

RCGP responds to Health Bill

“The College is not opposed to reform, but we must get it right for the sake of our patients” – that is the verdict of the RCGP following publication of the Government’s Health and Social Care Bill.

IN ITS RESPONSE, the College says that while it supports the overall principles of an NHS led by clinicians with patients at its centre, it remains concerned by the pace, scale and cost of change.

And it warns: “Depending on how the reforms are implemented, we must guard against fragmentation and unnecessary duplication within a health service that is run by a wide array of competing public, private and voluntary sector providers, that delivers less choice and fewer services, reduces integration between primary and secondary care and increases bureaucratic costs.”

But the College also expressed its willingness to work with Government to address the concerns of RCGP members, other NHS professionals and patients.

RCGP Chair Dr Clare Gerada said: “This is not about criticising the Government, but about improving health care and services for our patients.”

“The publication of the Bill is a key stage in the development of the Government’s plans for the future of health and social care, but it is not the end point. GPs want this to work for the sake

of our patients and we will work constructively with the Government, the Department of Health and others to achieve this. However, this cannot be done in a way or at a pace which puts quality or patient safety at risk.

“At a time when the NHS is being told that it needs to find £20 billion of savings, no evidence has been presented to demonstrate that the healthcare market approach increases quality or helps to manage costs. Reorganisation is hugely expensive and the administration and the transaction costs of running a market are vast.”

Dr Gerada welcomed proposals to give clinicians greater responsibility for commissioning services.

“The College believes that good commissioning is about being a good GP. It is about understanding the impact of clinical decisions on the public’s health and purse, the need to practise safely and effectively based on evidence, and how the needs of patients can be best served through the design of services that meet their needs.

“It makes sense for health professionals – both GPs and our specialist and social care colleagues – to be involved in the planning of ser-



RCGP Chair Dr Gerada: Good commissioning is about being a good GP

vices and in the allocation of contracts for these services.

“It is our view that this is best achieved through co-operation, collaboration and competition, but only where it adds value.

“The NHS has for more than 60 years delivered a fair and efficient system of healthcare for millions of patients. We acknowledge that improvements can always be made, but we must work with the Government to protect the founding principles of the NHS. The stakes are too high to lose it now,” she said.

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Sign up now for workshops on effective commissioning

The RCGP Centre for Commissioning is running a series of practical workshops for GPs on effective commissioning until the end of April.

The half-day workshops, *Foundations for Effective Commissioning*, are being organised across the country, via the RCGP Faculty network.

The Centre has also released its Commissioning Competency Framework, a useful educational tool indicating the range of knowledge, skills and attitudes required by every GP, whatever their past experience or role within a commissioning consortium.

Using the new Framework tool, the faculty workshops will help participants identify their own development needs and anticipate the wider needs of their practice and consortium in areas including:

- Meaningful patient and public engagement
- Assessing health needs and setting local priorities
- Partnership working
- Aligning services to meet the local vision
- Shaping local care pathways that improve patient experience and deliver better outcomes
- Using resources more effectively, improving efficiency and quality.



Foundations course: The workshops will provide practical support for GPs

The workshops cost £30 for RCGP Members and £45 for other delegates and will be facilitated by the Centre’s Clinical Commissioning Champions. Topics include the potential of GP Commissioning, the patient’s perspective, and meeting local Clinical Commissioning Champions. All workshops run from 12.30pm until 5pm.

Continued overleaf

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Progress report on new College HQ

Dr Colin Hunter
RCGP Honorary Treasurer

When I was elected to the office of Honorary Treasurer of the RCGP, I did not expect my role to include walking on scaffolding. Those who know me well will be astonished that I have now managed it on two occasions, around the new HQ building at Euston Square. I can manage heights – but am hopeless at edges. There were a few of the latter on my recent sortie – but I did draw the line when the project manager jumped on to the highest roof to show me some intricate repair work – expecting me to follow him.

We have been working on three main issues in the last six months: making the building asbestos safe; repairing and cleaning the external parts of the building; and planning and submitting for planning for the major refurbishment project.

We have completed the work on the asbestos risk ahead of schedule and on budget. The other good news here is that there were no hidden surprises. We were advised that, when working with a building like this, some major asbestos may be unearthed of which we were not aware. So the building is now asbestos safe. In most cases this has been achieved by removal, but in other cases they simply seal off the asbestos, for example in some shafts, and make it safe.

My trip around the scaffolding was fascinating. I was stunned by the care being taken by true craftsmen, particularly on the repair and cleaning of the stone and bricks. This is part of the Grade 2* listed building. The Victorian brickwork which will form part of the internal atria also looks now quite different – shiny and striking. Great care has been taken to ensure colour match with any replaced tiles.

As well as the stonework, work is being undertaken to replace or repair windows; to ensure all the roofs are in good condition (including re-slating all roofs); to repair all water drainage systems; and also to replace the glass which will form the sky window above the main reception room on the fifth floor.



Work in progress: New RCGP building in Euston is shaping up well, says Dr Hunter

The most gratifying thing about both these visits has been the dedication of the team from Paye who are not only highly professional in their approach, but who also wish to ensure that our building – which one stonemason described as one of the best he has worked on – is repaired to the best standard possible.

Finally on planning, we have now submitted our plans to Camden Council and will hear early in March. Early indications are that there are no 'show stoppers' but as always this is a risk and we will all be glad to get past that post. I hope to bring you further details in *RCGP News* in a couple of months.

High Speed Rail: Fly in the ointment or great opportunity?

You may have seen the plans for the controversial HS2 link. The proposals were published after we had completed on Euston Square and we had not anticipated that the 'red line' which

shows the potential enlargement of Euston Station would be drawn through the rear portion of our building.

We have of course taken considerable advice regarding the issue. We have been largely reassured by that advice and I will now try to summarise the key points. If you wish to read more, there is a Q&A briefing available at www.rcgp.org.uk.

What would the worst case scenario be? We have taken expert and legal advice on this. If the building was eventually included in the plans it would be subject to a compulsory purchase order. We have been advised that this would need to be the entire building – which would be costly for the developer. The price would reflect the market rate at the time plus ten per cent, plus costs.

All indications would suggest the earliest this would occur would be 2020 (and if you review transport projects of this magnitude, almost all suffer huge delays: Crossrail, for example). With the likelihood that property values in this part of London will increase, the College would be in a position to relocate and redevelop or build an alternative.

Meantime, given again the advice that HS2 are likely to be persuaded to move the station front 20 yards back, we are continuing to develop the building to meet all our needs. This is the sensible economic thing to do, as our business plan involves income generation from a world class conference centre.

A number of members have asked whether we will oppose the HS2 proposals. This is a more difficult question. In effect, if the HS2 does come into Euston and the station is just adjacent to the College, we will be in the premier site in London. So our main focus is Euston station coupled, of course, with preserving this truly unique and beautiful building. To that end we have already established strong links with English Heritage and the Victorian Society, who will fight tooth and nail to save the building.

