

# College gears up for revalidation

**A programme of work to help RCGP members prepare for revalidation has been given the go-ahead by RCGP Council**

While the government and the General Medical Council have yet to publish their timescales for relicensure and recertification, which together make revalidation – and which obviously impact on the College's own role and timings – Chairman Steve Field and College Council are putting steps in place to ensure that members have as much information and lead-in time as possible to

## BACKGROUND

- Revalidation encompasses two activities – relicensure and recertification.
- All doctors registered with the General Medical Council will be required to hold a licence to practise, which will need to be renewed (relicensure) every five years.
- Those doctors working unsupervised within specialties have been issued with certificates and appear on either the General Medical Council's Specialist or General Practitioner registers. In order to continue to be on these registers indicating specialist skills, doctors will need to renew their certificates every five years (recertification).
- The requirements for revalidation will include those for both recertification and relicensure so that one process covers both outcomes.

familiarise themselves and fully prepare for the process.

One of the first outputs members will see is the publication of *Good Medical Practice for General Practitioners* (GMP for GPs), which will be going out to consultation shortly.

Based on the GMC's Good Medical Practice, the document was first made specific to GPs in 2002 and subsequently revised in 2006. Its aim is to provide important guidance to general practitioners on the expectations of their peers and the public of GPs' standards of care and behaviour.

Key changes in the latest version include the replacement of the term 'excellent GP' with 'exemplary GP'; a new section on appraisals; reflection of the changes in out-of-hours provision; and the upsurge in web/e-mail communication.

The statements in GMP for GPs will inform the standards expected in revalidation. The 'exemplary GP' statements will guide the formative discussions in GP annual appraisals, while the descriptors of an 'unacceptable GP' and the requirements for revalidation will inform an appraiser's judgements.

Other revalidation activity already under way is the development of a managed CPD system by the RCGP Professional Development Board (see page 4 for the latest CPD update and information on Essential General Practice).

**"The exemplary GP statements will guide the formative discussions in GP annual appraisals"**

A UK-wide paper describing the principles and process of appraisal will also be posted on the RCGP website shortly. Work on appraisal has highlighted the need for a timetable for the collection of evidence to be developed over a five-year cycle. A short-life working group will be set up to build on the work already done in Scotland and Wales and develop Criteria, Standards and Evidence informing the content of the recertification portfolio. This will also take into account the Workplace-Based Assessment element of the nMRCGP.

The College has established three groups dedicated to the management, governance and delivery of revalidation:

- Revalidation Stakeholder Group, chaired by Professor Steve Field
- Recertification Technical Group, chaired by Professor Dame Lesley Southgate, to be tasked with specific pieces of work
- Revalidation Governance Group, chaired by RCGP Chief Executive Hilary De Lyon, which will ensure that the project is effectively managed and delivered cost-effectively.

Professor Field said: "The development and delivery of a system for the revalidation of general practitioners will be the greatest challenge for the College over the next 2-3 years. While the main focus of work is concerned with the recertification element, relicensure will also require College input.

## THE THREE PHASES

- Preparation of over five years of evidence, which will be discussed at annual appraisals.
- Submission and assessment of that evidence to ensure it meets the standards for revalidation – RCGP will lead on this second phase but the GMC will approve the standards and quality-assure the process.
- Third phase – only for GPs whom the RCGP is unable to recommend for revalidation (in which case the GMC will assess performance through Fitness to Practice processes before the GP's certificate is put at risk).

"This is something we must all commit to as it will improve the quality of care for our patients and I am determined that the process will happen without causing added bureaucracy or heartache for individual doctors and the profession."

## PROVISIONAL TIMESCALE

- 2008** Publication of *Good Medical Practice for GPs*. Development of proposals and start piloting.
- 2009** Incremental rollout, piloting and evaluation.
- 2010** Proposals available for agreement with GMC.

## Inside...

### OPINION PIECE

#### Salaried GPs

Dr Clare Gerada issues a warning page 2

### MEMBER IN NEWS

#### GP mentioned in Commons

An invitation to the Prime Minister page 2

### INTERVIEW

#### Question Time

RCGP Chairman interviews Lord Darzi page 3



### PROFESSIONAL DEVELOPMENT

#### Approaching CPD

Prioritising your learning needs page 4

### MENTAL HEALTH

#### Depression in older patients

Derek Beeston discusses warning signs page 5

### ASTHMA AND HAY FEVER

#### New treatments for children

Examining the options as the season approaches pages 6-7

### LAUNCH

#### NI Patient Group

Encouraging GP-patient cooperation page 8

## Government praise for the RCGP

Health Secretary Alan Johnson and the Secretary of State for Work and Pensions James Purnell joined forces with RCGP Chairman Professor Steve Field for the launch of a groundbreaking agreement acknowledging the important role of work in patients' health.

Leaders of more than 30 healthcare professional bodies came to the College to sign the consensus statement, developed in partnership with the National Director for Health and Work, Professor Dame Carol Black, and pledge their mutual efforts to help patients enter, stay in or return to work.

Work and Pensions Secretary Mr Purnell announced plans to extend a pilot education programme run by the RCGP and the DWP, which has been successful in providing over 150 GPs in six areas with training and practical help in treating patients on long-term sickness benefit.

He said: "Health professionals are recognising the role that

work can play in getting people fit and healthy and this will create a crucial culture change for the welfare state. I want to make

sure that we give GPs the support they need to help their patients see that work can be part of the solution not part of

the problem and that's why we'll be rolling out a new national training programme developed with their needs in mind."

