was established in 1983 as a tribute to the creative and inspired leadership of the late principal of the NBME during his 25 years as Chief Executive.

# Accreditation of Primary Care Providers

By Professor Helen Lester, FRCGP and Dr Stephen Campbell PhD, National Primary Care Research Development Centre, University of Manchester

Patients have the right to expect and receive high quality care. There are over 8,500 general practices in England, all providing primary medical care services, currently without any system of accreditation of the quality of organisational aspects of care. Indeed there are no contractual levers to promote quality in this important element of care beyond the voluntary indicators with the Quality and Outcomes Framework (QOF) organisational domain.

The purpose of this proposed, voluntary professionally led, developmental accreditation scheme of non-clinical aspects of care is to (see Figure 1):

1. Enable healthcare providers (that is, General Medical and Personal Medical Services as well as Alternative Provider Medical Services providers) to demonstrate their current standard of practice organisation.
2. Encourage continuous quality improvement within the provider team.
3. Mark the provider as a learning organisation.
4. Enable patients to see and be reassured that their provider is delivering a level of service that is above that required by law.
5. Encourage providers to focus on patient responsiveness and the patient experience.

## How has the accreditation scheme been developed?

Primary Medical Care Provider Accreditation (PMCPA) has been developed using the methodology of the RCGP Quality Team Development (QTD) scheme.

Using the criteria within QTD as a starting point, the accreditation group\* reviewed each criterion in turn and divided them into those that were summative (yes/no) and those that were formative in nature. They also reviewed other international accreditation schemes in primary care (including those in Northern Ireland, mainland Europe, Australia and New Zealand) and recent primary care policy documents, including the RCGP *Roadmap* and Standards for Better Health (SfBH), and against training practice criteria to ensure that the domains in the scheme reflected not only current accepted good practice but also issues that have been highlighted as key for the future development of quality primary care practice. The scheme focuses on organisational rather than clinical issues, although criteria that are organisational but support clinical issues have been included. Each domain was created to include a balance of core summative and developmental formative criteria.

The scheme was also commented on, particularly in terms of omissions, by the RCGP stakeholder group, which comprises representatives from RCGP Northern Ireland, Scotland and Wales, as well as Ailsa Donnelly, Chair of the RCGP Patient Partnership Group, the BMA, GMC, Department of Health in England, Healthcare Commission and others.

## What will the accreditation scheme look like?

The proposed scheme will include three key stages as follows:

1. A pre-entry qualification stage: this consists of contractual criteria that every provider is required to fulfil in law, for example:
  - provide free certificates in certain circumstances
  - ensure staff are fully qualified and receive training to keep skills up to date
  - refer patients where appropriate
  - offer a registration check
  - keep adequate records
  - notify the PCT of deaths on surgery premises
  - co-operate with any investigation
  - hold a register of gifts.
2. A set of 30 core or summative criteria.
3. A set of 82 developmental or formative criteria.

PMCPA has six domains:

- Domain 1 Health Inequalities and Health Promotion
- Domain 2 Provider Management
- Domain 3 Premises, Records, Equipment and Medicines Management
- Domain 4 Provider Teams
- Domain 5 Learning Organisation
- Domain 6 Patient Experience / Involvement

The number of criteria and dimensions within the developmental domains are as shown in the table.

## PMCPA assessment

Each criterion will be supported by evidence against which providers will self-assess. The evidence will then be entered into a real-time website during the pilot. A visiting team (which will include clinical, managerial and lay assessors) will therefore be able to review the evidence prior to the visit.

The RCGP will devolve the assessment process to the Primary Care Trust (PCT), as in the QTD model. RCGP assessor training will include calibration which will help ensure that assessments are valid, reliable, repeatable and equitable. The PCT will assemble the visiting teams, organise the assessment visits and review the evidence. The PCT will also be responsible for ensuring financial support for all aspects of delivery of the system at local level.

## Achieving accreditation status

To be eligible to seek accreditation status, a provider must fulfil the pre-entry legal and contractual criteria. To

DOMAINS AND NUMBER OF CRITERIA PER DOMAIN			
Domain	Number of summative criteria	Formative dimensions	Number of formative criteria
1. Health Inequalities and Health Promotion	2	Health Needs Assessment Children Patient responsiveness Supporting Parents Specific Groups	11
2. Provider Management	6	Roles and Responsibilities Team Member Records Infection Control Managing Performance Policies and Procedures	13
3. Premises, Records, Equipment and Medicines Management	5	Medicines Management Branch Surgeries Information for Team Members Records	13
4. Provider Teams	7	Home Care Patient Responsiveness Patient Safety Team Values and Teamworking	15
5. Learning Organisation	6	Continuous Quality Improvement & Audit Training and Professional Development Patient Complaints Relationships with Other Organisations	17
6. Patient Experience / Involvement	4	Patient Responsiveness Specific Groups Interpersonal continuity Information for Patients Patient and Public Involvement	13

achieve accreditation status they must fulfil each of the 30 summative criteria in the six domains and at least 50 per cent of the formative criteria in each of the six domains (approximately 41 criteria). They will be assessed and accredited at that point.

Each provider must then achieve more of the formative criteria in all domains in a year-on-year fashion from when they were accredited, submitting evidence of achievement annually. The provider will then be revisited three years after initial accreditation and if an agreed percentage of formative criteria have been achieved by the time of this assessment visit, and all summative criteria are still met, they will be re-accredited. This system encourages continuous quality improvement and enables patients to be sure that their provider has achieved high-quality care in all areas.

## Piloting the scheme

Forty providers with differing numbers of doctors and nurses and serving different populations are piloting the scheme from June–November 2008. The providers are part of the following PCTs:

- Haringey
- Nottinghamshire
- Warwickshire
- Oldham

The process of piloting will enable the RCGP to assess:

- which criteria are most/least challenging
- providers' opinions of the domains
- criteria and of the wider assessment process
- PCT views.

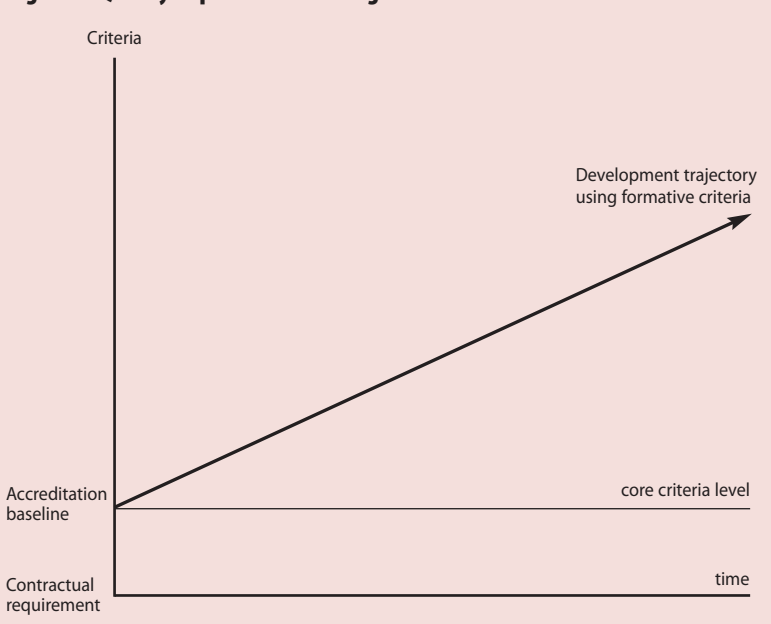
It will also provide opportunity to see areas where criteria are missing and highlight possible new criteria for inclusion.

In addition to completing all summative criteria, each provider will be asked to complete one specified formative domain, which means that each domain will have been tested in at least six providers during the 2008 pilot.

## \* Accreditation Group Members

Dr Stephen Campbell, NPCRDC  
Dr Umesh Chauhan, NPCRDC  
Dr Janet Hall, RCGP Council  
Professor Helen Lester, NPCRDC  
Dr Sathya Naidoo, RCGP  
Professor Nigel Sparrow, RCGP Council  
Dr Bill Taylor, RCGP

Figure 1: Quality improvement through accreditation



# Teams without Walls

The success of providing care closer to home lies in developing 'teams without walls', according to a landmark report launched by the RCGP in collaboration with the Royal College of Physicians and the Royal College of Paediatrics and Child Health.

*Teams without Walls – the value of medical innovation and leadership* suggests that jointly commissioned, integrated health services should be provided by primary and secondary care working together.

