

RCGP pledge to end of life patients

The RCGP is launching a Patient Charter for End of Life Care

Developed in partnership with the RCGP Patient Partnership Group and the Royal College of Nursing, the Charter represents an ideal of best practice that the College believes all patients should be able to seek from their Primary Health Care Team.

It makes seven pledges to patients reaching the end of their life – and their families – in order to help them live as well as they can, for as long as they can. These include:

- That GPs and their practice teams will do their utmost to ensure the patient's remaining days and nights are as comfortable as possible, and that they receive all the appropriate care and emotional support they need.
- That the primary care team will do all they can to help the patient preserve their independence, dignity and sense of personal control throughout the course of their illness.
- That the primary care team will support those close to the patient, both as the patient approaches the end of their life and through their bereavement.

The Charter - and accompanying guidance - is the culmination of three years work by Professor Keri Thomas, RCGP Clinical Champion for End of Life Care.

Copies of the Charter and guidance are being sent free of charge to over 8,500 GP Practices across England. The package offers practical support to GP surgeries and makes useful suggestions such as:

- Discussing the Charter as a primary health care team, including the community and palliative care nurses you work with.
- Seeking views from patient groups and talking about it with the patients and carers you are supporting
- Displaying the Charter in your waiting room and distributing it to patients and carers of those who are nearing the end of their life, for example, those on the practice palliative care and Gold Standards Framework (GSF) register.
- Using the Charter as a standard against which to review the care you provide in your practice: this could be included as part of your own appraisal, revalidation and practice accreditation.

Professor Thomas said: "GPs and their teams have a special relationship not just with their patients but with the people close to them, all of whom need special care and support through the process of dying.



Professor Thomas: new charter is an ideal of best practice

"We have the ability to co-ordinate good care and to help reduce some of the worry and stress when a loved one is approaching the end of their life."

The Charter will be reviewed over time based on feedback.

For more information, or to download a copy of the Charter and the Guidance Notes, please visit www.rcgp.org.uk/eolcare

- The RCGP has collaborated with organisations including the College of Emergency Medicine and the British Geriatrics Society to issue a joint statement on emergency care of older people.

It says that 'GPs play a vital role in the holistic care of older people in the community, in dealing with uncertainty, in managing unmet demand and through often early and targeted interventions in those identified as at risk.'

The full statement can be viewed on the RCGP website www.rcgp.org.uk/circ

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RCGP and the Listening Exercise

The College has been using the "listening exercise" - the Government's announcement of a pause in the legislation to reform the NHS in England - as a real opportunity to provide solutions and alternatives to the proposals and to engage positively.

The RCGP wrote to the Prime Minister listing changes that must be made to protect patients, and the principles of the NHS. It has

also provided opportunities for Members to send in their views and organised two web seminars for the listening exercise.

College Officers and senior staff have been meeting with the four leads working to former RCGP Chair Professor Field - who is chairing the NHS Future Forum - and continuing to make the RCGP's views heard amongst leading politicians, advisers and officials.

Last Chance for Early Birds!

Time is running out for you to take advantage of the Early Bird discount prices for the RCGP Annual Primary Care Conference in Liverpool from 20-22 October.

Cut-price ticket deals are available only until 27 June 2011

The full programme for the Conference, now in its fifth exciting year, can be viewed at www.rcgp.org.uk/annualconference

Speakers include Health Secretary Andrew Lansley, Lord Victor Adebawale, Chief Executive of the Turning Point charity, and Camila Batmanghelidjh, founder and director of Kids Company.

RCGP Chair Dr Clare Gerada said: "Our 2011 theme is Diversity in Practice – and the programme is shaping up to be one of our most exciting ever.

"From Associates in Training to long-standing GPs, there's someone for everyone; clinically, politically and of course, socially. Make sure you don't miss out!"

Annual Primary Care Conference
20-22 October 2011
ACC Liverpool



Royal College of
General Practitioners

Diversity in practice

Firmly established as the 'must-attend' primary care event of the year

Register online today

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www.rcgp.org.uk/annualconference

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New upgrade for e-GP

The e-GP e-learning resource - the RCGP's award-winning programme of e-learning modules for GP trainees and NHS GPs - is shortly to receive an upgraded Learning Management System (LMS).

The new e-Learning for Healthcare e-learning system, which is already in use by a number of other Royal Colleges, will provide a more sustainable and functional platform for the resource, funded by the Department of Health, and will provide new functionality for doctors using the materials.

The move will be happening over the summer of 2011. In the new system, learners will be able to more easily track which e-learning sessions they have completed, part completed, or not started at all, and will be able to run reports on their learning activity for appraisal and Revalidation purposes. The automatic link that records completed e-learning sessions in the RCGP trainee ePortfolio's learning log will be maintained.

Over the next few months, the RCGP will be sending email updates to all registered e-GP users on what to expect. The e-Learning for Healthcare and RCGP teams are working closely together to ensure that the upgrade to the new system is as seamless as possible.

This change will not affect the RCGP's Online Learning Environment, which hosts the Essential Knowledge Updates and other RCGP online courses and certifications.

For more info on the e-GP upgrade, visit www.e-lfh.org.uk/support/lms_intro

What's available on e-GP?

Over 400 e-learning sessions are now available in the e-GP resource. These include around 250 sessions written by the RCGP and around 150 sourced from other professional bodies. They are all freely available to NHS GPs, GP trainees and practice nurses.

Please visit www.e-GP.org to access the e-learning content or to view a list of all the topics now available.

- See **page 7** for information on RCGP's new *Autism in General Practice* online course.



Dr Lisa Argent

MBBS, DRCOG, FRCGP
RCGP Clinical Lead Revalidation ePortfolio

The first phase of the RCGP Revalidation ePortfolio, which includes full appraisal functionality, was launched in December 2010. By the middle of April 2011, approximately 60 primary care organisations (PCOs) had signed up to the ePortfolio and 10,000 GPs had registered to use the system.