So, yes – something we could have been doing without – but hopefully a huge opportunity.



Grand designs: Ian Greaves and his team have cut diagnosis times and costs by redesigning the dementia care pathway for their patients

Leading by example on dementia care

RCGP Fellow Dr Ian Greaves and his Gnosall Surgery are building an impressive national reputation for their work on dementia.

As well as being singled out for praise by dementia 'tsar' Professor Alistair Burns (*see interview opposite*), the practice in Staffordshire has also scooped a prestigious GP Enterprise Award – Innovative Clinical Care category – for its primary care memory service.

Dr Greaves and his team have reduced the diagnosis time for dementia from the national average of three years to four weeks. In 2009 they saved £400,000 in secondary care costs by redesigning the care pathway for their practice population of 8,000 patients.

They started by adding two questions about memory to the checklist used on patients attending QOF clinics. Those with memory concerns were visited at home by a health visitor, to carry out checks for dementia, depression and social circumstances, and to arrange blood and urine tests. A monthly clinic was organised at the surgery with a specialist old age psychiatrist, and the health visitor would attend with the patient and their carer. The specialist was given access to the data collected and the patient's medical records, so he could make a diagnosis and create a care plan, including a social care assessment and direction to support from charities.

Dr Greaves said GPs on average were detecting 40 per cent of dementia cases and referring them to secondary care.

"The other 60 per cent were not getting a diagnosis or the care they needed. I wanted to reach those people, make the diagnostic process efficient, and keep everything in primary care."

About one third of the patients visited are diagnosed with dementia. Other leading diagnoses include depression, B12 deficiencies, alcohol or medicines abuse and even brain tumours.

"The improvement in care for the dementia patients has been tremendous, and all but two patients have remained at home rather than going in to nursing homes," said Dr Greaves.

He has also helped South Staffordshire PCT to launch a £700,000 service across the area, with memory clinics in every practice served by six 'dementia facilitators' collecting data in homes.

Entries are now invited for the GP Enterprise Awards 2011. The awards are open to all GPs or practices that have developed or devised innovations to improve patient care or practice effectiveness. There are six categories with a total awards package of £10,000 available. *See page 6 for details on how to apply.*

Commissioning workshops

Continued from front page

RCGP Chair Dr Clare Gerada said: "These workshops offer GPs, nurses and managers from practices and GP Consortia team members a chance to develop practical skills and knowledge that will stand them in good stead as they prepare to meet the future challenges of GP-led commissioning.

"We have had a tremendous response since launching the RCGP Centre for Commissioning – it is clear from the feedback that professionals in the general practice community are keen to get involved and they want access to practical resources. Our 2011 workshops series responds to that need."

Forthcoming workshop dates are:

SOUTHAMPTON	15 February
BRIGHTON	16 February
MANCHESTER	17 February
LONDON	1 March
LUTON	3 March
LEICESTER	10 March
NEWCASTLE UPON TYNE	17 March
EXETER	23 March
LIVERPOOL	29 March
BIRMINGHAM	31 March
PORTSMOUTH	5 April
MILTON KEYNES	6 April
LONDON	7 April

Launch of bowel cancer symptoms campaign

Professor Mike Richards
National Clinical Director for Cancer

In the November 2010 edition of *RCGP News*, I explained some of the work that we have underway to try to tackle late diagnosis of cancer, and thereby to improve cancer survival rates. This article updates you on the launch of the regional pilots for a national bowel cancer symptoms campaign.

First, though, I should mention the recent launch of *Improving Outcomes – a Strategy for Cancer*. This translates the underpinning principles of the Government's reforms for health and social services into the steps that need to be taken to improve cancer outcomes.

Although it covers a range of outcomes, a major focus is on improving England's cancer survival rates. The commitment is made that, by 2014/15, an extra 5,000 lives will be saved every year, which would bring England in line with the European average.

The Strategy is supported with more than £750 million over four years and sets out a range of actions to improve cancer outcomes, including actions to diagnose cancer earlier. The funding for earlier diagnosis covers awareness raising initiatives to get the public to present earlier with symptoms, extending GP access to diagnostic tests and additional costs in secondary care to test and treat additional referrals.

From 31 January a campaign encouraging people to 'Be clear on cancer' will be piloted by the Department of Health in the East of England and the South-west. The advertising will run on the TV and radio and in local press. It features a GP encouraging people to 'Just tell me' if they recognise the signs and symptoms of bowel cancer – 'blood in your poo, or looser poo for three weeks'.



Professor Richards: new campaign encourages patients to tell GPs about bowel cancer concerns

Running for seven weeks, the pilot campaign activity will target the over-55s, as this age group has a higher risk of bowel cancer. It hopes to raise awareness of the symptoms and encourage people to visit their doctor if they have had them for three weeks or more as it 'could save your life'. It also reassures people by saying that the chances are that these symptoms are nothing to worry about, and that finding bowel cancer early makes it more treatable.

The campaign will be fully evaluated and, on the basis of that evaluation, we will decide next steps. We know that we cannot match cancer survival rates in comparable countries unless we diagnose cancer earlier, and we see this campaign as an important step in tackling the issue.



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Given the National Strategy's commitment to earlier diagnosis – is there a programme planned and how would GPs be supported to deliver?

Good quality early diagnosis is one of the priority areas for the outcomes-focused dementia implementation plan which we launched in September 2010. The four priorities are: early diagnosis and intervention for all; improved quality of care in general hospital; living well with dementia in care homes; and reducing the use of antipsychotic medication. Underlying each of these is continued support for carers.

The aim of the new implementation plan is to support local delivery of the National Dementia Strategy. The Department of Health is working with the Oxford Deanery to trial a new approach to learning for GPs and their practice staff. It involves primary care teams being encouraged to reflect on their practice involving people with dementia, and their carers, and identify ways, using the GP QOF register as the starting point, to improve care of people with dementia and their carers. The primary care team will be encouraged to consider issues such as the numbers of people with dementia on their register and how that reflects the expected number in practice, how often they review people on the register, and whether this could be improved.

At local levels there are some examples of best practice. For example, the South West Dementia Partnership is making available some £20,000 for each PCT to support GP leadership for the next two years. This resource will build and enhance that local leadership and capacity for the delivery of the strategy. We are shortly to publish a compendium of good practice which shows examples of best care for people with dementia across the country.

The practice developed by Ian Greaves and colleagues in Gnosall (see news story on the left) is another example. Support from secondary care is, of course, very important.