Recommending an integrated model of care, where multi-professional teams work across services to manage patients on an agreed care pathway designed by local clinicians, the report stresses the importance of clinical leadership

and says that the incentives and disincentives of Payment by Results need to be re-balanced to bring integrated specialist and generalist care closer to home.

The report also calls for the Department of Health to explore the idea of payment by pathway for an episode of care and annual payments by condition for long-term conditions.

Professor Steve Field, RCGP Chairman, says: "Despite the need for healthcare professionals to work together, the current system based on demand management creates barriers between generalist and specialist practitioners."

"Developing closer working relationships between primary and secondary care clinicians – as

recommended in the RCGP *Roadmap* – will enable us to set up smoother care pathways and provide a wider range of integrated health services. This is particularly important for patients who move frequently between primary and secondary care, such as those with long-term conditions and the elderly."

Dr Rodney Burnham, Registrar of the Royal College of Physicians, says: "*Teams without Walls* celebrates medical innovation and leadership and shows that generalists and consultants can work together effectively in one team with other healthcare professionals. We believe that the Department of Health and commissioners should encourage such

medical innovation and leadership so that patients can benefit from the best clinically integrated care."

Dr Simon Lenton, Vice President for Health Services, Royal College of Paediatrics and Child Health, says: "The future challenge is to align management structures, healthcare financing systems and commissioning strategies to promote this type of collaboration. Patient care needs to be delivered by teams based on pathways within managed networks, unconstrained by traditional or organisational boundaries."

The *Teams without Walls* report can be downloaded from [www.rcgp.org.uk/teamswithoutwalls](http://www.rcgp.org.uk/teamswithoutwalls)

## KEY FEATURES OF SUCCESSFUL INTEGRATED WORKING IDENTIFIED BY THE REPORT

- Clinical leadership and involvement
- High-quality partnership between clinician and professional manager
- Primary and secondary partnerships
- Committed commissioners willing to innovate and fund flexibly
- Clear patient focus for a defined group
- Clear governance arrangements
- Agreed measures and standards to improve the quality and quantity of work.

## ELEMENTS THAT HINDER INTEGRATION

- Clear separation of managerial and clinical aims
- No clinical leadership
- Targets with unintended negative consequences
- A culture of competition rather than collaboration
- Financial flows that encourage efficiency without considering effectiveness
- A 'command and control' ethos that does not value learning.

# The future's bright

RCGP Curriculum Fellow **Dr Ben Riley** talks about his ideas for modernising general practice education, and explains why GPs in the early stages of their career need more support to reach their full potential



His name may not yet be familiar to you, but Ben Riley is a rising star to watch out for.

Despite being a qualified GP for only three years, he is already making his mark as the RCGP Curriculum Development Fellow and is tasked with developing new learning resources to support the College's education and CPD strategies.

Ben first became interested in medical education during his GP registrar year when he identified a need for easily accessible, quality learning resources to help trainees navigate their way through the maze of GP specialty training.

"The biggest challenge I faced during training was coming to terms with the breadth of knowledge and skills required and the uncertainty generated from realising that as a GP you really do need to know a bit about everything," says Ben.

After passing the MRCPGP with distinction, he was eligible to apply for the post of curriculum fellow and, after a rigorous selection process, was appointed to the post, which he has now held for almost two years.

## From being a GP to supporting GPs

Now a part-time GP at a rural practice in Oxfordshire, Ben splits his time between clinical work and the demands of his role at the RCGP.

"I only qualified a few years ago, so although I have lots of other professional interests, my main focus is on becoming a good family doctor," he says. "Also, if you lose touch with clinical practice then it's difficult to produce anything that's going to be useful to practising GPs, and I want to avoid floating off into ivory-tower thinking and developing educational resources that are divorced from dirty day-to-day practice!"

This down-to-earth approach has paid dividends and has contributed to the success of the resources developed to support the launch of the GP curriculum, which will soon enter its second phase.

Ben says: "For the first few months after being appointed curriculum fellow I was just finding out what needed to be done. A number of projects grew out of this and then things really took off.

"We're now coming to the end of the first phase of our curriculum resources plan, which was essentially making sure that the curriculum was accessible. The next step is to re-evaluate our resources, refine them, and then fill in the gaps."

One issue that needs to be addressed, he says, is the tendency of trainers and trainees to focus on the assessment process, the nMRCGP, instead of the curriculum itself.

"It's become obvious that we need to make the link between the assessment and the curriculum more explicit – it's vital that everyone understands how important it is to base their learning on the curriculum," says Ben.

"Trainees have to learn the curriculum, not the logistics of the assessments. As a recent GP registrar I understand how they feel – after all, their future as a GP depends on passing the exams – but to succeed as GPs they need to learn the curriculum, not the assessment process."

Another area we need to address is the mistaken belief that a curriculum is just a boring checklist of topics – we need to emphasise the central role of the core curriculum statement *Being a General Practitioner*, which explains what makes a GP so different from a hospital doctor.

"If you understand the core statement then you can apply it to every other topic," says Ben. "However, we do realise that at the moment it feels quite generic, so we're looking into how we can make it more applicable to real life as a GP."

So far, Ben has led on RCGP education-related projects, including the web-based Curriculum Map and

search engine, and e-GP, an innovative collaboration between the College and e-Learning for Healthcare to create a comprehensive e-learning programme for general practice to support GP training and CPD. The project will launch in August, at the start of the next GP training year, and will then be rolled out to all UK GPs over the following 18 months.

He is also a contributing editor to the new curriculum-based monthly journal for trainees, *InnovAIT*, and has co-authored one of the RCGP's bestselling books, *The Condensed*

*Curriculum Guide*, which has sold over 5,000 copies since its launch six months ago.

"We're very pleased that *The Condensed Curriculum Guide* has been so successful, although my fellow authors and I feel that every GP should have a copy! It was aimed at trainees and educators but deliberately designed to be useful to all GPs at all stages of their career," says Ben.

So successful has the guide been that, due to reader demand, an extract of the self-assessment rating scale it contains has been incorporated into the curriculum website.

"Self-assessment is very big in GP training and CPD because it is an important reflective learning skill that all GPs should be able to do," says Ben. "It also highlights the fact that the curriculum is about translating theory into real practice. If you think you've learnt something new but realise it hasn't changed what you do in practice, then you haven't really learnt it properly."

## But it doesn't stop there . . .

Ben's remit is wider than developing resources for GP trainees and trainers, and he is also RCGP CPD Educational Resources Fellow.

His next big project is to support the CPD strategy for revalidation, where his role will be to help create resources that will assist GPs throughout their careers. As with GP training, Ben points out that the

curriculum will play a central role in CPD and revalidation.

"The curriculum defines the attributes of a competent GP so it is applicable to all GPs,

whatever stage they are at in their career. It's the architecture underpinning GP education from specialty training through to retirement – or death!" he says.

However, he adds that although the basis of training and CPD is the same, the College must take into account the gulf between trainees and established GPs in terms of technical skills and attitudes towards learning.

"Young GPs accept that things have changed – they're a different generation with different expectations. They're used to having to prove their abilities, but much of this seems a bit threatening to the older generation and they may find it more difficult to get to grips with the revalidation side of things.

"There's also the issue of having to learn more than just clinical skills – for example, GPs need business skills and support if they are to compete on a level playing field with private providers. Instead of being defensive, we should take a more aggressive approach. This means putting our profession at the

heart of these new models of healthcare so it is general practice shaping the providers, and not the providers shaping general practice."

## Important College role

"For the College," says Ben, "this means putting innovative structures in place to support GPs who are no longer able to follow the traditional partnership career, including salaried or sessional GPs, and those who choose to work for private providers. This will ensure our profession and our values remain central and strong, whatever the future NHS looks like."

With the GP trainee and the established GP partner being well catered for, Ben highlights an urgent need to recognise those family doctors in the 'middle stage' of their career for whom, he says, there is currently very little in the way of guidance and support.

With a lack of available partnerships, he says, and the temptation of working for private providers a likely prospect, the College must now focus on this group and work out ways to connect with them.

"It can be hard to develop professionally as a salaried GP. Many are happy to be salaried when they first qualify, but then hit a glass ceiling after a few years when they want to progress professionally and make their mark but can't find a route to do so," says Ben.

After an unsuccessful search for a suitable partnership, Ben decided to tackle this problem from a different angle by becoming a portfolio salaried GP, an option he sees as "a viable way forward" for ambitious young doctors who feel they have gone as far as they can down the salaried route and find themselves having to look outside the traditional GP career path.

However, he recognises that this may not be an attractive option for all GPs, and says that the College must step up to the plate and look at new ways of offering career support.