Overall, feedback has been positive and we continue to develop the system in response to user requirements. Because it has been developed "by GPs for GPs" in line with the RCGP's proposed requirements for Revalidation (and will eventually become interoperable with other RCGP online products), we are confident that the system is the best one available for use by general practitioners - our aim being to become the dominant provider of such a system for GPs.

In time the ePortfolio will be developed to provide an "end to end" system to support GPs, Primary Care Organisations (and consortia) and others, such as the General Medical Council through the Revalidation process. The system will be free to use for all GPs and PCOs until April 2012, after which there will be a charge for GPs who are not members of the College.

In order to increase usage, the College wants to ensure that it promotes the tool as widely as possible. The RCGP Faculties, who have shown considerable support for the ePortfolio throughout its development, are in an excellent position to disseminate knowledge about the tool to local colleagues - whether they be GPs or PCO/consortia managers (or in some cases both).

The role of the ambassador will be to actively promote knowledge and understanding of the RCGP Revalidation ePortfolio, and to raise its profile amongst colleagues.

Apply now to be a Revalidation ePortfolio ambassador

We are looking to recruit at least one "ambassador" from each RCGP Faculty who can promote the ePortfolio on the ground and act as a knowledge resource for colleagues who are using the system. Although this will be a voluntary role, we hope that Faculty members will see this as an exciting developmental opportunity.

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Activities

- To liaise with Faculty leads in order to identify opportunities to demonstrate the tool at local events using the various resources provided by the Revalidation ePortfolio project team (see below). These resources will be updated regularly as the tool develops.
- To identify key players in appraisal and Revalidation roles in primary care organisations and consortia and raise their awareness of the tool, providing demonstration where possible.
- To signpost any queries to the central team for response.

Resources on offer

- RCGP central information sharing session (a half-day workshop)
- An introductory video
- A generic PowerPoint presentation (updated every two months)
- Quick start guidance for Appraisees, Appraisers and PCOs/consortia
- A suite of bite-sized "microvideos" offering guidance on specific areas of the tool
- FAQ sheets
- Dummy logins to facilitate live demonstrations
- Access to Helpdesk support
- Alternate month bulletins signposting updates, new FAQs etc

Criteria

This is an informal role and we do not intend it to be overly onerous. An ambassador simply needs to be a Faculty member who is familiar with the Revalidation ePortfolio. The purpose of the role, above all, will be to signpost and raise awareness of the tool - therefore, it will not be necessary for the ambassador to have a detailed, technical knowledge of the tool. We would welcome GPs from all stages of their careers, from First5s to those who are long established. We will invite all those who volunteer to an information sharing session to help them perform the role, to be held centrally at the College.

What to do next

If you or a colleague is interested in this role, please contact Mat Lawson mlawson@rcgp.org.uk / 020 3188 7608.



Back to the future

RCGP calls for ideas for Time Capsule

Dr Mary Selby FRCGP

The new building at Euston is going to be stunning, a beacon to showcase GPs now and in the future. We hope it will be our College for the next 100 years and more.

But what will it say about us, the GPs of today? It should say something that people can look at in 100 years and say 'I can imagine what they did. I can see how they were. What a job they did. Weren't they great?'

So how do we represent that certain something that defines the GP of today? How do we represent you? The canvas is blank, and this is a proposal and a call for ideas...

Clearly one option would be to install a life size waxwork of me right in the entrance hall. Feel free to vote positively on this. Alas I fear that despite the huge upswell of support I know you will want to express for this proposal, the shock factor might make small children weep for their mothers and examination candidates hyperventilate, and I'm not quite sure what face of general practice it would really show.

You may feel that a wall of life consisting of tiny pictorial images of every member, built up into a fantastic overall collaged image of something relevant, (don't you dare suggest a white elephant) has real merit.

I think it does, and perhaps there is room for this, although we probably need more ways of reminding passers-by of who we are, rather than a picture consisting only of our own images. We are, in the end, more than just an image. We are a role, a vocation, an institution, a tradition. We do something unique. We evolved ourselves this way, and we continue to change. How do you capture all that in an image?

This is the idea. **The 2012 GP** is an installation, a visible Time Capsule, set into the floor of the Euston building. People will walk all over us – which perhaps in itself represents a good portrayal of 2012 general practice – and they will see us as they step forth into the building to enjoy what we began.

We need you to help us decide what should be in the capsule. Progress is rapid. By the time the current trainees retire it's likely that the objects that represent our working lives will be as unfamiliar to them as Dr Findlay's Janet will be to most of you. What represents YOU? If you had to select a few objects, now, to represent the job you do, what would they be?

I have considered this question carefully, as trying to think what should represent the 2012 GP in a vacuum sealed four foot by two foot glass-topped coffin (memories of Snow White, one feels) is in a way like trying to decide what precisely our image consists of. Is it honestly still a pipe and tweeds? For some of us it may be so.

I'll give you my initial thoughts which, like my subsequent thoughts, are probably of very little merit. A stethoscope seems obvious to me, and an FP10. A half eaten biscuit would offer an accurate picture of my working day, as would the last jelly bean in the tin, but we don't really want twenty-first century rats in our capsule so we may have to forego anything perishable. A faxed referral form and a pulse oximeter look businesslike, and a blood request form may have novelty value soon as we move to computerised

pathology requesting. A pickled drug rep has appeal but probably fails on the rat test.

I, personally, could be represented by a spectacle case without specs because I've lost them, a box of old laxatives from the passenger footwell of my car because they've been there FOR EVER, and a pint mug of cold tea because I never get round to drinking it. Unfortunately these don't paint quite the image of glamour and sophistication that I had rather hoped for at this stage of my life, and they may not have the kind of impact and visual appeal we are after. Nevertheless the truth, as they say, isn't pretty, and if you saw the inside of my car you'd be forced to agree.