Why is there such a variation in services? As a GP, I am frustrated by lack of clear pathways. How can co-ordination between health care, social services, charities and GPs be improved, so as to deliver comprehensive and timely care to those with dementia and their carers? (The continued emphasis on Critical and Substantial levels of need means that referrals are often not made until a person's situation has deteriorated.) In what way can unplanned and unscheduled admissions for these very vulnerable people be lessened and prevented?

I agree that variation in services for individuals with dementia is unacceptable and improving the quality of services is exactly what the National Dementia Strategy is all about. The Coalition Government is committed to implementing the strategy, which is why dementia was one of only two new areas included in the revised NHS Operating Framework, issued in June 2010. This commitment has again been underlined in the new NHS Operating Framework for 2011/12.

The Department is also working with a number of colleagues across health and social care to develop a commissioning pack for dementia which will be published by April 2011. The pack will act as a tool to help local commissioners improve the quality of services for people with dementia and their carers through clearly defined outcomes, which will help drive efficiency by reducing unwarranted variation in services. The pack will contain a set of tailored guidance templates, tools and information to assist commissioners both for existing providers and for use in new procurements. People with dementia will be placed at the forefront of the service and are central to decisions about their care.

Prevention is a key aspect of dementia care; both in terms of preventing unnecessary admission to hospital or to care homes, and by linking up health and social care unnecessary and unscheduled admissions should be avoided.

How is it envisaged that the reorganisation of services towards GP commissioning will be directed to ensure appropriate local coverage of dementia care services?

The thinking around these services is at an early stage of development and GP-led

The memory man



National Clinical Director for Dementia **Professor Alistair Burns** answers RCGP members' questions and concerns on diagnosis, treatment and care of patients with dementia within primary care

commissioning is part of ensuring services are designed, developed and provided with full involvement of the people who know the needs of their local population best.

What strategies are proposed to ensure good end of life care planning for patients with dementia?

The end of life care strategy covers all adults regardless of their condition, including a generic pathway from identifying that someone is approaching the end of their life through to bereavement care. We recognise that dementia poses specific challenges for end-of-life care and are determined to improve the standard of care that people with dementia receive; including ensuring that support is available in the community.

During the second year of implementation of the end of life care strategy the National End of Life Care Programme (NEOLCP) has published the first practical guides in the *Route to Success* series for care homes and acute trusts; a commissioning guide, with NICE, for end of life care for people with dementia; and, with the Department's dementia team, good practice guidance to support the NICE guide.

What should GP training and CPD priorities be over the next few years?

The National Dementia Strategy emphasises the need for effective training and development for all professionals across health and social care. Skills for Health and Skills for Care have produced a report for the Department which maps the workforce involved in the care of people with dementia and their education and training needs. The Department has an established workforce advisory group, chaired by me, which is currently taking forward the reports findings.

How can we increase our detection and treatment of dementia without increasing referral to secondary care colleagues who are afraid their service will be swamped?

We probably can't. That is why the strategy calls for effective diagnostic services to be developed throughout the country. There are innovative models of care: for example in Gnosall. I think this local development of innovative services is a key way forward to improving the care of people with dementia and allaying the fears of secondary care colleagues.

How can we develop protocols to steer us through the ethical minefield of reducing redundant QOF medication and preventing unnecessary interventions/investigations for patients with severe dementia?

NICE published their suggestions for changes for the 2011/2012 QOF covering dementia in August of last year for consultation. It was stated at this time that negotiations for provisions of QOF would be influenced by a move towards outcome-based indicators.

Access to memory clinics can be sparse and treatment is often not available according to NICE guidelines. Why should we rush to make a devastating diagnosis unless and until effective treatment is available and secondary care has the capacity to see people quickly?

It is important that people with dementia receive a timely diagnosis which allows for the instigation of appropriate treatment and care, and facilitates their adaptation to that diagnosis to ensure they can live well with the condition. A number of surveys have shown that people with dementia want a diagnosis. It also allows for advanced planning, with issues like advanced directives, powers of attorney and driving to be discussed openly. By not making referrals, people in primary care would run the risk of perpetuating inadequate diagnostic services in secondary care and if a GP believes that a diagnosis is required they should not hesitate to make the necessary referral. As there becomes increasing transparency in the outcomes of local people, that is one of the ways in which the quality of local services with be improved.

Do we need to introduce another system of diagnosis and care that is more primary care based? Could this be managed by GPs as an enhanced service?

How local NHS commissioners and local authorities achieve the best system of diagnosis and care is for them to determine, and we know that different models of successful memory services exist in different areas. I have mentioned the service in Gnosall, but there are many others, and the compendium of good practice will highlight these.

Are there any plans for a uniform scoring system throughout England to diagnose dementia, with clear guidance on what scoring levels to refer patient to the specialist for confirmation of diagnosis? It is confusing for GPs with so many tools out there.

I appreciate that a simple diagnostic scheme for dementia would be helpful. The problem is that many of the tools test solely cognitive function and, as we know, dementia is more than just loss of memory, disorientation and language problems. There are standard tests that can be done to assess cognitive function such as the GPCOG ([www.patient.co.uk/doctor/General-Practitioner-Assessment-of-Cognition-\(GPCOG\)-Score.htm](http://www.patient.co.uk/doctor/General-Practitioner-Assessment-of-Cognition-(GPCOG)-Score.htm)). People in primary care know their patients best and are ideally placed to interpret a score on such a test in the light of the patients' history and other medical conditions, if any.

Are GPs effectively providing a private service to specialist dementia care homes?

The local care home brings us many high demand patients, almost all whom were not previously our patients. We strive very hard to provide a gold standard of care to these people and their distressed families but this comes at a price, and currently we are bearing the cost as a practice.

GP funding allocations are worked out according to local populations, age/health profiles and associated health conditions. If there is a care home with a lot of highly dependent people the funding which the GP practice(s) receive should recognise this fact. In the future when GPs take the lead for commissioning services for their local populations, including those with dementia, any anomaly should be addressed.

I very much appreciate the opportunity to address all these questions about dementia and would be happy to come back in a year and assess how things are going, and revisit any of the issues raised.

A PDF of the full text of this interview can be found on the RCGP website at www.rcgp.org.uk/rcgpnews

Sharing a common goal: How football's finest are working to improve the nation's health

Dilbinder Dhillon

Community Development Health
Project Manager
The Premier League

The Premier League (PL) commits 3.7 per cent of its revenue to corporate social responsibility good causes under the Premier League Creating Chances (PLCC) banner.

The purpose of PLCC is: 'Through the power of football we make a difference, empowering our clubs to create opportunities at the heart of their communities that bring people together and change lives for the better'.

PLCC has five key areas of focus – Community Cohesion, Education, Health, Sports Participation and International. The health objective is to 'use the power of football to promote healthy lifestyles, increase physical activity, tackle sensitive issues and improve health and wellbeing, changing lives for the good in our communities'.