"We need a more structured career path so that targeted support, advice and resources are available to GPs in the period immediately after training and throughout their career.

"During training we receive a lot of help and advice, but when we qualify we're left to make our

way largely on our own. Now that healthcare is becoming more fragmented, I think the College education strategy needs to put more emphasis on supporting newly qualified GPs, to help them build on their core skills and progress to exemplary level, because patients deserve the best quality care we can provide," he says.

"If I'm able to influence the education agenda at the RCGP to help address this need, I'll feel I've done something worthwhile."



## Resources

Copies of the *Condensed Curriculum Guide* can be purchased through the RCGP Bookshop: [www.rcgp.org.uk/acatalog](http://www.rcgp.org.uk/acatalog).

The RCGP Curriculum and Assessment Site is available at [www.rcgp-curriculum.org.uk](http://www.rcgp-curriculum.org.uk). From here you can access all the latest information about the GP Curriculum and nMRCGP, the Curriculum Map and other tools to support your use of the GP Curriculum.

## Calling all GPs – join the pilot for Essential General Practice

The RCGP is launching its first pilot of the EGP Update Programme and we need your help.

Essential General Practice Updates are self-assessment e-learning tools designed to support GPs' continuing CPD. They can be used in annual appraisal and, in due course, recertification.

The Updates focus on new information of national importance and for each EGP Update we will suggest ways that you can reflect on and compare your own practice against the standards and best practice described.

To take part in the first pilot of 20 items, please contact Jacqui Smith by email: [egpfeedback@rcgp.org.uk](mailto:egpfeedback@rcgp.org.uk). You will be sent a registration form and access to the pilot website.

# Primary care: the cornerstone of public health surveillance

By **Dr Alex Elliot**, Primary Care Scientist, RCGP Birmingham Research Unit, and Health Protection Agency, West Midlands and

**Dr Gillian Smith**, Consultant Regional Epidemiologist, Health Protection Agency, West Midlands

## Primary care surveillance

Data derived from primary care have been used for the purpose of public health surveillance for over 40 years. The RCGP Weekly Returns Service (WRS) traditionally provided the mainstay of these surveillance activities. However, in the last decade a number of new and novel systems have been introduced to enhance our ability to track, predict and respond to health protection incidents on a national and regional scale.

and is considered the 'gold standard' for GP sentinel surveillance across Europe. Data collected from the WRS are fed into the HPA national surveillance systems on a weekly basis. In addition, data obtained from the WRS are used to monitor threshold rates of influenza-like illness, which determine the 'trigger' used by the Department of Health for switching on antiviral usage during the winter months.<sup>3</sup>

The WRS also provides a unique opportunity to combine clinical surveillance with integrated microbiological investigation. 'Structured surveillance' allows us to further understand the underlying aetiologies of many commonly diagnosed conditions in general practice, e.g. acute respiratory infections, and gastrointestinal infections in young children.

## NHS Direct

NHS Direct has been operational for seven years. This telephone-based health helpline provides

cases of influenza-like illness diagnosed by GPs of the WRS; these comparisons demonstrate that NHS Direct call data can be more sensitive to the activity of influenza viruses and can provide early warning of rises in the community.<sup>5</sup>

The other main advantages of the NHS Direct/HPA surveillance system are twofold: first, data are timely and can be reported on a daily (and even hourly) basis. In the event of a major public health event, NHS Direct data have provided 'real-time' surveillance. Such real-time data would be available in the event of, for example, an influenza pandemic or bioterrorist attack. Second, NHS Direct is available to the whole population of England and Wales and the data thus cover the whole population rather than being 'sentinel'; data can also be analysed by postcode, which results in a system that provides information at a very local level.

## QSurveillance®

QSurveillance® is a near real-time, sentinel, GP-based surveillance system, similar to the RCGP WRS, utilising data from practices running the EMIS clinical software suite.<sup>6</sup> The largest system of its kind worldwide, QSurveillance® extracts data from over 3,300 practices, covering a population of over 22 million on a daily and weekly basis. Due to its size and representativeness, QSurveillance® is able to monitor a range of diseases at PCT level providing support to those managing disease outbreaks. Alongside the WRS (against which it has been validated), QSurveillance® will help alert to and manage a major public health event such as an influenza pandemic. QSurveillance® is designed to provide daily consultation data for a range of respiratory indicators to facilitate management of the pandemic. QSurveillance® is also able to report on a range of prescribing data, e.g. cases of influenza-like illness with antivirals, uptake of vaccines in patients at risk, treated conjunctivitis, treated cellulitis, treated impetigo, etc., and also be used to investigate rapidly unexpected drug safety issues and respond to other urgent public health problems.

## Putting theory into practice

These primary care systems provide routine analyses on a weekly basis during 'peace time'. There have been, in the past few years, events where this surveillance was stepped up in response to major public health incidents.

## Ricin – 2003

In January 2003, traces of the chemical poison ricin were found in an apartment in North London. The NHS Direct/HPA surveillance scheme was used to provide enhanced surveillance of the affected areas: data were collected on difficulty in breathing, fever and cough, and were updated every two hours. NHS Direct data and other data sources demonstrated no evidence of any untoward increase in community symptoms.

## Buncefield Oil Depot explosion – 2005

In December 2005 the Buncefield Oil Depot in Hemel Hempstead exploded, resulting in the largest fire recorded in Europe since the Second World War.

The smoke plume could be clearly seen over London and the southeast of England, eventually reaching France and Portugal. Primary care surveillance was used to produce daily reports from affected areas, with QSurveillance® (previously known as QFlu®) providing data at PCT level for the first time; of interest were respiratory conditions and cardiovascular complications. Prevailing weather conditions limited the potential exposure to the smoke plume, and primary care surveillance systems and other data sources were unable to identify any effects on public health in affected areas.

## Flooding – 2007

During the summer of 2007, large areas of Northern and Central England were subject to severe flooding. Primary care surveillance systems were used to monitor the population at risk for increased cases of gastrointestinal infections, skin complaints, insect bites and other conditions thought to be related to the incident. No significant rises were detected; however, using the RCGP WRS it has been possible to maintain surveillance of long-term effects, e.g. psychological trauma of the flooding.

## The future

The systems incorporated in primary care surveillance are continually evolving. Government preparations for the next influenza pandemic will rely heavily on primary care surveillance to alert to rising numbers of influenza cases in the early stages of the pandemic, and will also be important in providing real-time estimates of the burden of disease during the pandemic. The use of structured surveillance (RCGP WRS) will also provide integrated microbiological results from clinical cases of pandemic influenza alerting to changes in the virus structure (influencing pandemic vaccine design) and antiviral susceptibility of circulating viruses (affecting patient management strategies). New 'syndromic' surveillance systems monitoring data from GP out-of-hours systems and over-the-counter pharmacy sales may also yet play a future role in the national systems to monitor trends in acute illness in our community.

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Buncefield Oil Depot fire, December 2005. © Chilern Air Support Unit

The effective management of infectious diseases and the ability to respond to health protection emergencies depends on good surveillance. The surveillance of infection and of other threats to public health in primary care and the community forms a cornerstone of health protection surveillance. The Health Protection Agency (HPA) houses the Primary Care Surveillance Team; this is a small team based in Birmingham which takes a national lead for the HPA on health protection surveillance in primary care.<sup>1</sup> The team work in close collaboration with other organisations, such as the RCGP Birmingham Research Unit, NHS Direct and QSurveillance® (EMIS/Nottingham University), as well as other HPA centres and academic units.