We'd like your opinions, though. What about a speculum? Does a speculum, that delightful object of icy torture designed, I suspect, by a man, say something profound about you? And if so, should it be a nice shiny metal one whose screw locks when you are trying to extract it post-cervical smear, or should it be the ghastly plastic one that feels about as substantial as a Kinder Surprise? Iodine, or hibiscrub? A parking ticket, or a doctor permit? A College tie, or a stuffed owl (don't you dare say a stuffed owl). A copy of RCGP News or the BMJ? And what about the heads of last few Health Secretaries, suitably shrunken via Papuan New Guinean technology and preserved for our delight?

We are looking for ideas, suggestions, the thoughts and images that come into your mind when you think of the 2012 GP. Those that work

– those that are visually appealing, will need to be viewable through glass now and in 50 years time, from a distance of about six feet (the height of the future general practitioner, you understand).

The chosen objects need to survive in a vacuum sealed box without festering unappealingly. We don't want to be commemorated by fungi, even if we spend a lot of time dealing with them. Neither do I want Mr Handsome's mole in there, even though when I removed it yesterday he generously offered to let me keep it in memory of him.

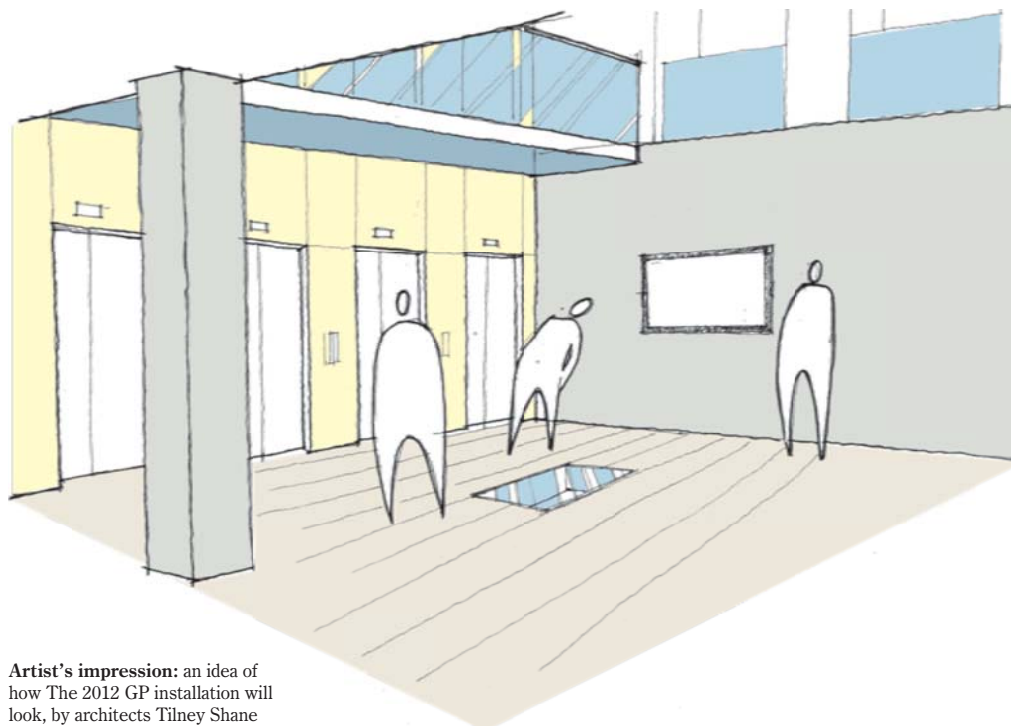
If we choose something branded, like a drug company branded biro (soon to be lost from memory) then we may risk accusations of advertising (the day all the Viagra pens fell out of my bag in Marks and Spencer comes painfully to mind).

So this is the first call for ideas. What would you like to see in the glass topped capsule which will represent the GP of 2012?

Please send your ideas in an email to timecapsule@rcgp.org.uk – backing your suggestions up with 100 words explaining why you've chosen them.

We will keep these in the College archives forever so you too will become a part of history. If you can add in a small photo of yourself that would be even better. I promise to read them all, laugh at some of them, cry at a few of them and take everything just as seriously as you think appropriate.

I look forward to hearing from you and we'll keep you posted.



Artist's impression: an idea of how The 2012 GP installation will look, by architects Tilney Shane

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



Global health in general practice

RCGP Junior International Committee holds third national meeting

Dr Rachael Tait MRCGP
First5 GP, Norfolk



Having recently returned from a year working with Voluntary Service Overseas in Malawi, I thought the Junior International Committee (JIC) national meeting might give me an opportunity to wax lyrical about treating crocodile bites and operations conducted under the light of a mobile phone. Indeed, it did, but there is a lot more to the JIC than I had initially thought.

Ordinarily, the only reason for me to venture to East Croydon is to sample the haute cuisine curries concocted by my in-laws.

The cynics amongst us might have thought international ventures are an excuse for a holiday. However out of inspiration from our European peers at the 2008 WONCA Europe conference in Istanbul, the JIC has grown into a network of around 200 young UK GPs led by a team of "Bright Young Things" in the form of the core Junior International Committee, who have shown phenomenal drive and commitment to facilitate international educational activities to the newer cohorts of RCGP members.

There are now similar groups popping up all over the world, and the Committee was recently awarded nearly 80,000 Euros by the European Union to fund exchanges between Associates in Training (AiTs) and First5 GPs and their counterparts in countries as diverse as Lithuania and Portugal as part of the Hippocrates exchange programme. The annual meetings have become a cornerstone of the RCGP International department's calendar.