Premier League has invested £4.9 million in health projects delivered by football club community schemes over the past three years. This investment has engaged over 100,000 beneficiaries and attracted over £2.5 million of partnership funding from a wide range of partners including Primary Care Trusts and local authorities.

The wide variety of projects include:

- schools' physical activity, healthy lifestyles, diet and nutrition programmes
- projects addressing the isolation, stigma and discrimination surrounding mental health
- activities aiming to increase physical activity and knowledge of health-related issues among 11 to 16-year-olds, particularly girls, through a range of sports, physical activity and dance
- the development of community sports clubs in deprived areas for young people aged 13 to 19 years to play a wide variety of sports.

The PL has also worked with the Department of Health on a Health Trainer programme. There are now 99 qualified health trainers operating within clubs delivering health projects.

The future for Premier League and its health agenda

With the changing landscape of the NHS, the Premier League is aware it needs to re-focus and forge stronger working partnerships in its regional and local areas to keep on providing its communities with opportunities that bring people together, and change lives for the better.

The Premier League shares the view of shared social/corporate responsibility – that is why it invests its time and funding into its good causes work.

Although we can't be sure exactly how the landscape will look, we want to bridge the gap between sports, physical activity and health programmes happening in your areas.

PL clubs are now more engaged with their local communities than ever before and positioned as key local deliverers of community development programmes that meet local need and provide positive benefits to participants.

PL clubs all over the country are beginning to raise awareness of the health and wellbeing agenda and it is very good to see clubs taking an interest in their communities. What is important for the future in this ever-changing landscape is working relationships.

For example, clubs currently link in with PCTs and Strategic Health Authorities and need to now develop closer relationships and forge new relationships with their local authorities and other key partners in the profession, such as GPs.

Examples show how PL clubs are providing and creating opportunities at their heart of their communities by using the power of football to promote health and wellbeing. Power to engage,



*Getting players onside:
West Brom is one of the
Premier League clubs linking
up with local communities*

motivate and inspire and reason why PL is happy to commit to investing four per cent of revenue into community good causes through the PL Creating Chances programme

PL hopes that the health profession and the Government recognise the power of football and sport can have, and the PL work goes some way in helping to shape the government's health and wellbeing agenda as we aim to reach one common goal – a healthier and more active nation, empowering individuals to take control of their own health.

■ *If you would like to find out more about what your local PL clubs are doing or you can assist the PL in helping deliver the health and wellbeing agenda in your area, please contact me at ddhillon@premierleague.com*



*Net gains: The Premier League
Men's Health Project is already reaching
its health improvement goals*

How Premier League clubs are promoting health improvements

WEST BROMWICH ALBION ALBION COMMUNITY SPORTS CLUBS

Working in partnership with its PCTs in Sandwell and Smethwick, the programme encourages 13 to 19-year-olds to become more physically active and increase the level of participation of sport and physical activity beyond the age of 16. The programme also contains some prevention work for 13 and 14-year-olds. It is in essence a multisports-based programme dealing with continued physical activity beyond the age of 16 years and includes some health prevention and awareness work.

Participants are offered a range of sporting activities either appropriate to the facility or linked to a local sports club, from football, cricket, basketball and netball to other sports. These clubs have strong links with the PCT, which provides smoking cessation sessions, sexual health advice and free family health checks.

WBA also provides the Albion Active Adults, their Premier League Health project, a £1.63 million nationwide programme funded by the New Football Pools, and PCTs at a local level. This programme consists of different elements, one of which is aimed at families, where dads can attend with their children to take part in football and dance sessions.

Other sessions in West Bromwich work with unemployed adults with mental illnesses. Again, this programme has evolved from a method of relationship building to participants also attending health workshops, as highlighted above.

Attendees have been encouraged and rewarded with stadium tours of The Hawthorns and free tickets to home games – culminating in a four-team tournament involving over 40 men played on The Hawthorns pitch.

WOLVERHAMPTON COMMUNITY TRUST (WCT): 'TACKLE DIABETES' PROGRAMME

WCT are working in partnership with its PCT to tackle the local issue of high levels of diabetes in the region. The project will raise awareness of associated risks of diabetes as well as educational as well as offering support with those diagnosed with diabetes to lead a healthier lifestyle. The programme is delivered by a combination of workshops, physical activity and support.

Participants in the programme will receive workshops to reinforce positive behaviour or change negative behaviour, depending on baseline information gathered at the recruitment stage. They will also receive a session from a health trainer who will take height, weight and blood pressure measurements and provide ongoing support throughout the project in the form of a Lifestyle Case Manager, which includes identifying a physical activity element. Health Trainers then engage with each participant after the event. These meetings will provide support required to address five key lifestyle risk factors and promote physical activity facilitated sessions.

PREMIER LEAGUE MEN'S HEALTH PROGRAMME

Launched in February 2009, Premier League Health (PLH) is a unique programme to help improve the state of men's health all over the country, particularly in deprived areas. PLH sees 16 football clubs targeting men aged 18 and over on locally-focused projects, which include placing NHS health trainers in the stadiums; taking referrals from local GPs; and working with local health agencies, such as PCTs.

The programme aims to promote physical activity, while tackling issues as diverse as depression linked to unemployment, obesity and general poor physical health, as well as alcohol and substance misuse. It refers men who take part in the programme to other agencies that might be able to help improve their health.

The first year of PLH has been very successful, with more than 3,000 men participating in the 16 projects ranging from a simple health check, attending health workshops or taking part in an in-depth structured course. Early results indicate that the programme is being successful in encouraging men to look at their health – a member of Liverpool's project classified as obese has lost more than half his body weight since being involved.

Professor Alan White and his team from the Centre for Men's Health at Leeds Metropolitan University have begun conducting their three year research to better understand the issues surrounding male health in England and the possible impacts of the Premier League Health in the long-term.

New migrant health guide

A new free-to-use online resource is now available to support primary care practitioners who look after patients who have come to live in the UK from abroad. The resource has been developed by the Health Protection Agency (HPA) with endorsement from the RCGP and the Royal College of Nursing and has been designed and piloted with input from many individual primary care practitioners. The resource can be accessed at www.hpa.org.uk/migranthealthguide

Dr Jane Jones and Karen Wagner
Travel and Migrant Health Section
Health Protection Services, HPA

The United Nations estimated in 2008 that there were 214 million migrants in the world (or around one in every 33 of the world's population) and that number is continuing to increase⁽¹⁾. The last census completed in the UK in 2001 showed that around eight per cent of the UK population were born abroad, and in 2009, an estimated 567,000 migrants arrived in the UK⁽²⁾.

They were a diverse group in terms of their reasons for migration and their country of origin. Most were young adults who had chosen to come to the UK, mainly to work or study, and who may have a similar risk profile for a range of health issues as the indigenous UK population.