## The RCGP Weekly Returns Service

As has been featured in recent issues of *RCGP News*, the WRS is a sentinel GP surveillance system coordinated by staff at the RCGP Birmingham Research Unit.<sup>2</sup> It has provided a continuous community-based disease-monitoring service for over 40 years

nurse-led health information to callers, resulting in call outcomes that can range from immediate 999 response, to obtaining pharmacy advice for minor complaints.<sup>4</sup> The HPA and NHS Direct have worked closely to create a unique 'syndromic' surveillance system, utilising the call data collected by a network of call centres located across the UK. Information provided by callers is categorised using a series of clinical algorithms that have a specific outcome; there are over 30 algorithms currently used by NHS Direct that are subject to constant review and change. For surveillance purposes, call data are routinely analysed for ten core syndromes, including cold/influenza, fever, cough, diarrhoea, vomiting, difficulty breathing, double vision, eye problems, rash, and lumps. Call numbers for each syndrome are calculated as a percentage of the total calls received. These call proportions have been validated using data from other surveillance systems and modelled mathematically using laboratory reports of related pathogens. For example, proportions of calls for cold/influenza have been compared with



Flooding in Oxfordshire, July 2007. © Health Protection Agency, Jane Bradley

# RCGP supporting you in keeping up to date –

## EGP Updates and much more

By **Professor Ruth Chambers**, Clinical Lead Managed CPD and Essential General Practice for the RCGP;

**Professor Nigel Sparrow**, Chair of the RCGP Professional Development Board and

**Dr John C. Howard**, Vice Chair, RCGP Professional Development Board

Many other medical Royal Colleges, both in the UK and internationally, run CPD programmes for members. In fact the UK is behind in this area – most developed economies require doctors to undertake CPD programmes run by the relevant professional body. The RCGP supports CPD through masterclasses and a range of awards and Faculty/College events across the UK. Now it's going a step further – evolving and piloting the Essential General Practice (EGP) Update programme for GPs. This should be useful to all GPs, whatever their work setting or stage of career; it should help those on career breaks to keep in touch and those working overseas to stay up to date with what's going on in UK practice.

### So how does the EGP Update programme fit in?

EGP Updates are all about trying to present GPs with a synopsis of new and changing knowledge and information about all aspects of practice, from clinical to organisational matters. The scheme will sift the plethora of national guidance, research publications, reviews of evidence and legislation to focus on what is 'not to be missed' information that a GP should apply in their everyday practice.

Essential General Practice is one of the core components of the RCGP approach to recertification – helping GPs to keep up to date and to demonstrate that they are up to date.

Keeping up to date isn't just about new and changing information. It's also about applying that knowledge and information in practice. The first pilot EGP Update will cover current best practice in:

- Atopic eczema in children
- Deep vein thrombosis
- Inhaled corticosteroids for children with chronic asthma
- Ezetimibe for the treatment of primary hypercholesterolaemia
- Opioids for chronic low back pain
- Secondary prevention following a myocardial infarction
- Assessment of pain in older people
- Menorrhagia
- Varenicline for smoking cessation
- Urinary tract infection in children
- And 10 more topics

The online programme will cover each item and will include key points and a clinical scenario that brings out the essential information about best practice for a GP to self-assess their knowledge of the topic.

Take a look at Box 1 for an example of such a scenario and the linked test questions (answers in brackets). You can opt to work through all the scenarios with their test questions before you start the EGP Update programme so that you can select the topics for which you appear to have learning needs. Or you can complete the scenario/questions in each EGP Update item as you work systematically through all of the items if you wish – probably reading through and reflecting on one item at a time in 20-minute chunks. You might delve into the original source of evidence upon which the EGP Update item is based if you want to know more, or read about the wider context in one of the hyperlinked references in the Further Reading section.

Applying your knowledge is what it's all about, so each of the 20 EGP Update items has a suggestion for how you might compare what you do as a GP with the best practice relayed in that EGP Update item.

### Box 1: Example of clinical scenario in relation to secondary prevention after a patient has had a myocardial infarction (extracted from EGP Update 1)

#### Clinical scenario

*Mr Smith, a 56-year-old HGV driver, comes to see you in surgery. He was discharged from hospital last week. According to the discharge note, he suffered a myocardial infarction five days previously for which he has received thrombolysis. His discharge medication was aspirin, clopidogrel and atenolol. Since discharge, he has developed some shortness of breath, particularly at night, but has had no chest pain. Before going into hospital, he smoked 40 cigarettes per day. His blood pressure today in surgery is 160/95 and 165/95.*

**What do you do now?** (Correct answers in brackets)

**Stop clopidogrel on cost grounds?** (No – he should continue clopidogrel for four weeks as he will have had ST-elevation with his MI).

**Stop the beta-blocker?** (No – beta-blockers are beneficial post-MI and in heart failure, which is the likely cause of his shortness of breath).

**Start an ACE inhibitor?** (Yes – an ACE inhibitor is beneficial for the heart after an MI, for patients with and without left ventricular dysfunction and will help to reduce his blood pressure too. Check his renal function first and again after one to two weeks of therapy).

**Start an aldosterone antagonist?** (Yes – for symptoms or signs of left ventricular dysfunction, 3–14 days after an MI, preferably after you have started the ACE inhibitor).

**Check that a cardiology follow-up appointment has been arranged?** (Yes – this patient will need exercise tests and angiography with a view to having an angioplasty or revascularisation).

**Advise him to return to work as soon as he feels well enough?** (No – early return to work is good, but this man drives an HGV, and therefore must be advised not to return to his old job of driving until exercise investigations have shown that he can be relicensed. He could consider retraining for a different career as an alternative way forward).

### Credit where credit's due

You will get guidance in how to self-accredit your learning within the EGP Update programme. You might include the learning from the exercises you do comparing your own practice against the EGP Update key points of best practice, as well as the time taken to read and reflect and self-assess your knowledge through the clinical scenarios.

### There's a wide range of RCGP knowledge and information resources already available

EGP is just one of the many types of support the RCGP provides to help GPs keep up to date. Most College members are probably not aware of the strength and range of the information and library resources within the RCGP from which GPs can obtain knowledge and information about best practice. Box 2 summarises some of the RCGP resources that you can access now or that will soon be available.

### Box 2: Information and resources for RCGP members or Associates in Training

1. Knowledge and Information resources – already existing and being evolved: Enquiry Service (phone and email); *Journal Watch*; *Seven Days*, e-bulletin, information sheets and summaries; full text journal search facility for members, non-clinical guidance database (scans 80+ key websites for new/updated guidance), ethics database, patient centre work, useful links (20+ categories with approx. five links to reliable sources of information for GPs in each; reviewed and updated three times per year).

2. British Journal of General Practice (BJGP) – our renowned College journal has the highest impact rating of any international journal of general practice.

3. The Phased Evaluation Programme (PEP) e-kit and nPEP from RCGP Scotland are multiple-choice-based knowledge self-assessment packages. Any GP in the UK can use them – they're good so take a look: [www.pep-ekit.org.uk](http://www.pep-ekit.org.uk).

4. RCGP Curriculum Series books – a range of RCGP publications being developed for the Curriculum and nMRCGP. [www.rcgp.org.uk/acatalog](http://www.rcgp.org.uk/acatalog).

5. The Clinical Innovation and Research Centre (CIRC) is developing a GP Expert Reference resource with members from its clinical and research programmes in the first instance.

6. Four clinical champions appointed to CIRC lead in the areas of: prescribing, urgent and emergency care, palliative and end of life care, mental health. Four more to be recruited in 2008.

7. Masterclasses / supporting materials – there's always a list advertised in the *BJGP*.

8. e-Learning modules – e.g. from the RCGP Substance Misuse Unit; MS and Migraine packages developed from the RCGP Bath Learning Unit materials.

9. The e-Portfolio for GPSTs – concepts from this will guide the development of an e-Portfolio for established GPs

10. Materials associated with GPWSIs – frameworks for appointment and re-accreditation including curriculum content.

11. e-GP – a comprehensive programme of e-learning modules to support blended learning of the RCGP curriculum; each of the GP curriculum statements will be underpinned by modules consisting of short, interactive learning sessions, written by experts in the topic: [www.e-lfh.org.uk/Projects/General-Practitioners.aspx](http://www.e-lfh.org.uk/Projects/General-Practitioners.aspx).

12. *InnovAiT*, the new monthly RCGP educational journal for Associates in Training (AiTs): [www.oxfordjournals.org/our\\_journals/innovait](http://www.oxfordjournals.org/our_journals/innovait).

13. The Curriculum Map – a searchable map of the RCGP curriculum mapped to online guidance and resources: [www.rcgp-curriculum.org.uk](http://www.rcgp-curriculum.org.uk).

14. RCGP postgraduate qualifications such as the Certificate in Substance Misuse.

15. The Map of Medicine project. This will have a decision support system on practice computers that flags up resources relevant to GPs' practice; it is part of the National Programme for IT.

16. Toolkits to support appraisal, CPD, personal learning and clinical governance in Wales and Scotland.

### Stunning, isn't it?

Take a look at these resources. Go to the library and information team ([info@rcgp.org.uk](mailto:info@rcgp.org.uk)) if you want help accessing any of the sources described here. Make the most of your College membership. Help us to help you – join in the EGP pilot and give us feedback about the first Update to help us develop the EGP programme to match what GPs need and want.

## The importance of genetics in primary care

Family doctors must continue to make the best use of advancing genetics knowledge to improve diagnosis, prevention and treatment of disease – that was the message to the profession from RCGP Chairman Professor Steve Field.