For the Third Annual Meeting, RCGP President Iona Heath kicked the day off, and Val Wass

(RCGP International Committee Chair) chaired the morning session. I was in awe of the experience and passion of my 'junior' peers, a sentiment echoed by Val and Iona.

Emily Spry (ST3, London) recounted her time working in Freetown, Sierra Leone, as Medical Coordinator of the Welbodi Partnership, a charity which improves child healthcare. In the odd spare moment she has also squeezed in being President of Medsin and led the International Federation of Medical Students' Associations (IFMSA).

She considered some of the practicalities of taking time out of GP training to undertake Out Of Programme Experiences. It was good to hear from Steve Mowle (RCGP International Committee & London Deanery Associate Director) that, at least in London, the Deanery is now much more supportive of such ventures, and recognises the value of these experiences.

Jienchi Dorward (ST1, London) inspired the audience highlighting the need and opportunities to engage in global health issues from within the UK through work with refugees and asylum seekers.

Greg Irving (Immediate past AiT chair, Liverpool) revealed how his peccadillo for writing love letters

to the likes of Julian Tudor-Hart resulted in him occupying an office overlooking Lake Geneva undertaking an internship for the WHO. He deferentially referred to himself as an imposter, but with a Masters in Public Health and a considerable amount of published research under his belt, I find this hard to believe.

We also heard from Neil Pakenham-Walsh, founder of HIFA 2015; a virtual network with over 4000 members in 157 countries worldwide whose central goal is for every person worldwide to have access to an informed healthcare provider by 2015.

Over the past three years JIC has been complementing the RCGP international committee as an accessible way for younger GPs to develop their international interests. This does however raise the issue of what becomes of the members when they fly the nest after the inaugural half decade. As the new RCGP international strategy unfolds, developing a greater international infrastructure and diversifying activities, I hope opportunities will arise for GPs such as myself who have experienced the benefits of combining a career in General Practice with international work and would like to continue to do so.

In the afternoon session, Sara Cato (ST3, Henfield) offered her personal reflections of how taking part on a Hippocrates exchange to Spain had given her a new perspective of primary care in the UK. Jessica Watson (ST2, Bristol) and Liz Brown (ST3, London) related their experience as UK academic clinical fellows of the benefits of complementing academic work with running international workshops at WONCA conferences, and of joining the European General Practice Research Network (EGPRN).

A series of workshops followed. The Research group workshop discussed the innovative concept of a junior primary care researchers' network forum, considering the requirements that a modern day participant would want from a social networking facility with a focus upon primary care research. Some excellent suggestions were made to allow such a project to be brought into actuality and eventually expanded to allow international collaboration.

The Education and Training workshop started with the opportunity for participants to share their varied experiences of the benefits gained from international work/global health related activities and to link these benefits to the RCGP curriculum. This was followed by a lively debate on the pros and cons of introducing

a 'global health stream' into the RCGP curriculum. Participants then broke into small groups to consider which of the current RCGP curriculum statements might benefit from global health teaching or international experiences. There was a real buzz and enthusiasm to the session which was summed up perfectly by one participant; 'Global health is being brought to the doorstep'.

The Exchange workshop considered the increasing interest in undertaking and hosting international exchanges through the Hippocrates programme. There was recognition of the barriers to organising exchanges and in recruiting hosts. Language barriers, study leave permission and financial support were considered the main obstacles. However the unique learning and teaching opportunities for GP practices were recognised as invaluable.

The 'Going Global' workshop considered the benefits and risks of undertaking international experience in General Practice. Group members were able to share their first hand experiences of working abroad with NGOs such as MSF and VSO, and even forming educational links with Colombian GPs. There was clearly a thirst for knowledge in this area. It was recognised that a form of "buddying" would help those hoping to undertake overseas work to make more informed choices and access first hand information about practical issues such as Performers Lists and pensions, as it was clear that concerns in these areas could be barriers to those hoping to work outside the UK.

What a day. I felt inspired, uplifted and, rather frighteningly, the wanderlust which I've been keeping at bay since I came back from Malawi rearing its head. It was great to be able to share my experiences and link in with like-minded peers, links which I certainly hope to foster in the future.

Before leaving, the technical genius of the committee, Soleman Begg (First5, Newcastle), invited those with flashy phones to point them at some barcode on a piece of paper which instantly took you to a link with all the information from the day. But no matter how much I waved my Luddite Nokia 6310, nothing happened. Maybe it's time I moved to the senior section.

For more information on the RCGP International activities & WONCA:

www.rcgp.org.uk/international.aspx
www.globalfamilydoctor.com

The Committee has grown into a network of around 200 led by a team of 'Bright Young Things' who have shown phenomenal drive and commitment to facilitate international educational activities to the newer cohorts of RCGP members.

The ethics of GP commissioning

Dennis Cox

RCGP Council Member

Martin Marshall

Chair of RCGP Ethics Committee

Christine Johnston

Clinical Lead RCGP Centre for Commissioning

As GPs contemplate the responsibilities they will face as commissioners, there will be few who will not have questions about the ethical implications of this emerging role.

GP commissioning is to be a compulsory activity which is integral to possessing a primary care contract. The statutory duty to offer appropriate services to your population will put those doctors who wish to act purely as patient advocates in a difficult situation.

At first sight, the General Medical Council appears to be uncompromising when it states that you must make the patient your first concern. You have to look hard to find an equivalent responsibility towards the population but it is there in the section dealing with management. The section on management applies to GP commissioners because GPs will be accountable for public funds.

An emphasis on the practice population is not new, pioneers such as John Fry (age sex registers) and Julian Tudor-Hart (hypertension screening), led the way in demonstrating the importance of this approach. Modern GPs have ably risen to the challenge of the Quality and Outcomes Framework which contains many population measures, and if you consider the achievements of public health - most (e.g. vaccination and smoking cessation) have been delivered through primary care. If we ask whether or not it is right for the GP to balance the needs of the many against the needs of the individual, the answer must be yes. You have a duty of care to your patients but that is not your only responsibility. In a service funded by taxation, free at the point of delivery both doctors and patients have a civic responsibility to ensure that resources are used appropriately and to the best effect.