Some may however have increased health needs: related to their country of origin, for example, or their experiences before and after migration. The new Migrant Health Guide has been developed to support primary care practitioners in assessing and managing those health needs. It is organised into four main sections:

- **General information** These pages contain information and resources on areas such as language interpretation services; cultural competence and understanding; entitlements to NHS care; spirituality, religion and health beliefs; and vulnerable migrants.
- **Countries A-Z** This section contains pages specific to the individual countries of origin of migrants to the UK. Each country has five pages:
 - Country home; including background information, languages, religions and migration history.
 - Children's health
 - Infectious diseases
 - Nutritional/metabolic concerns
 - Women's health
- **Health topics** These are divided into infectious diseases and other health concerns. Where available, patient resources in English and other languages are included on individual topics pages as well as other useful external links.
- **Assessing migrant patients** This section contains information and a checklist for assessing the health needs of new migrant patients as well as algorithms for assessing patients with symptoms.

Although the HPA has a primary focus on

communicable diseases, the resource has been designed to cover a wide range of health issues. It concentrates on the additional health issues that should be considered for a migrant patient rather than explicitly covering areas familiar to GPs from their work with UK-born patients.

The guide brings together available online sources of printable patient information leaflets that are available in a range of languages. Much of the information on the resource can be found through searching multiple sources but this is the first time that all this information has been brought together in one place so that practitioners can easily access it during a consultation.

Most non-UK born people do not have infectious diseases but much of the burden of infectious disease falls on those who were not born here. For example, the majority of the cases of TB, HIV, malaria, enteric fever and chronic hepatitis B that are reported in this country are in people who are non-UK born and come from countries with high incidence of these infections^(3,4).

Primary care practitioners have a key role in identifying those who are infected and referring as appropriate for further management. This is important for both individual and public health. They also have a role in prevention; for example, in appropriately advising migrant patients who are travelling to visit friends and relatives in their family country of origin.

The country specific part of the website directs practitioners to which infections they should be alert to and consider testing for in migrants from different countries and also links to country specific travel advice provided by the National Travel Health Network and Centre⁽⁵⁾. There are more than a hundred countries profiled in the Migrant Health Guide, selected based on their disease epidemiology and UK census ranking. Topic pages on each infectious disease are included to guide practitioners in diagnosis and management according to national guidelines.

The resource is free-to-use and practitioners are encouraged to register with the site so that they can be alerted when there are significant changes to the resource or issues that they should be aware of in relation to migrant health.

The Migrant Health Guide ultimately aims to address the health needs of migrants to the UK promptly and effectively through supporting the practitioners who care for them. The HPA welcomes feedback on the site (tmhs@hpa.org.uk) and suggestions so that it may evolve according to practitioner needs and to reflect global movements of people in the future.



*Worldwide web:
The new site
will help GPs
look after
patients who
have come to
live in UK
from abroad*

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Peer review scheme to support clinical audits

Dr Imran Rafi
Medical Director
RCGP Clinical Innovation
and Research Centre (CIRC)



Supporting role: Pilot will encourage GPs to deliver high quality audits, says Dr Rafi

As a way of supporting GPs with their audit work, the RCGP's Clinical Innovation and Research Centre (CIRC) is piloting a peer review audit process over the next year for members.

The pilot project is funded by the Health Quality Improvement Partnership (HQIP). For a small charge, members will be able to submit their clinical audit projects and receive feedback from peer reviewers on their audit work. In this way it is hoped that the advice given through peer review will encourage individuals and practices with their audit work.

CIRC are working on this project with key people interested in audit in primary care such as Dr John McKay, Associate Advisor from the West of Scotland Deanery. NHS Education for Scotland has had such a system in place for many years and their experience has been that the peer review system is considered feasible and acceptable to GPs, including appraisers.

Dr McKay says: "The evidence from those who have participated in the NES peer review model demonstrates that GPs value this method of feedback. Constructive educational feedback from trained peers is recognised as providing additional support for the practitioner's audit, as well as enhancing and verifying evidence that GPs present as part of their appraisal portfolio."

"The CIRC audit process builds on the strengths of this external peer review model to encourage GPs and their practices to deliver high quality audits."

The excellent peer reviewers trained for this project are drawn from the London Deanery Appraisers network with Dr Julia Whiteman,

Deputy GP director at the London Deanery on the steering group for this project.

Audit should lead to quality improvement when done well and CIRC are pleased that Dr Paul Myres Chair of Primary Care Quality Forum, Public Health Wales, has also been providing advice as a steering group member.

■ *For guidance on how to submit your audit project and any further details, please go to the CIRC website: www.rcgp.org.uk/clinical_and_research/circ.aspx*

■ *For any further information, please contact Dr Imran Rafi, Medical Director of CIRC: irafi@rcgp.org.uk*

Final call for good ideas in practice

The deadline for the GP Enterprise Awards 2011 is 7 February. Run by the RCGP and GP Newspaper, with sponsorship from the Medical Defence Union, the awards publicise innovative ideas from grassroots practices that can easily be replicated by other GPs and their teams to improve patient care.

Prizes worth £10,000 are available for innovations in general practice. This year's categories are:

- | | |
|---------------------------------------|---|
| 1 Practice Team | 4 Innovative clinical care (Patient Safety) |
| 2 Innovative Clinical Care (General) | 5 Enterprising use of IT |
| 3 Innovative Clinical Care (Specific) | 6 Sustainable healthcare |

■ *Download an application form at www.healthcarerepublic.co.uk/awards, select a category and provide a short statement (up to 500 words) on what your practice has achieved.*

SUPPORTING CLINICAL AUDIT The RCGP Peer Review Audit Scheme

Would you like to have your clinical audit project reviewed?

- The Peer Review Audit Scheme is a formative process to support GPs through clinical audit.
- It provides written educational feedback on your audit project from two informed peer reviewers to facilitate improvement
- It is completely voluntary and confidential
- It supports continuing professional development

FOR FURTHER INFORMATION

Please visit the RCGP Clinical Innovation and Research Centre (CIRC) website on www.rcgp.org.uk/circ or email the Medical Director of CIRC, Dr Imran Rafi, at irafi@rcgp.org.uk



A new approach: Promoting resilience for mental health

Alastair Dobbin (right) is a GP in Edinburgh. He is also managing director of the Foundation for Positive Mental Health, a charity set up in Scotland to develop resilience training in all sectors of life. He developed Positive Mental Training – a self-help tool for treating anxiety and depression – in 2002.



Dr Dobbin: Focused on providing GPs with the tools necessary for treating emotional distress

MANY YEARS AGO I set up a clinic within NHS Lothian treating people referred from primary care with mental health problems using hypnosis. Along with the Department of Neurophysiology at Imperial College and the Department of General Practice in Edinburgh, we co-ordinated a two-year study of the outcomes⁽¹⁾, and as well as significant improvements in anxious patients in SF-36 Quality of Life indices – mental health, social function and emotional role – we also found widespread ongoing use of simple self-hypnosis tools (77 per cent at six weeks after discharge).