Professor Field was responding to the Department of Health's progress review on the implementation of the 2003 genetics White Paper, which highlighted the key achievements of £70 million of investment including the establishment of the UK Genetic Testing Network and the National Genetics Education and Development Centre.

Professor Field said: "GPs have been involved in the detection and management of genetic diseases for many years and with advances in genetics knowledge, this role will increase.

"Many features of general practice are particularly relevant to genetics, for example counselling, screening and health promotion, and an understanding of the impact of disease on patients and their families. We must all be committed to working towards realising the vast potential of genetics in primary care for the good of our patients and the population as a whole."

Recognising the growing importance of genetics in primary care, and the need to support GPs in diagnosing and treating patients with genetic diseases, the RCGP has included in its training curriculum a core statement 'Genetics in Primary Care', written in conjunction with the National Genetics Education and Development Centre. The curriculum statement provides the key information needed to identify patients with genetic conditions, refer appropriately and to prepare for future clinical advances.

Later in the year, the College will publish a book on genetics in primary care. Teaching sessions will be held at the RCGP's October national conference.

## New care guide for Charcot-Marie-Tooth

A care guide on the management of Charcot-Marie-Tooth (CMT) disease has been launched by patient support group CMT UK.

A non-life threatening but progressive disease that affects the peripheral nerves, CMT is the most commonly inherited neurological condition, affecting around 25,000 people in the UK.

The *CMT Good Care Guide, Working Together with Your Healthcare Team* includes information for both patients and health professionals, such as how GPs can support patients with the condition and what should be done to prevent and treat complications of the disease.

Karen Butcher, secretary of CMT UK, says: "The idea that this disease is untreatable is no longer the case. Various therapies and treatments can lessen the impact of CMT and improve the quality of people's lives. Our members want to make sure they get all the help they can from their GPs and this guide is designed to help doctors work out with each patient how to establish the best care plan."

For more information call 0800 652 6316, email [secretary@cmt.org.uk](mailto:secretary@cmt.org.uk) or visit [www.cmt.org.uk](http://www.cmt.org.uk)

## RCGP Vice-Chair receives RCP fellowship

RCGP Vice-Chair Clare Gerada will be awarded a Fellowship of the Royal College of Physicians in July. A GP in Lambeth, Dr Gerada is already a Fellow of the RCGP and a Member of the Royal College of Psychiatrists.

She says: "It is a great honour to be awarded a Fellow of the RCP, both personally and professionally. I look forward to working on a number of projects with the RCP in the future."

## Mental illness and disability law in your practice

Mental health charity Rethink has produced a guide for GPs on mental health and disability law.

*What's reasonable? Mental illness and disability law in your practice* is based on the result of a joint Rethink and RCGP brainstorming event involving mental health service users, carers, GPs and practice staff. The report offers practical examples of how to make 'reasonable adjustments' for patients with a mental illness and the people who care for them so that GP practices can fulfil their legal obligations under the Disability Discrimination Act.

The report can be downloaded from [www.rethink.org](http://www.rethink.org), or by contacting Michelle Smith [michelle.smith@rethink.org](mailto:michelle.smith@rethink.org) / 020 7330 9123.

## Two in a row

The Riverside Practice from Inverness has achieved its second Quality Practice Award.

Dr Andrea Henderson said: "We didn't undertake the process lightly but as we already had a lot of the protocols in place, it was slightly more straightforward."

Practice staff celebrated with a dinner at Culloden House Hotel, where Bonnie Prince Charlie stayed the night before the Battle of Culloden.



# Dementia

By Dr Louise R Newson, GP, West Midlands

Dementia is common and its prevalence increases with age. Approximately 5 per cent of people aged 65 and over have some form of dementia. This rises to about 20 per cent by 80 years and nears one in three by 90 years. A report from the Alzheimer's Society estimated that there are currently 700,000 people with dementia in the UK and that this number will grow to over one million by the year 2025.

## 1 Mild cognitive impairment

Mild cognitive impairment refers to the transitional period between normal cognition and dementia, but is not an extension of normal ageing. Those with mild cognitive impairment have subtle but measurable cognitive impairment that is not severe enough to interfere with independent living or fulfill diagnostic criteria for dementia. Studies have shown that approximately 10–15 per cent of patients with mild cognitive impairment progress to Alzheimer's disease each year.<sup>1</sup>

One population study showed that global cognitive impairment with no dementia is not, on its own, a sufficiently valid predictor of dementia.<sup>2</sup> Although people with global cognitive impairment but with no dementia had a three-fold higher risk of developing dementia over three years than unimpaired people, one-third of them improved in cognitive functioning or remained stable with time.

## 2 Types of dementia

The aetiology of the dementia syndromes remains unclear, with different brain structures being affected in different ways. The three main types of dementia are:

### Alzheimer's disease

This is the most common form of dementia. Alzheimer's disease is characterised by a gradual insidious onset and progressive course, often beginning with memory failure before other cognitive functions (e.g. language, praxis) become affected. Non-cognitive features (depression, psychosis, wandering, aggression, incontinence) are common. Physical examination is often normal, as are routine blood investigations.

### Vascular dementia

In contrast to Alzheimer's disease, vascular dementia usually has an abrupt onset, often in association with a stroke and is associated with a fluctuating course, a stepwise decline and reasonable insight in the early stages of illness. An exception to this course is subcortical vascular dementia, which may cause some 20 per cent of all vascular dementia, when sudden onset and a stepwise course may not be seen. Patients will often have risk factors for vascular disease, for example hypertension, cardiovascular disease, diabetes mellitus and hypercholesterolaemia.

### Dementia with Lewy bodies

Dementia with Lewy bodies is characterised by the triad of fluctuating cognitive impairment, recurrent visual hallucinations and spontaneous parkinsonism, though not all occur in every patient. As with Alzheimer's disease, onset is insidious and may begin with cognitive problems, parkinsonism, or both. Cognitive impairment initially affects attentional and visuospatial function, with memory relatively spared. As with Alzheimer's disease, non-cognitive features are common. Parkinsonism consists mainly of bradykinesia rather than tremor.

There are also rare types of dementia, including frontal lobe dementias, Huntington's disease and new variant Creutzfeldt-Jakob's disease. Mixed patterns of dementia types also occur in some patients.

## 3 Diagnosis of dementia

The diagnosis of dementia takes, on average, 18–30 months by GPs. Early diagnosis allows patients and families to adjust both emotionally and practically to the illness. In addition, patients with early dementia are more aware and therefore more able to discuss the future and participate in management decisions.

Making the diagnosis can be difficult and daunting. Investigations should include:

- FBC
- Basic biochemistry (U&Es, calcium, glucose, LFTs)
- TFTs
- Vitamin B12 and folate
- MSU
- Possibly a CXR or ECG depending on the individual circumstances.

Do not test for syphilis or HIV routinely, unless the patient is high risk.

MRI imaging is preferable to CT scanning in detecting vascular changes.

Assessments and screening exercises should include a simple cognitive test such as the Mini Mental State Examination (MMSE) or the Abbreviated Mental Test (Table 1). Alternatives are the 6-item Cognitive Impairment test (6-CIT), the General Practitioner Assessment of Cognition (GPCOG) or the 7-minute screen.

The most commonly used tool is the MMSE, where a score below 26 is suggestive of dementia. Cognitive assessments alone are not sufficient to diagnose dementia, which requires comprehensive physical, psychological and social appraisal of the individual.

The amended NICE guidelines have stated that clinicians should not rely solely on the MMSE test in circumstances where it would be inappropriate to do so (see Table 2).

## 4 Prognosis

Patients with dementia have markedly decreased survival rates compared with those without dementia, and are two to four times more likely to die at a given age than those of the same age without dementia.<sup>3</sup> Even mild cognitive impairment is associated with an increased relative risk of mortality.<sup>4</sup>

One recent study found that the estimated median survival time from onset of dementia to death was 4.1 years for men and 4.6 years for women. However, there was a difference of nearly seven years in survival between the less elderly (ages 65–69 years) and the oldest people (ages >90 years) with dementia.<sup>5</sup>

A patient with suspected dementia should be referred early to the local psychogeriatric team or memory clinic to enable a precise diagnosis and early information, support and treatment if indicated.

## 5 Treatment with acetyl cholinesterase inhibitors for dementia

There are currently three acetyl cholinesterase inhibitors licensed in the UK for Alzheimer's disease:

- Donepezil (Aricept)
- Rivastigmine (Exelon)
- Galantamine (Reminyl).