The proposed system will however present GPs with serious ethical dilemmas as they try, in the absence of NICE guidance, to provide the services that they can afford in order to fulfil their legal obligation to balance the books. Ingenuity and innovation might enable them to succeed - we can only hope.

Many see GP-led commissioning as a new task and ask whether it is right to accept a new responsibility for which they have not been trained. Others wonder how they will find the time. These are

valid points. As doctors we must only act within our competencies. GP commissioning applies to all GPs but some will take the lead and will need specific training and time protected by adequate funding.

The value of GP-led commissioning must lie in the fact that doctors understand clinical pathways and are able to influence the patient's journey along them (it does not necessarily lie in the fact that we are able to absorb additional portfolios). Formal commissioning (e.g. proper needs assessment, tendering, procurement and contract management) is complex and must be done in conjunction with public health and competent managers. Having said that, GP commissioning does require new skills and our CPD must reflect the new competencies that are required - in addition we owe it to our Associates in Training to make sure that the GP curriculum includes sections on commissioning.

Those that do not seek a leadership role may prefer to leave commissioning up to the enthusiasts whilst they get on with the "real work" of seeing patients. Ignoring the changes is not a sensible option. As the bill stands, the consequences of non-engagement with commissioning can be severe, your consortia could report you to the National Commissioning Board and this could put your primary care contract under threat.

If we try to look beyond the legislation and ask ourselves "what does it mean to be a good doctor in this new world?" we might conclude that "commissioning" at a practice level really means appraising and reflecting on what we do with the aim of improving the care that all of our patients receive, and how we do the most good with the limited resources we have.

If we are able to accept this then we should have no moral objections to reviewing our referrals with the question "was this the best pathway of care", reviewing our prescribing with the question "are we using resources efficiently" or collaborating with others to improve clinical outcomes. Whilst these activities are integral parts of "commissioning" we could just as easily call them "good medical practice".

The new world will be different though because when services get stopped, care becomes rationed or waiting lists get longer, you will no longer be able to blame the Secretary of State or the Primary Care Organisation for not providing a comprehensive health service - it will be the responsibility of your GP consortium to provide those services it considers appropriate.

In an article of ethics, it is perhaps relevant to ask ourselves whether it is right for the government to downgrade its own responsibilities from being the provider of a comprehensive health service to that of being a regulator (in the same manner that gas or electricity is regulated).

One way of looking at GP commissioning is to say that the Secretary of State has devolved accountability for the NHS budget down to GP consortia as statutory bodies and removed the need to provide a standard set of NHS services. This means that GPs will be obliged to decide what services are appropriate for their population but because the budget is fixed they will have to prioritise.

A necessary consequence of this is that variations in service will emerge. This may be appropriate where the local need is different, it is likely however that there will be areas where variation of services will occur because of financial constraints.

The pursuit of equity has been a long term aim of the NHS. Efforts have been made in the past to address the inverse care law by increasing the NHS funding in geographically deprived areas. The government's plans to abolish geographic GP lists means that it will not only be more difficult for a practice to take responsibility for a deprived area but it might also usher in an era of primary care advertising or cherry picking where young fit patients in city centres are encouraged to join city centre practices. As a profession, we need to think carefully about the conflicts of interest that might arise in these circumstances.

GPs are providers of health care and many have been encouraged in recent years to form links with private companies or organisations. It is likely that in their role as commissioners they will have to make decisions which might impact on their business interests. Arguably, there are conflicts of interest whenever GP consortia use the commissioning budget to pay GPs for a service over and above their basic contract (this includes Local Enhanced Services and Commissioning Incentive Agreements).

There also might also be conflicts when savings from the secondary care budget pay for equipment or improvements to GPs' property. The law is clear - interests need to be registered and declared - but we may need to go further than this, we only have to look at the MPs' expenses scandal to see the devastating effect that loss of public confidence can have on a profession.

The only way to reassure the public must be complete openness and transparency which includes holding our meetings in public, publishing our minutes and open book accounting - this must be the right thing to do when we are accountable for spending taxpayers' money. The Nolan Committee set out seven principles which those with public accountability (such as GP consortia) should adhere to.

A simple test: If you think you might be embarrassed to explain something to the Daily Mail, a conflict probably exists.

Not all professional groups or patients are happy with GPs being given so much control over the NHS budget. Using GPs in this way is probably the nearest that the government can get to giving individual patients control of healthcare spending in view of the unpredictability of individual health care spending.

Personal healthcare budgets have been devised for some long term conditions but progress has been slow. GPs do have a democratic mandate

in the sense that the government was democratically elected however they do not have a direct accountability to the public in the same way that local councillors do.

They should engage fully with local councils, HealthWatch, overview and scrutiny committees and health and wellbeing boards. Failure to do this will leave GPs vulnerable to criticism from all sides when difficult rationing decisions have to be made.

Autonomy is an important ethical principle in relation to patients; many GPs anticipate increased professional autonomy under the new system. They may have resented the balanced scorecards, prescribing restrictions and referral management imposed on them by PCT managers, however, as a member of a GP consortium, it is likely that practices will experience similar pressures from their consortium leaders especially when budgetary constraints bite. The difference under the new system is that non compliance could result in loss of your primary care contract.

Increased competition has been proposed as a mechanism to make the NHS more efficient. The NHS is no longer experiencing growth and this means that competition will make existing providers weaker unless they in turn make productivity gains. The dilemma facing GP commissioners is whether to support existing local providers with a view to increased co-operation and integration or whether to improve quality and budgetary control by putting services out to tender.