In discussion with the Chief Scientist in Scotland and working with the department of General Practice in Edinburgh, we then chose to investigate new possibilities for the treatment of people with depression. At that time, John Teasdale and Ed Watkins were doing groundbreaking empirical work in thinking style and mindfulness, culminating in the successful

treatment of depression using mindfulness-based CT⁽²⁾. Seeing marked similarities between the processes of hypnosis and mindfulness – both promoting an experiential perspective – I considered using self-hypnosis for the treatment of people with depression.

Along with Sheila Ross, a health promotion specialist, I developed Positive Mental Training (PosMT) from a sports-based peak performance programme from Sweden, created for the development of excellence in sport and used successfully in Olympic training for many years. This was based on a developmental model (looking at what Olympic gold medal winners did right) rather than the prevailing clinical model, looking at what the losers did incorrectly. It seemed to us that this model reversal could beneficially be applied to treatment of emotional distress (depression and anxiety) while also fulfilling a preventative role, promoting resilience in individuals.

This sports programme was largely self-administered, and the system came about through recognising the benefits of self-hypnosis (paralleling my own observations) and the recognition that at the core of hypnosis, as with mindfulness, are a number of beneficial mental skills that can be simply taught and which, when systematically developed, can be transformational.

This approach serves both arenas of sport and health, sharing one important aim: to increase the resilience of the trained mind. Athletes reach the top level because they can 'bounce back' from poor performances.

In 2004/5 we conducted a randomised preference study of Positive Mental Training (PosMT) versus anti-depressants for depression, with referrals from GPs⁽³⁾. Benchmarking our results against all the major primary care mental health studies showed that our self hypnosis programme, administered in one 20-minute consul-

POSITIVE MENTAL TRAINING (PosMT)

Positive Mental Training is an evidence-based, self-help, psychotherapeutic programme for emotional distress. Through watching a 13-minute video once, then listening to a sequence of audio tracks, the mind and body can develop relaxation, beneficial thinking styles, positive memories, confidence and problem solving skills. It is safe, easy to use and available in CDs or MP3s.

PosMT can:

- Improve patient mood and well-being
- Reduce depression and anxiety
- Improve patient choice with immediate psychological treatment in primary care
- Consolidate the GP/patient relationship
- Increase the GP's sense of personal efficacy

treating emotional distress. A key aspect of PosMT is its ability to build the resilience of GPs and other staff.

In my opinion, this is not only due to the direct impact of having immediate psychological tools available, thus improving the care pathway for patients and removing the gate-keeping role of the GP – hence empowering both – but is also due to the adoption of a developmental rather than a clinical model.

In the clinical model, the responsibility for illness is all put back on the doctor; the doctor holds and understands the therapy. When things are going well this is great; doctor and patient feel good. But let's face it, progress can be slow or nonexistent; the patients come back with tales of catastrophe and re-traumatise themselves and us, and we blame ourselves for 'our' failure. The developmental model shifts the focus from pathology to education.

THERE NEEDS to be a fundamental shift in our approach to mental health in primary care which involves all of us – GPs, psychiatrists, nurses, psychologists, therapists – signing up to the same understandings. IAPT achieved much, raising the profile and rationale for mental health treatment and establishing some centres of excellence and good practice. What it did not do is establish a model for treatment of emotional distress by frontline primary care staff.

If the model of primary care is all about referral rather than shared knowledge, everyone sitting on their own area of expertise, then the GP is deskilled and demotivated and ends up thinking 'I haven't got the time, energy or skills to deal with this, I'll just refer on', and the message to our patients and implicitly to ourselves is 'I can't help my mental health patients' and more importantly 'I can't help myself'.

A recent independent study using Positive Mental Training to treat occupational health referrals in the NHS showed a significant decrease (high to moderate) in exhaustion and cynicism, and a significant increase (from low to high) in personal efficacy⁽⁴⁾. This bears out our survey (see box below) which showed that GPs who attended the training felt more able to treat people with mental health problems, and also felt more able to deal with their practice overall. Could this be a model for a mentally healthy practice?

PosMT is in its fifth year in primary care where it is now integrated into stepped care⁽⁵⁾. Its use is being expanded to the third sector – such as carers, counsellors and in prisons.

The programme is designed to be used as part of a normal GP consultation and is easily fitted into other health professionals' working patterns. It is used for the treatment of depression, anxiety-based disorders, psychosomatic and chronic pain syndromes.

■ **Contact Dr Dobbin at:** alastair@foundationforpositivementalhealth.com

THE TRAINING PROGRAMME

Target audience

All NHS staff – GPs, CPNs, nurses, psychologists; speech, physio- and occupational therapists. Also Third Sector.

Learning objectives

- An increased understanding of the nature of depression, anxiety and emotional vulnerability.
- An appreciation of the theoretical underpinnings of resilience and psychological therapy
- An understanding of the background and research basis of PosMT
- The confidence and knowledge to integrate and use PosMT in everyday practice.

Training environment

- Multi-disciplinary networking with discussion of local mental health needs and services
- Stimulating learning environment – interactive demonstrations, video material of patient experiences, patient histories and some lecture-style presentation.
- Comprises two half days.

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Refs (1) and (3) are also available at www.foundationforpositivementalhealth.com/index.php/links

tation with a nurse, and telephone follow-up, was as effective in moderate to severe depression as face-to-face counselling and Cognitive Behavioural Therapy, and Computerised CBT.

It also demonstrated that it was safe and significantly more popular than anti-depressants. We obtained support from our local Pharmacy Development Fund and Community Health Partnership (Scottish PCT) to train primary care staff to use PosMT, and have spent the past four years refining the delivery of the training.

We have trained 550 primary care staff including 300 GPs, 70 CPNs, 70 nurses and various interested mental health workers, and we estimate 40 to 50,000 patients have been given the programme with no reports of harm⁽⁴⁾.

ONE OF THE most interesting observations from clinicians is the change it can bring about in patients' memories. Patients remember events, sometimes traumatic, from a place of safety and stability, and are able to change their relationship to the memory; there have been no reports of 'flooding' with PosMT.

Barbara Fredrickson showed that the key to resilience is positive emotion⁽⁶⁾. Subsequent research has shown that positive emotion results from autonomous autobiographical memory⁽⁶⁾: from such memories we can access the emotions we need to cope effectively with difficult events. We are currently developing a research programme with McGill University (Montreal) looking at the effect of PosMT on memory 'networks'⁽⁷⁾, key groups of memories that have a direct influence on resilience and depression.