They may benefit about 50 per cent of patients, but once stopped, the decline in the patient's cognitive function may accelerate. A recent systematic review of 59 trials looking at acetyl cholinesterase inhibitors and memantine (*Ann Intern Med* 2008;148:379–97, 370–8) concluded that these drugs improve cognition but probably not enough to make a significant difference to patients or their carers; they produced small but statistically significant improvements in cognition scores and in doctors' global impressions compared to placebo. There was only patchy data on behaviour and quality of life.

Most of the studies looked at patients with mild or moderate Alzheimer's disease rather than vascular or mixed dementia. The studies were short term and so conclusions about whether medication helps to delay progression of Alzheimer's disease could not be made. The drugs did not benefit patients with mild cognitive impairment.

There has been an ongoing heated debate over recent years between NICE and dementia interest groups regarding the use of medication and cost versus benefits.

Current NICE guidance recommends that patients with Alzheimer's disease (but not mild cognitive impairment or vascular dementia, for which acetyl cholinesterase inhibitors are not licensed) should score between 10 and 20 points on the MMSE to be considered for treatment with acetyl cholinesterase inhibitors – however, see Table 2 for exceptions to this rule. Treatment should be initiated by a specialist.

Patients who are on acetyl cholinesterase inhibitors should be reviewed every six months and the drug should only be continued if the MMSE score remains at or above 10 points AND the patient's global, functional and behavioural condition indicates a worthwhile effect.

## 6 Indications, efficacy and side effects of memantine

Memantine (Ebixa) works by reducing high levels of the neurotransmitter glutamate, which has been shown to be toxic to the memory-important cholinergic neurones. Memantine is not recommended by NICE as an option for people with Alzheimer's disease unless it is being used as part of a clinical trial.

## 7 Dementia and driving

Although the Driver and Vehicle Licensing Agency (DVLA) has the legal responsibility of deciding on medical fitness to drive, general practitioners and specialists have important parts to play.

Whenever dementia is diagnosed it is vital to inquire about the driving status of the patient and to maximise traffic-related health (for example, checking visual acuity, ensuring arthritis does not affect ability, and reviewing medications). The DVLA must be notified by the patient as soon as dementia is diagnosed. Patients with poor short-term memory, disorientation, and lack of insight and judgment are almost certainly not fit to drive. However, in early Alzheimer's disease, where sufficient skills are retained and disease progression is slow, a licence may be issued subject to annual review or a formal driving assessment.

There is an obligation for the doctor to disclose the diagnosis of dementia to the DVLA if the patient refuses to tell the DVLA themselves. The doctor should first write to the patient to inform them of this.

## 8 Behavioural and psychological symptoms in dementia

'Non-cognitive' features of dementia, which are often extremely upsetting for family, carers and friends, are referred to as behavioural and psychological symptoms in dementia (BPSD).

It has been estimated that 20 per cent of patients with Alzheimer's disease will have BPSD; however, 80 per cent of those with dementia in care will have BPSD. The development of BPSD is associated with a worse prognosis and a more rapid rate of illness progression.

There is limited evidence to support the use of atypical antipsychotics in the treatment of BPSD. They are not licensed for this use. An approximately three-fold increased risk of cerebrovascular events, including stroke, has been seen in randomised controlled trials in patients with dementia given atypical antipsychotics.

The Royal College of Psychiatrists only recommends drugs for BPSD in the following situations:

- Where drugs have a specific indication (e.g. depression or psychosis)
- Where the problem symptom is severe and treatment is needed quickly (e.g. serious behaviour problems)

NICE guidance makes the following specific recommendations:

- Do NOT use antipsychotic drugs for mild-to-moderate BPSD in:
    - Patients with Lewy body dementia (because of the risk of severe adverse effects)
    - Patients with Alzheimer's disease, vascular dementia or mixed dementia (because of the risk of stroke and death) and
    - Reserve antipsychotics for severe symptoms only and first address issues such as cerebrovascular risk factors and monitor adverse effects on cognition.
  - Consider acetylcholinesterase inhibitors for significant non-cognitive symptoms in:
    - Patients with Lewy body dementia
    - Patients with mild, moderate or severe Alzheimer's disease where antipsychotics are inappropriate or ineffective and where non-pharmacological treatment has failed
- but
- Do not use them for patients with vascular dementia.

## 9 Depression and dementia

Depression causes unnecessary disability in about two-thirds of people with dementia. Dementia may cause depression either by direct effects of the underlying pathology that controls normal mood or alternatively there may be psychological mechanisms leading to depression. It is important to identify depression and offer treatment for it as this may considerably benefit both patients and their families.

## 10 The Mental Capacity Act

The Mental Capacity Act 2005 came fully into force on 1 October 2007. It aims to protect people who cannot make decisions for themselves due to a learning disability or a mental health condition, for example Alzheimer's disease, or for any other reason. It provides clear guidelines for carers and professionals about who can take decisions in which situations.

The Act intends to protect people who lose the capacity to make their own decisions. It will:

- Allow the person, while they are still able, to appoint someone (for example a trusted relative or friend) to make decisions on their behalf once they lose the ability to do so. This will mean they can make decisions on the person's health and personal welfare. Previously, the law only covered financial matters.
- Ensure that decisions that are made on the person's behalf are in their best interests. The Act provides a checklist of things that decision makers must work through.
- Introduce a Code of Practice for people such as healthcare workers who support people who have lost the capacity to make their own decisions.

People with no one to act for them will also be able to leave instructions for their care under the new provisions.

### Useful websites

Information about the Mental Capacity Act:  
[www.publicguardian.gov.uk/mca/mca.htm](http://www.publicguardian.gov.uk/mca/mca.htm)  
 Royal College of Psychiatrists: [www.rcpsych.ac.uk](http://www.rcpsych.ac.uk)  
 The Alzheimer's Society: [www.alzheimers.org.uk](http://www.alzheimers.org.uk)

### References

1. *International Psychogeriatrics* 1997; 9:65–69.
2. *Am J Psychiatry* 2002; 159:436–442.
3. *Alzheimer Dis Assoc Disord* 2005;19:178–83.
4. *Dement Geriatr Cogn Disord* 2006;21:403–10.
5. *BMJ* 2008; 336:258–262.

Table 1: Abbreviated Mental Test score

#### The 10-point test:

1. Age: must be correct.
2. Time: correct to nearest hour without looking at time.
3. 42 West St: give this address and check registration; check memory at end of test.
4. Month: exact.
5. Year: exact; previous year fine in Jan/Feb.
6. Location name: if not in hospital, type of place or area of town.
7. Date of birth: exact.
8. Start of World War I: exact.
9. Name of present monarch: exact.
10. Count backwards down from 20 to 1: patient can hesitate and self-correct; can give prompts for 20,19,18.

#### What it means:

- ✓ Score 8–10: normal.
- ✓ Score 7: probably abnormal.
- ✓ Score <7: abnormal.

Table 2: People for whom the MMSE score may be unreliable

- Those who are not fluent in English
- Those who score >20 but who have moderate dementia as judged by significant deterioration in functional ability and social functioning compared with pre-morbid ability
- Those who score <10 but have only moderate dementia according to the above criteria
- Those who have learning difficulties (there are other tests available for these people, including the Cambridge Cognitive Examination).

# Taking the mystery out of PQQs

By Dr Clare Gerada, Vice-Chair, RCGP

## What is a PQQ?

A PQQ or pre-qualification questionnaire is essentially your practice's CV and is the first stage in the tendering process. A PQQ will be used to sift out applicants invited to submit the full tender.

## What information is required for a PQQ?

A PQQ needs to reflect the following:

- Who are you?
- What have you done?
- Why do you want the tender?
- Why you?
- Proof you can do it, e.g. 'Here's something I did earlier.'

## Is there a set format for a PQQ?

On the whole there will be a pro-forma accompanying most PQQs. If not, then there will be a series of specific questions that you will need to address. Most of the questions relate to:

- who you are
- what you have done
- why you want the tender
- why you
- prove it.

There is nothing magic in this. Getting the evidence together takes time and it is worth starting the whole process with a brainstorming session and developing the 'vision thing'. Look at the strengths and weaknesses of your practice. Where do you think you want to be in three years' time (five is too far away)? Where you are now? What is blocking your advancement and what resources (people, premises, resources) do you need to help realise your vision?

Also at this stage, see if you can recruit someone for the short term to help put your bid together – or at least to give advice on the PQQ and tender. There are many former and current Primary Care Trust (PCT) employers who are more than capable of helping out (for a fee), and if you approach a neighbouring PCT they might even have been involved first hand in a tender process. However, only you can write the tender, only you know your practice, and only you will have the energy, commitment and drive to get a PQQ together.