EU competition law (together with the actions of Monitor) might force GP consortia to do the latter. If our hospitals or community services come under too much pressure they will have to make cuts and GPs will have to consider how they explain the loss of local hospital services to an angry public. The issue here is whether any benefits coming from engaging with alternative providers is outweighed by the adverse consequences.

General practice is constantly changing and GPs are good at adapting to change. GP commissioning places GPs at the centre of the NHS and perhaps now is the time to bring an independence of mind to these changes when assessing the impact that they might have on our patients.

The Seven Principles of Public Life are:

- Selflessness
- Integrity
- Objectivity
- Accountability
- Openness
- Honesty
- Leadership

www.public-standards.gov.uk/About/The_7_Principles.html

This is the latest in an occasional series of articles initiated by the RCGP Ethics Committee and designed to stimulate thought and debate on ethical dilemmas in general practice.

The article does not represent the views of the College or of the Ethics Committee but is intended to provoke discussion.

If you think you might be embarrassed to explain something to the Daily Mail, a conflict probably exists.

Addressing the mental health needs of Veterans

Richard Williams

Registered Nurse (Mental Health),
Military Veteran and Managing Director
Military Mental Health CIC (MMH)

National Veterans Awareness (NVA) is a campaign run by Military Mental Health Community Interest Company (CIC), a new type of company introduced in the UK in 2005 under the Companies Act 2004. It is a social enterprise that uses its profits for social benefit. NVA aims to raise awareness on a number of levels:

- **Primary care staff** – Military Veterans Awareness Workshops
- **Families of veterans** – Veterans' Families Stress Awareness courses
- **Veterans** – Veterans Stress Awareness Courses
- **The general public** – public events

Carolyn Chew-Graham, a GP in Manchester and co-chair of the Primary Care Mental Health Forum (www.rcgp.org.uk/mental_health.aspx) and former RCGP Clinical Champion for Mental Health is patron of the organisation.

Overview

Currently there are ten million veterans, including their families, in the UK (Royal British Legion, 2005) and each year between 18,000 and 25,000 people leave the services (MOD, 2009).

According to the National Association of Probation Officers, there are approximately 8,000 veterans in prison and a further 12,000 on

probation (NAPO, 2008). Over the coming years there will be a scale-down in the size of the Armed Forces and it is expected that for the year 2010/11 there will be 25,000 service leavers.

Of the population of service leavers, four per cent have post-traumatic stress disorder relating to their service on discharge, and 19.7 per cent of veterans experience depression and anxiety (The Lancet, 2010). During 2009 3,103 new cases of mental disorder were identified within the UK armed forces by Defence Analytical Services and Advice (DASA, 2010).

In addition, many veterans perceive that health care professionals do not fully understand their needs, may feel that they don't fit into their own communities and that they are alone and isolated.

Veterans' psychological wellbeing is seen as a priority for the NHS and veterans are entitled to priority treatment in the NHS depending upon clinical need. In addition, the Coalition Government has set an agenda to improve care for veterans in the NHS, particularly those with mental health problems.

GPs and Military Veterans

An online survey of 500 GPs in England and Wales by Ipsos MORI in 2009 found that 81 per cent said they did not know very much or knew nothing about priority treatment for veterans. In addition, 85 per cent had not informed



secondary care providers of veterans' entitlement to priority treatment in the past 12 months. In the same survey 64 per cent of veterans said they were not even aware that they could be entitled to priority treatment.

It is known that veterans are difficult to engage and most of the patients questioned in the survey also said that they had not been asked 'are you a military veteran?' by their GP – and they had not disclosed that they were veterans.

In addition, in the resettlement process the Early Service Leavers who are in an age group typically between 18-25 are not entitled to a comprehensive resettlement programme.

The Mental Health Foundation revealed in 2010 that ESLs are two to three times more likely to attempt suicide than people in the same age group with no military experience. Early identification of this group of veterans is vital in offering early interventions.

The goals of the NHS in relation to Military Veterans can be summarised as follows:

- Veterans to receive priority treatment for conditions attributed to service
- For primary care staff to make timely and appropriate referrals
- To ensure services are effective for veterans
- To increase confidence amongst staff in working with veterans
- To liaise with ex-services organisations to ensure that the needs of veterans are included in developing services
- Staff to take measures to broaden their understanding of military culture

Mental Health problems relating to time served in the armed forces are often overlooked. These problems may relate to trauma experienced during service life and/or difficulties adjusting to life outside of the armed forces.

Healthcare professionals should have knowledge and understanding of military culture and ethos and of the experience of service as explained through the lived experience, professionals should also routinely ask clients if they have a background in the armed forces and follow the appropriate pathway to support and further treatment.

Veterans often respond to those who share the common bond of service and are more likely

to engage in support that is led, or that has been informed, by veterans. National Veterans Awareness is designed to raise awareness of the challenges that face veterans and of the referral pathways that exist into NHS services such as IAPT and trauma services as well as the pathways into the service charities.

Professor Carolyn Chew-Graham adds:

"I was asked to become Patron of this Manchester-based organisation partly because I am a Manchester GP, but also because of my role as co-chair of the Primary Care Mental Health Forum.

"Richard was very keen to gain the support of the RCGP to the campaign as GPs are the first point of call for people with mental health problems and have a vital role to play in identifying distress in ex-military personnel who present to them.

"As a result of my involvement, I have added an extra question in my consultations and now ask whether the patient is ex-military."

www.nationalveteransawareness.org.uk

RCGP support on Veteran healthcare

The Royal College of General Practitioners has published its own guidance to support GPs in identifying and meeting the healthcare needs of veterans more effectively.

Produced in partnership with The Royal British Legion and Combat Stress, it looks at how GPs can best care for the physical and mental health of Veterans after they have left the Forces and rejoined civilian life.

It provides useful advice on medical records and accessing priority treatment, along with dedicated sections including mental health needs, health behaviours, the provision of prostheses and hospital waiting lists.