As a GP myself, I have particularly focused on providing GPs with the tools necessary for

GP SURVEY

In 2009, an anonymous questionnaire on using PosMT was sent to GPs in Edinburgh; 53 (of 222) who attended training replied.

100% (53/53) found the training helpful. 100% (53/53) were using PosMT for their patients

85% (45/53) felt more able to cope with their mental health patients; 47% (25/53) more able to cope with other patients; 47% (25/53) more able to cope with their own working practice.

GPs also expressed that they:

- felt more motivated to work with depressed and anxious patients
- had become much more interested in non-pharmaceutical methods of dealing with mental illness
- had improved management of anxiety

Prime yourself for Primhe

Dr Dobbin will lead a workshop on Emotional Resilience for GPs at the Primhe Conference at the Novotel, St Pancras, London, on 16 February.

This year's theme is *Examining the future strategic direction of primary care mental health*. The programme includes Lord Layard on psychological therapies for children and RCGP Chair Dr Clare Gerada on how GP commissioning will meet patient needs. Government mental health 'tsar' Hugh Griffiths and David McDaid discussing the health economics impact of GP commissioning complete the morning line-up. A summit on Medically Unexplained Symptoms will take place in the afternoon.

■ **For information or to book direct, ring 0121 557 4215 or email admin@primhe.org.uk**
Website: www.primhe.org.uk

Health for Healthcare Professionals: RCGP launches pilot programme

Dr Rhona Knight

Clinical Lead

Health for Healthcare Professionals (HHP)

Both nationally and internationally we are increasingly seeing concerns raised about the issue of physician health. Poor physician health adversely impacts on the care of patients, on NHS costs, on the lives of the physician's colleagues, family and friends, and on the life of the physician themselves. Improving the health of physicians has beneficial effects, yet encouraging them to access help to improve their own health is not easy.

DOCTORS MAKE poor patients. They tend to not consult their GP, they often self treat and prescribe and have corridor consultations. While there are many reasons for poor access to healthcare, there are also complicating factors. Doctors are the only patients who can sit in both chairs in the doctor patient consultation: the doctor's chair and the patient's chair. The doctor-patient needs to be willing and able to become a patient and the doctor caring for them needs the required knowledge and skills to manage the doctor-patient consultation.

We have seen many initiatives to address this complex issue. There have been international conferences run by the American, Canadian and British Medical Associations on physician health, and there is a European Association of Practitioner Health, providing a forum for sharing good practice.

In the UK we have seen many developments over the years to provide support and healthcare to practitioners who are patients: House Concern in Newcastle, MEDNET in London and more recently the Practitioner Health Programme (PHP) in London, for example. The last of these uses a specialist interest primary healthcare model.

All these programmes have been successful in benefiting the doctor-patients in their care and in facilitating safe maintenance in or safe return to work. Added to this are many other support organisations for doctors in difficulty: for example, the BMA Counselling and Doctor Advisor Service.

It appears that the nature of medicine as a career is one in which those who do the job well are often at more risk of stress, illness and burn-out. If one looks at those doctors being reviewed by the GMC for health reasons, physical health problems contribute to a very small percentage of the cases. The large majority of these doctors have problems with mental health or substance and alcohol misuse.

If we assume that this is just the tip of the iceberg, there will be many doctors currently working who have compromised health and wellbeing. As a result of the nature of the problem, the impact on patient care and costs to the NHS, we must find ways of accessing and caring for doctors with health problems all over the UK. While localities may have different needs, and service provision may vary, there will be some common foundations and strategies that can be used to help.

IN 2010 the Department of Health (DH) provided funding to three organisations involved in practitioner health: the Royal College of Psychiatrists (RCPsych), the Faculty of Occupational Medicine (FOM) and the RCGP.

This funding has been timely and has enabled the three organisations to look at ways of addressing the area of practitioner health and of working together and learning from each other. It has enabled each organisation individually to look to developing the knowledge and skills in their members to promote health and wellbeing in doctors; each organisation now has its own competency framework underpinning its approach.



Twice the benefit: Dr Knight says work will support doctors and patients

Some of the fruits of this labour can be seen in the development of a joint National Collaborative Invitation Conference: *Ensuring Health for Health Professionals*, hosted by the RCPsych and planned collaboratively with the FOM and RCGP, which took place on 19 January this year. This conference aimed to highlight national developments, showcase good practice, announce joint training plans to increase regional capacity and encourage service development.

THE RCGP PILOT PROGRAMME

Health for Healthcare Professionals

RCGP CERTIFICATE IN PRACTITIONER HEALTH

WITH DH FUNDING, the RCGP has been tasked to develop and run a training programme for the care of health professionals. This is an innovative project based largely on the work of the Practitioner Health Programme pilot and is a part of the RCGP Health for Healthcare Professionals (HHP) Programme.

The curriculum for this training has been based on the HHP document *Guidance and Competencies for the Provision of Services using Practitioners with a Special Interest*. This document was put together as a result of a series of meetings which included the RCGP, the RCPsych, the Association of NHS Occupational Health Physicians (ANHOPS) and the BMA.

The aim of the HHP programme is twofold. The first is to upskill all GPs in the area of health and wellbeing of doctors who are patients, henceforth known as practitioner patients. The second aim is to train a cohort of GPs from England and Wales, with a specialist interest in practitioner health, equipping them to work in various area specific locality-based practitioner health programmes.

The intention is that they can act as a point of initial contact and assessment of health practitioners with health issues that threaten to impact on their professional work – typically these are issues of alcohol and substance abuse and mental health.

The programme is divided into two parts: the Certificate in Practitioner Health (CPH) Part 1 and the CPH Part 2.

- **Part 1** aims to upskill all GPs and will consist of two e-modules and a face-to-face training day.
- **Part 2** is a year-long programme that aims to equip fifty GPs to take on the role of becoming a GPwSI in Practitioner Health.

THE CERTIFICATE IN PRACTITIONER HEALTH PART 1

The requirements of the Part I Certificate include the completion of two e-modules on practitioner health.

- **E-module 1** covers key concepts in in practitioner health and wellbeing. It emphasises a reflective approach, including analysis of current structures and practices.
- **E-module 2** covers the areas of mental health, substance and alcohol misuse and regulation in the context of practitioner patients in more detail.

The face-to-face day will consolidate this learning and help participants explore how best to implement change in their own individual contexts. E-module 1 will be launched in February 2011 and E-module 2 in May 2011. Face-to-face training days begin in April 2011.

THE CERTIFICATE IN PRACTITIONER HEALTH PART 2

The requirements for Part 2 will include:

- a focused programme of workplace-based study;
- two master classes with pre- and post master class assignments;
- two formal educational supervision sessions; and
- final assessment of a learning portfolio.

Advertisements for trainers and educational supervisors for both Certificate Part 1 and Part 2 of this programme will go out in February.