## Are there any special features about writing PQQs?

The pro-forma might dictate the number of pages required, word count, etc. It will almost certainly ask pretty standard questions about your current set-up, previous experience and what you plan to do with the new tender. It will also ask for information about financial viability.

Read the information accompanying the tender. Highlight any special features in the tender that might influence whether you want to proceed at this stage. For example, has the practice got a building or do you need to locate one? Does the tender specify hours that the service needs to be delivered, for example 8 a.m.–8 p.m. Are you happy with this? Read the deadline for submission and any special instructions (for example, send by email only, send two copies, etc). Also read when the full tender document needs to be submitted and when the interviews will be. If you think you stand a chance you might need to cancel your annual leave!

## How long does it take to write a PQQ?

How long is a piece of string? A PQQ is the pre-tender questionnaire and by definition is a much shorter document than the full tender. The PQQ is the screening document. However, it *will* take you time. My estimate is that it takes around 5–10 days' worth of work. Most of this work can be done in the evenings or weekends, but it is good to

get an agreement that the main writer can have time off from normal surgery duties.

## How do we start?

At the start do a brief project plan, for example:

Key date	Milestone	Action
1 May 2008	Get going	Partners' meeting to decide 'vision' Divvy up sections Appoint a lead writer Identify support for admin. issues Identify lead for financial section Brainstorm <i>why us?</i>
10 May	1st draft	Identify referees
20 May	2nd draft	Practice meeting to finalise work and ensure on track
1 June	Finance draft	Meet with accountants Check figures Check document Get someone other than the main writer to read
5 June	Final draft	Get paper to print Get folders Jane to proofread Peter to finalise financial sections
9 June	Submission	Mary to deliver by hand

If you are to do this as a group, perhaps a Practice-Based Commissioning (PBC) group, then make sure you are all signed up to the vision.

Give the lead writer time off to write the document. The main sections of a PQQ vary but generally are:

1. details of the bidder
2. legal and regulatory
3. financial information
4. clinical capacity and capability
5. general capacity and capability
6. declaration
7. references
8. bank contact details
9. appendices.

*Don't be frightened!*

You can do this! Just tell who you are, what you have done before, what you are going to deliver and provide proof that you can do it. I tend to free-associate and just fill each section with as much information as I can, not worrying too much at this stage about format, structure or language, instead focusing on getting something down. It's a little like doing finals. Just answer each question. You know the answers. There is no mystery to this.

## What sort of details should we be providing?

Provide details of previous occasions where your team or any of its members has worked together in healthcare-related projects in recent years. For example, describe what you have done, who was involved, what you did and so forth. So, for example, describe your General Medical Services (GMS) or Personal Medical Services (PMS) practice. What size is it? How long has it been in existence? What services do you provide? What additional services have you been commissioned to provide (for example, care

of violent patients, drug users, level 2 sexual health services). The more you can add the better. Think of any services that you provide but which are outside the practice – for example, have you set up a teaching programme? Do you provide services to a care home? Were you involved in setting up the out-of-hours co-operative?

## What do we put in the financial section?

Don't be frightened. Ring your accountant or go and talk to him or her. Don't be frightened by the finance section. As an existing practice you have the turnover required. Do not be tempted to under-cost the bid. The PCT does not need to go with the lowest bid. By all means use economies of scale to reduce costs, for example sharing back-office functions (HR, IT, cleaning, key holding) between the existing practice and your new one, but do not under-bid for staff where they are only able to be on one site at any one time (for example, doctors and nurses). Opening 12 hours per day five days per week is expensive, and you should not underestimate this. If the successful applicant fudges the real costs in order to get the bid then this could be open to legal challenge.

## What do we say about our general capacity and capability?

Give lots of examples and think about the following areas where you can demonstrate that you have made a difference. Don't be frightened – you have evidence in this area. Just think of everything your practice has done in the last ten years. Think of the patient groups you have had, of the General Practitioner with a Special Interest (GPwSI) service you developed, of the local practice you helped get off the ground, of your work on the Local Medical Committee (LMC) or PBC group, of your teaching and training experience. Consider using the following headings and examples:

	What we have done	What we will do
<i>Clinical development</i>	We have set up a GPwSI service in ...	We will ... use the GPwSI doctor to ...
	We scored xxxx/1000 QoF	We will improve QOF by ...
	We are a training practice	We will target the hard-to-reach by...
<i>Improving quality</i>		
<i>Practice development</i>		
<i>Delivering innovation</i>		
<i>Sharing resources</i>		
<i>Working with the community</i>		
<i>Experience in setting up out-of-hours services</i>		
<i>Experience in strategic working</i>		

## What else should we think about?

- Don't use jargon.
- Use the third person, the *surgery name* (not 'I' or 'we').
- Use pictures.
- Use 1.5 spacing.
- Use 11 point font size.
- Use a good typeface, such as Georgia.
- Answer all the questions.
- If they want two copies, send two copies.

And finally, a tip – leave all formatting to the end. If several people are working on the same document at the same time, date and time each document at the top of the first page and save with initials.

*Good luck!*

# Pensions boost for overseas volunteers

The government has recently announced it will be supporting public service workers who volunteer their skills overseas with a fund to pay pension contributions.

GPs who choose to share their skills and give their time to help some of the poorest and most disadvantaged people in developing countries previously missed out on pension contributions when they volunteered. The new fund will ensure that GPs' pension contributions are maintained whilst they are volunteering overseas.

International development charity VSO hailed the fund of £13 million as a strong endorsement of international volunteering.

VSO is the world's leading international development organisation working through skilled volunteers. With 3,300 volunteers in 49 countries since 1958, health volunteers are a crucial part of VSO's work overseas.

The charity aims to support disadvantaged people in fulfilling their rights to physical, mental and social well-being and to accessing good-quality essential services. Seven of VSO's country programmes have a specific health goal, and 20 programmes work on HIV and AIDS in Africa, Asia and the Pacific.

Today, 10 per cent of all VSO volunteers are from health backgrounds, a figure VSO hopes to increase through the government's pension support for public service health workers.

Two recent GP volunteers are Dr Jason Christopher, from Kent, and Dr June McIntyre, from Glasgow.

Jason Christopher swapped Kent for Kampala in Uganda to work for Reach Out, a community-based organisation caring for people living with HIV and AIDS.

He says: "Reach Out started in 2001 with one doctor doing home

visits one day a week for ten clients living with HIV and AIDS. Now there are 1,800 HIV-positive clients, with over 780 receiving free life-saving antiretroviral drugs (ARVs) in a holistic package delivered by 230 workers.

"I felt lucky to have been placed in such a great organisation. Reach Out has arisen from community initiative in a low-resource setting. Money hasn't gone on vehicles, buildings and extras – even the nurse-run clinic still operates from an empty church room.

"The typical new client at Reach Out is a sick 35-year-old jobless widow, often homeless, yet caring for several of her own children and several from extended family members who have been orphaned because of AIDS. Her needs cannot be met by ARV drugs alone, which do not work in somebody who has no food. Hence the importance

of holistic care, where consideration is given to the wider needs.

"About half of my time was spent in the clinic where 150–200 clients are seen each day by eight to ten nurses. I would rotate amongst the nurses, observing their practice and informally training individuals or pairs. This exposed many areas of training need, such as use of ARVs, history-taking and examination, consultation and communication skills, use of sputum testing to diagnose TB, awareness of extra-pulmonary TB, how to diagnose opportunistic infections, awareness of drug side-effects and more.

"These topics were covered by a six-month training programme of weekly seminars which I facilitated. The senior nurses and I also established weekly case presentations where a nurse presents for general discussion a case which they found difficult or illustrates



some area of deficiency of the clinic. I tried to assist the nurses rather than do everything myself, which passes on no knowledge. If I had a personal working motto it would be 'Jason – don't do any work by yourself.'

"Reach Out is an uplifting place to work, with many young people, much singing, fun and laughter – a far cry from the gloomy picture many of my UK

friends and colleagues imagined when I told them I was going to work in an African AIDS clinic. The warmth and tenderness my colleagues have with each other and me gives a family feel to the workplace I hadn't had in any of my past medical placements. I plan to continue into a career of public health in developing

*continued on page 8* ➤

# Antenatal care – routine care for the healthy pregnant woman

NICE Clinical guideline no. 62, March 2008

By Dr Rupal Shah, Clinical Editor, RCGP News

## Recommended schedule of visits

NICE recommends only ten antenatal visits for women in their first (uncomplicated) pregnancy and seven in subsequent pregnancies, since there is no evidence that care is improved by the woman being seen more frequently. Women do not need to be seen by a consultant if the pregnancy is uncomplicated.