It also shows how GPs can identify veterans on their lists and encourages best practice when referring veterans for further care. This includes provision of a written statement confirming that the patient is a veteran and whether or not their health problem could be related to their military service.

- Meeting the Healthcare Needs of Veterans: a guide for general practitioners is available free of charge from www.rcgp.org.uk/pdf/veterans.pdf

RISKS TO VETERANS

RISK TO SELF:

Isolation

- Strong social networks can promote a sense of wellbeing, help develop confidence and allow greater access to employment or volunteering opportunities. Social networks can be reduced when veterans leave the forces.

Depression

In a recent study undertaken of a sample of 315 veterans, 167 (53.4 per cent) were found to have a depressive illness and 51 (16.3 per cent) PTSD (Iverson *et al*, 2005).

Suicide

- Stigma associated with depression makes reporting symptoms extremely difficult.
- More than 300 Falklands veterans have ended their own lives since the end of the conflict in 1982 which is more than were killed during the conflict.

- Those at particular risk of suicide are men aged 24 and under who served in the army for fewer than six years, were of low rank and unmarried. Risk of suicide is greater in the first two years of discharge from the armed forces.

RISK TO OTHERS:

Aggression/Violence

- 8,000 veterans in prison: convictions primarily included violence. The majority of cases were drug- or alcohol-related. Nine per cent of the prisoner population in England and Wales are veterans.

Family Breakdown

- Domestic violence, divorce and impact on children – 49 per cent of early service leavers cited impact of service on family life (National Audit Office, 2006)

Harnessing patient experience to improve the care of people with autism

The RCGP's new Autism in General Practice online course is a groundbreaking new resource that uses real patient experience to raise awareness of Autistic Spectrum Conditions and to highlight the challenges that people with these conditions face on a day-to-day basis.

The course is available now on the Online Learning Environment (www.elearning.rcgp.org.uk). It has been developed in collaboration with Healthtalkonline, the award-winning website featuring the personal stories of over 2000 people covering a wide range of health conditions, with funding from the Department of Health's Autism Strategy Team.

Incorporating patient experience

To help GPs and their teams understand the challenges faced by patients and their carers, the course contains video clips of patients and carers describing their experiences, collected by Healthtalkonline. Healthtalkonline (www.healthtalkonline.org) is a patient-centred resource founded by Dr Ann McPherson CBE and Dr Andrew Herxheimer after their own experiences of illness. The website provides a unique database of personal and patient experiences based on rigorous qualitative research methods by the Health Experiences Research Group, University of Oxford. These personal stories of health and illness enable patients, families and healthcare professionals to benefit from the experiences of others.

The Healthtalkonline research team, based at the University of Oxford, is also working with

the RCGP's e-learning team to evaluate the effectiveness of incorporating patient experience into the design and content of educational materials used by primary care practitioners.

This new e-learning course integrates clinical information on autism with clips of patients and their carers, providing a uniquely patient-centred learning experience. The videos bring to life aspects that patients identify as particularly important - such as making a diagnosis, the sensory and communication challenges of autism, employment issues, and the impact of autism in older life.

The Autism Strategy

Autistic Spectrum Conditions affect approximately 400,000 people in England and GPs and primary health care teams throughout the UK perform a vital role in supporting these patients and their carers from diagnosis through to old age.

The 'Fulfilling and Rewarding Lives' document from the Department of Health proposes that all primary care staff should be aware of autistic spectrum conditions and the ways that affected patients may present. The Autism Act 2009 has made provision that all those suspected of having an ASC should be entitled to diagnosis and treatment - however, it is likely that there are some patients in your own practice who have not had the benefit of this. The people involved in the care of people should be offered a carer's assessment.

The core features of autism include difficulties with social communication, social interaction and social imagination - but patients with autistic spectrum conditions show large variation in how this translates to them as an individual and the challenges they face, and therefore the ways they will present to a primary health care team vary also. How confident do you feel in recognising the ways that these characteristics may present in surgery or how to rapidly screen for the key features of an autistic spectrum condition? You may be surprised to find how prevalent these features are in the population.

It can be a challenge to communicate with someone who is on the autistic spectrum and there are simple steps that can be taken to increase success, both with the patient and with those involved in their care.

How GPs can help

Once someone is diagnosed with an autistic spectrum condition, there are many interventions that can help improve their social skills and ability to interact. These interventions are critical at the times of transition from childhood to adulthood. Once out of the educational system, general practice becomes the key place where patients and carers may seek help. The new course sets out some practical tips that GPs and their

practices can take, such as organising reviews to help during key times of transition. It also explains where to signpost people to, so they can find more information.

The fundamental aim of the *Autism in General Practice* course is to enable primary healthcare staff to improve their consultations and communications with autistic patients, and their carers, and so improve the health and opportunities of this group.

The *Autism in General Practice* online course is available free-of-charge to RCGP members, AITs and other primary care professionals at the RCGP's Online Learning Environment www.elearning.rcgp.org.uk.



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"Extremely impressed by the conference and based at the right level for GPs."
Bethan Forgie, GP

"It was an excellent conference - well worth the money. The speakers pitched the information at the correct level and were knowledgeable. I came away buzzing and can't wait to put what I learnt into practice."
Dr Emma Rawson, GP, Worcester

"A good one-day conference and much more GP-relevant than most."
Liz Williams, GP, Lambeth

"The conference reinforced knowledge I already had and gave me an update on assessment and interventions that will enhance my patient care."
Lorna Rowe, Physician Assistant

The Healthtalkonline research team, based at the University of Oxford, is also working with the RCGP's e-learning team to evaluate the effectiveness of incorporating patient experience into the design and content of educational materials used by primary care practitioners.

Commission gathers pace

The first phase of the Commission on Generalism is now well underway.