REGISTERING INTEREST

The Certificate Part 1 is open to all GPs. It may also be used by other healthcare professionals involved in the care of practitioner patients. The e-modules will be accessed through the RCGP website.

More information about the face-to-face days can be gathered by contacting Nick Paterson at the RCGP (npaterson@rcgp.org.uk). For the duration of the pilot programme the face-to-face days will be free. Each day will be facilitated by experienced tutors and will cater for 50 participants.

In the pilot programme, the Certificate Part 2 will be available to a selected group of 50 doctors and will also be free of charge. If, following the pilot, the programme becomes established and self-funding, fees will be charged.

DOCTORS' HEALTH and wellbeing is an important aspect of health care as a whole, contributing to the better health of patients, yet thus far it has received little attention.

The increasing demands of 21st century medicine and the increasing consumerist approaches entering healthcare result in competing time demands for doctors, as well as an increase in complaints about their practice. Doctors will become under increasing pressure which has the potential to have a significant adverse effect on their health.

Now is the time to address this issue and start taking time to look after our own and our colleagues' health and wellbeing. It will benefit us as a profession, but also, and just as importantly, will benefit the patients in our care.

RCGP Royal College of General Practitioners

ONE-DAY ESSENTIALS

A series of one day conferences, each with a specific clinical focus

Register online at www.rcgp.org.uk/essentials

RCGP ACCREDITED FOR CPD

Musculoskeletal

Tuesday 22 March 2011 | Royal College of Physicians, London

A one-day conference providing expert specialist clinical training and essential information in musculoskeletal medicine.

SAVE 15% Register before 24 January



Respiratory medicine

Wednesday 6 April 2011 | Royal College of Physicians, London

A one-day conference providing expert specialist clinical training and essential information in respiratory medicine.

SAVE 15% Register before 9 February





Worthy winner: Dr Britto holds his GP of the Year Award, accompanied by (l-r) Paul Williams, Director General of Health and Social Service in the Welsh Assembly, RCGP President Dr Iona Heath and Dr Bridget Osborne, Chair of RCGP Wales

A golden night for Welsh general practice

RCGP Wales celebrated the best of general practice in Wales with a gala awards evening held at Cardiff's prestigious Museum of Wales.

Dr Bridget Osborne, Chair of RCGP Wales, played host to guests including RCGP President Dr Iona Heath and Paul Williams OBE, Director General Health and Social Services, Chief Executive NHS.

Dr Raj Britto of Llys Meddyg, Conwy, won the prestigious GP of the Year 2010 after receiving a glowing tribute from his patient Mrs Muriel Wait. Mrs Wait said: "I cannot not thank him enough for the care that he has shown me and my whole family. He is dedicated, thorough and caring. I feel that we are not just names or numbers to him, just people who need his help and he does just that."

"When I decided to bring my sister home from hospital Dr Britto came round and made sure that I had everything she needed but, above all, reassured us we were not on our own and that he was only a telephone call away."

"He came to see her nearly every day or he rang me. Even on New Year's Eve he rang me six times about her dressings and her medica-

tion and to ask if I had all that I needed. My family and I could not have coped without the help of Dr Britto and the nurse that he arranged for us. He saw us through every day of the last six months of my sister's life. We can face each day knowing that we have the support of a great man who we can not thank enough. I hope he stays with our surgery!"

Runners-up for the GP of the Year Award were Dr Richard Evans of Padarn Surgery, Aberystwyth and Dr Stephen Lloyd, from Meddygfa Bodowen, Holywell.

OTHER AWARDS presented during the evening included Practice Administration Team of the Year which went to High Street Surgery, Swansea, a small but committed group of colleagues who are providing innovative care in the treatment of the homeless and people with drugs and alcohol problems. The practice hosted the UK's first-ever Health Day for the Homeless.

Runners up were Vauxhall Practice in Chepstow; South Street Surgery, Bargoed, and Overton Medical Practice in Wrexham.

The first-ever Caring About Carers Award for Wales, run by the RCGP in partnership with the Princes Royal Trust for Carers, went to Newport Surgery, Pembroke.



Top team: High Street Surgery, Swansea – winners of the Practice Team of the Year Award



Carers' champions: Representatives of the Newport Surgery, Pembroke, winners of the Caring About Carers Award with Dr Bridget Osborne



Three's company: Muriel Wait, who nominated Dr Britto for his award, with Dr Catherine Lloyd and Gillian Whitehead, Chair of Patient Group RCGP Wales

Memorial plaque honours College founder

Dr David McKinlay
Retired Northwest Deanery GP Director, Clitheroe GP and RCGP Heritage Committee member

An unveiling ceremony held at The Guild public house in Preston brought to conclusion a six-year plan to remember Dr Fraser McIntosh Rose, the Preston GP who, with Dr John Hunt, founded the College.

In 2003, after the North West England Faculty's 50th anniversary Rose lecture, Dr Malcolm Craig (a successor in the practice) put me in touch with Dr Rose's practice secretary, Miss Parker, who showed me the building where Dr Rose had lived and practised.

The building is now listed (otherwise it would have been demolished) so planning permission was needed for the plaque. The Preston and South Ribble Civic Trust has a plaque scheme and supported the project, which was financed by the Faculty. The City Council kindly

waived the planning fees. The ceremony was a delightful affair with hospitality from the pub management, marred only slightly by Lancashire rain. It was an added pleasure to be the cause of a Rose family gathering. Drs John and Donald Rose, Fraser's sons, attended with their wives and a nephew, Martin, came from Canada with his wife and daughter.

Sir Denis Pereira Gray represented the College and Heritage Committee and eloquently summarised Fraser Rose's huge contribution to the renaissance of British general practice. Professor Jacky Hayden, Postgraduate Dean, represented the Deanery. The Mayor and Mayoress of Preston attended with representatives of the Faculty, the Civic Trust, and retired partners of the practice.

The Faculty has bought a die of the College crest which can be reused by other faculties to have plaques made for other heroes of the College. Sir Denis and I have produced some guidance on what can become a complex or simple process depending on circumstances.



Permanent reminder in Preston: A fitting tribute to Fraser Rose

Sign up for final round of work and health workshops

The National Education Programme for Health and Work in General Practice has been running since June 2009, with excellent feedback from GPs who have attended the workshops.

The workshops are delivered through a series of interactive half-day sessions offering recent evidence about work and health – along with skills and strategies for managing difficult consultations. The programme ends in March 2010.

- Workshops running in February include:
- 1 February **Abergavenny and Nottingham**
 - 2 February **Preston**
 - 3 February **Swindon**
 - 8 February **Exeter-Barnstable**
 - 9 February **Cambridge**
 - 10 February **Harrogate and London**
 - 15 February **North Birmingham**
 - 16 February **Maidstone**

Find out more and book online at www.rcgp.org.uk/healthandwork