## Ultrasound screening in pregnancy

Routine ultrasound foetal size estimation for suspected large-for-gestational-age babies is no longer recommended.

An early scan is recommended for all women (ideally between 10 and 13 weeks, possibly combined with the nuchal scan), to confirm dates and exclude multiple pregnancies.

The nuchal scan can be done between 11 weeks and 13 weeks and 6 days.

The anomaly scan is usually done between 18 weeks and 20 weeks and 6 days.

Women in whom the placenta extends across the internal os at the 20-week scan should be rescanned at 32 weeks.

## Alcohol

NICE recommends that women should avoid alcohol during the first trimester, then consume no more than 1–2 units once or twice a week.

## Nausea and vomiting

Natural remedies that are recommended are ginger and acupressure on the 'p6' point (3 fingerbreadths proximal to the wrist, on the volar aspect of the forearm). If medication is necessary, use antihistamines as a first line (promethazine or prochlorperazine).

## Screening for haematological conditions

All women should be screened for sickle cell diseases and thalassaemia. This should be done as early as possible in the pregnancy.

## Vitamin D supplementation

Women should be advised about the dangers of vitamin D deficiency during pregnancy and when breastfeeding. They may choose to take a supplement of 10mcg vitamin D per day. Particular care should be taken when assessing women who are likely to be at higher risk of vitamin D deficiency (women of South Asian, Afro-Caribbean or Middle Eastern descent).

## Testing for gestational diabetes

Routine glucose tolerance testing is no longer recommended by NICE unless the woman falls into one of the following groups who are at high risk of gestational diabetes:

- South Asian descent (specifically women whose family originates from India, Pakistan or Bangladesh)
- Afro-Caribbean descent
- Middle Eastern descent (Saudi Arabia, United Arab Emirates, Iraq, Jordan, Syria, Lebanon,

Oman, Qatar, Kuwait or Egypt)

- Family history of diabetes in a first-degree relative
- BMI >30
- Previous macrosomic baby weighing  $\geq 4.5$ kg
- Previous gestational diabetes.

NICE recommends screening most high-risk women with a 2hr oral glucose tolerance test (OGTT) at 24–28 weeks gestation. However, women who have previously had gestational diabetes should be screened earlier, at 16–18 weeks. If the first test is normal, repeat it at 28 weeks.

## Pre-eclampsia

Blood pressure measurement and urinalysis for protein should be carried out at each antenatal visit to screen for pre-eclampsia. At the booking appointment, consider whether the woman has any of the following risk factors for pre-eclampsia:

- Age 40 years or older
- Nulliparity
- Pregnancy interval of more than 10 years
- Family history of pre-eclampsia
- Previous history of pre-eclampsia
- BMI of 30 kg/m<sup>2</sup> or above
- Hypertension or vascular disease
- Renal disease
- Multiple pregnancy.

More frequent blood pressure measurements should be considered for pregnant women who have any of the above risk factors.

## Down's syndrome testing

It is recommended by NICE that all obstetric units should be able to provide nuchal translucency measurement and blood tests for b-hcg and pregnancy-associated plasma protein-A (done between 11–13 weeks and 6 days). This is the so called 'combined test'.

Women who book later in pregnancy should be offered the triple or quadruple serum screening test (done between 15 weeks and 20 weeks).

## Further information on the guideline

NICE clinical guideline 62 developed by the National Collaborating Centre for Women's and Children's Health partially updates and replaces NICE clinical guideline 6. This quick reference guideline can be accessed at: [www.nice.org.uk/nicemedia/pdf/CG062QuickRefGuide.pdf](http://www.nice.org.uk/nicemedia/pdf/CG062QuickRefGuide.pdf).



## RECOMMENDED SCHEDULE OF VISITS

### Gestation

### Purpose of visit

8–12 weeks (ideally before 10/40)

- **Booking visit.** Women should be referred to hospital, and given information on:

Down's syndrome screening, exercise, pelvic floor exercises, breastfeeding, antenatal classes, maternity benefits, smoking cessation and dietary advice including alcohol reduction, food hygiene, folic acid and vitamin D.

- BMI should be calculated, BP checked and urine tested for protein.
- Women should receive information about the schedule of antenatal visits and ultrasound scans.
- **Booking bloods** (including FBC, blood grouping, rhesus status and screening tests for haemoglobinopathies such as thalassaemia and sickle cell disease, red cell alloantibodies, HIV, hepatitis, syphilis and rubella immunity) and a urine culture should be sent off (to detect asymptomatic bacteriuria).
- Women under 25 should be advised about the high prevalence of chlamydia in their age group and be given information on how to be screened.
- Women at high risk of pre-eclampsia and diabetes should be identified (see below).
- Mood should be assessed along with the risk of developing depression.
- Information on the baby's development should be given.

11–13+6 weeks

16 weeks

- Down's syndrome screening.
- Information on the anomaly scan.
- Review of blood test results. If Hb <11g/dl, consider iron supplements.
- BP and urine dipstick for protein.

18–20+6 weeks

25 weeks\*

28 weeks

- Anomaly scan. If the placenta extends across the internal cervical os, rescan at 32/40.
- Routine care: BP, urine dipstick, and symphysis-fundal height (SFH).

- Routine care: BP, urine, SFH.
- Second screen for anaemia and atypical red cell alloantibodies. If Hb <10.5g/dl, consider iron supplements. Anti-D prophylaxis to rhesus -ve women.

31 weeks\*

34 weeks

- Routine care as above. Review results of screening tests.

- Routine care: Second dose of anti-D to women who are rhesus -ve.
- Specific information on preparing for the labour and birth, including birth plan.

36 weeks

38 weeks

40 weeks\*

41 weeks

- Routine care, including checking presentation of the baby (this should not be attempted before 36 weeks as examination may be inaccurate and cause anxiety). Offer external cephalic version if indicated. Any suspected malpresentation should be confirmed with ultrasound.
- Specific information on breastfeeding (e.g. UNICEF baby friendly initiative, [www.babyfriendly.co.uk](http://www.babyfriendly.co.uk)), care of the new baby, vitamin K, newborn screening tests. Teach woman about 'baby-blues' and postnatal depression.

- Routine care and information leaflet regarding options for prolonged pregnancy.
- Routine care and further discussion about options for managing prolonged pregnancy.
- Routine care: discuss labour plans and possibility of induction. Offer a membrane sweep and induction of labour. If a woman declines induction after 42 weeks, she should have increased monitoring (twice-weekly cardiotocography and use of maximum amniotic pool depth).

\*visits for primips only

◀ continued from page 7

countries and my experience at Reach Out is showing me how a community programme treating HIV and AIDS can really work."

While Dr Christopher was volunteering in Uganda, Dr June McIntyre was using her skills at St Luke's, a Catholic mission hospital in Zambia.

St Luke's is in the rural village of Mpanshya, 200 kilometres from the capital Lusaka. With no electricity other than that provided by a generator for a few hours at night, it serves a population of 180,000 people. Twenty per cent of adults here are HIV positive.

"The hospital had an antiretroviral (ARV) clinic, which had been running for two years with about 100 patients receiving treatment," says June. "My job title was ARV support doc-

tor. My main focus was to be helping the staff with the development of the ARV clinic and looking after hospice inpatients."

But the hospital hadn't had a resident doctor in 18 months, so on June's arrival, expectations were high.

"Trying to make local staff understand what they could reasonably expect a UK-trained GP like me to do was difficult," she says.

However, volunteering in such difficult circumstances made her far more confident and as a result she learned to trust in her own judgment.

"It took me a while to feel like I was a useful member of the team. But over time I learned new skills, and I rediscovered skills that I'd forgotten I had."

"Volunteering wasn't easy but I'm so glad I did it. I'd say to any health worker contemplating doing the same that what you'll be able to contribute is probably far more than you might expect."

## Want to know more...

VSO is currently recruiting MBBS or MBChB qualified GPs with at least three years' post-registration experience and an interest in working in HIV to work in countries like Zambia, Uganda, Tanzania and Namibia. VSO volunteers receive a local living allowance, accommodation, flights, insurance, pension and NI contributions, and comprehensive training.

For more information visit [www.vso.org.uk](http://www.vso.org.uk) or call 020 8780 7500.

## RCGP News invites your comments or letters...

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