The Panel of Commissioners, chaired by Baroness Iora Finlay, has held an initial seminar to hear experts' views on generalism and are now undertaking a series of oral evidence sessions.

Their work will also include a consultation with external healthcare organisations including the other Medical Royal Colleges, the Department of Health (England), third sector and charities, alongside internal RCGP Committees and groups.

Closing date for responses is Friday 17 June and the Commissioners will report their findings in September.

Phase two will be led by the College and will involve testing the Commissioners' recommendations at six regional events across the UK in the autumn, as well as a written consultation of the entire RCGP membership.

Findings are expected to be published in early 2012.

Further information - including consultation questions and the project's terms of reference - can be found on the RCGP website at: www.rcgp.org.uk/policy/commission_on_generalism.aspx or by contacting: commission@rcgp.org.uk

GPs take centre stage

The achievements of the GP world were celebrated at the RCGP Spring General Meeting, held at London's Mermaid Theatre.

Thirty six College members were awarded Fellowships and former Chair of RCGP Wales Dr Terry Davies gave the prestigious William Pickles Lecture, discussing whether GPs sometimes put too much emphasis on the 'straight line science approach in their diagnoses' when often their initial 'hunch' was correct.

Professor Sir Ian Gilmore, former President of the Royal College of Surgeons, and public health leader Dr Alan Maryon-Davis were among those receiving Honorary Fellowships for their support of the RCGP and generalism.

RCGP President Dr Iona Heath said: "In this post-White Paper world, it has become all too clear to clinicians in both primary and secondary care that working more closely together, after decades - if not centuries - of unhelpful separation simply has to be the way forward."

The Rose Prize, awarded biennially with the Worshipful Society of Apothecaries of London, for original work in the History of General Practice, was presented to Dr Alena Chong for her essay on Sir Arthur Conan Doyle's experiences as a GP.

As always, the event had its light-hearted and humorous moments and new RCGP Fellow Dr Glen Hedworth Hall from West Scotland delighted the audience by showing off the socks he had hand-knitted especially for the occasion!

Further information on the award-winners and photos from the event can be found at www.rcgp.org.uk/sgm

RCGP research grants now available

Apply now for research grants of up to £20,000 from the RCGP Scientific Foundation Board.

The Scientific Foundation Board is a charitable funding body of the College. Chaired by Professor Greg Rubin, it supports high quality primary care research studies, particularly where they demonstrate research skills in general practice. It awards grants for research projects where findings will be of direct relevance to the care of patients in the general practice setting.

A valuable source of funding for interesting studies which do not fall within the NHS research

agenda, priority is given to applications from young and/or new researchers who have not previously been funded, or pilot studies and short term studies lasting up to about 18 months.

Any GP, primary health care professional or university-based researcher may apply for a grant for scientific research to be undertaken in the UK.

To apply or for more information, please visit: www.rcgp.org.uk/circ

Deadline for applications is Thursday 30 June 2011.

College seeks new clinical lead to combat gambling addiction

The RCGP is looking to recruit a clinical lead to run its unique training programme to support GPs in identifying patients at risk of or facing harm from gambling.

The programme - a collaboration between the RCGP and the Responsible Gambling Fund - will support GPs with a training

package that includes online learning, workshops and reflective analysis, supported by web-based toolkits, factsheets and case studies.

If you are interested, please send a CV and personal statement to gamblingawareness@rcgp.org.uk

GPs on the lookout to prevent sight loss

National Eye Health Week runs from 13-19 June and the Royal National Institute of Blind People (RNIB) is calling on GPs to promote good eye health and help prevent avoidable sight loss in the UK.

The RNIB is calling on GPs to:

- Ask all patients when their last eye test was and remind them they need a test every two years, or annually if aged 70+ or in an at risk group
- Ask all diabetic patients if they're attending their retinopathy screening appointments and remind them how important it is
- Make sure your patients with glaucoma understand the importance of taking their drops and attending regular check-ups
- Consider the possibility that sight loss could be the cause if patients repeatedly present with cuts, burns and falls
- Follow up with stroke patients to ensure they have had a recent sight test. Sight loss can effect up to two thirds of stroke survivors but diagnosis is often missed

RNIB offers practical advice and emotional support for anyone living with sight loss. Encourage your blind and partially sighted patients to call RNIB Helpline on 0303 123 9999.

At rnib.org.uk/gp, you can also access GP education resources to help update your clinical understanding of sight loss conditions and find out more about how to treat and support patients in your surgery.

Three key areas are covered:

- **Prevention:** practical tips on identifying and preventing sight loss in susceptible groups
- **Treatment:** features a guide to managing eye conditions, an interactive patient case study and more
- **Solutions:** information about services available that can improve your eye health management and help patients

Additional education resources are also available through Doctors.net.uk

For more information on National Eye Health Week or the work of the RNIB visit rnib.org.uk/gp

RCGP News invites your comments

Please write to:

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Royal College of General Practitioners
1 Bow Churchyard, London EC4M 9DQ
email: rcgpnews@rcgp.org.uk

A richness of research in this month's Journal

Acupuncture and Aspirin are the themes of two separate papers published in the June edition of the British Journal of General Practice.

Seonaidh Cotton and colleagues from Aberdeen also report on their study of over 1000 women on their experiences after having smear tests, with almost one third reporting symptoms such as pain, bleeding and discharge.

Other papers include Corlien de Vries and colleagues from Amsterdam on the patient benefits of giving GPs direct access to transvaginal ultrasound scanning.

RCGP Clinical Champion for Headache Dr David Kernick argues that headache in adult patients should be investigated by direct access to CT scanning but not to MRI, because of the greater costs involved and the incidental findings often encountered.

The BJGP is the leading journal of family medicine in Europe and is distributed free every month to over 42,000 members. www.rcgp.org.uk/bjgp



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