Later that same day, Health Secretary Alan Johnson also praised the College for its work on provider accreditation.

In a keynote national speech to the NHS Confederation, he said: "Throughout general practice, doctors and other health professionals take a justifiable pride in the service they provide to patients. But there are significant variations in the quality of primary care and we want to support the profession's efforts to maintain high standards of care for all patients everywhere. This is why we welcome the work of the Royal College of General Practitioners to develop a professionally led accreditation scheme for GP practices.

"It will both recognise and celebrate excellent practice and encourage all surgeries to develop and improve the quality of services they provide to their patients. Improving quality is at the heart of the government's strategies for the NHS and we are working with the College and the BMA to explore a variety of approaches as we develop further proposals on primary and community care."



# The enemy within

The Darzi review is commanding our attention, but there is another issue – equally as important as polyclinics – that threatens to destroy general practice as we know it.

The tragedy is that this change is not being imposed on GPs by central government; rather, it is being brought upon the profession by itself.

This ticking time bomb is the growth of the salaried GP.

Quite simply, the loss of GP partnerships is leaving the door open to the private sector to entice salaried doctors into ostensible lucrative positions. Salaried doctors are talking about 'dead-end careers' and being 'staff grade' doctors. They are fearful that they have lost their chance of ever being able to shape general practice and have lost the opportunity to influence the provision of primary care. A collective helplessness, confusion and malaise is pervading the profession, with those who are partners being set against the ever-growing workforce of salaried doctors.

There is a strong chance that general practice could implode. Despite the ongoing debate over the Darzi review and privatisation, we seem to have missed a crucial point. Without recognising that we must incorporate salaried GPs into future development plans, we run a significant risk that GPs of the future will be forced to work for private providers or the impersonal polyclinics we are so passionately against.

The time has come for us to sit up, take notice – and take action.

As a GP in central London, where 60 per cent of doctors are salaried, I am troubled by the lack of options open to young GPs and the consequences to the profession of offering only salaried positions.

Because of these concerns, I've recently presented a discussion paper to College Council entitled *Independent Contractor Status and the Rise of Salaried General Practitioners*.

This document echoes the fears raised in RCGP Honorary Secretary Maureen Baker's 2000 paper *Is there a Future for Independent Contractor Status in UK General Practice?*

The latter concluded that doctor involvement in the running of a practice helped streamline practice management, was highly cost-effective, and that many of the innovations in general practice, primary care informatics for example, were developed by enthusiastic GPs who invested time, money and energy to bring them about. By contrast, it was unlikely that salaried doctors could or would be able to commit their time or personal finances to a practice in the same way.

I am not saying for one moment that salaried GPs are in any way inferior to their partner colleagues, or that all salaried GPs are dissatisfied and disenfranchised. Indeed, there can be many benefits to salaried GPs – they may help reduce the workload and burden on busy practices and in many cases provide high-quality care, commitment and innovative practice.

My concerns centre on the frustrations of those who are forced into a salaried position and the growing numbers of young GPs who desperately want a partnership – there are over 100 applications for each advertised partnership and it is unusual to see a partnership being advertised at all, the vast majority of new positions being for salaried options only. We are not giving the next generation of doctors a choice.

Since 2004, the number of salaried GPs has increased. A survey of GPs in 2005 found that 88 per cent were principals and 12 per cent were salaried. By 2006, the figures showed that the number of salaried doctors had doubled and the number of new GP partners had fallen by 5.6 per cent. The 2007 General Practitioners Committee (GPC) survey of the UK GP workforce has shown that this trend towards salaried employment is continuing with around one-third of all respondents in salaried positions.

In my view, a major reason for this trend is the 2004 GP contract. The contract provided the drive for all practices to engage salaried doctors, as it signified the end of the GP monopoly for primary care services. Because the government abolished the Medical Practices Committee

mechanism for securing fair distribution of GPs and of primary care services, this meant that money was linked to the patient and not to the number of GPs in practice. Consequently, if a GP left a practice, the practice could try to save money by employing fewer partners, replacing them with 'cheaper' salaried GPs.

Already there is a lack of new recruits to GP education, training and medical politics, and this situation will only deteriorate as the existing numbers of partners become older and less able to continue leading the profession.

Over time, the loss of the traditional GP partner may result in a gradual diminution of the role that the GP plays in their community – having a personal investment in a practice leads to stability in terms of both geography and length of tenure in post, which contributes to continuity of care and the principles of personal doctoring. The patient advocacy role of GPs, especially in deprived and vulnerable communities, is strengthened by independent contractor status and could be irrevocably lost with the expansion of the salaried model.

A three-tier structure is appearing: a smaller older workforce of GP principals; a growing,

currently younger group of salaried doctors; and an unknown number – estimated to be 10,000 – of freelance GPs. Meanwhile, the machinery of privatisation is gaining pace.

It's been widely reported that Sainsbury's has just opened a GP service within one of their stores. Increasingly, under APMS arrangements, large companies are winning tenders to provide

PCT; salaried GPs under what is often a poorly constructed and ill-thought-through contract with their employing partners.

The debate should be about the nature of contracts and how they can be used to optimise the environment within which GPs work and, crucially, to ensure high-quality patient care.

If we are to stem the tide of the salaried GP and dissuade our colleagues against working for private providers, we must take urgent action. In my paper I suggest that the College promotes the partnership model of practice organisation in order to preserve the culture and ethos of general practice; listens to the new workforce to determine their needs; and works with the GPC to develop career pathways for salaried GPs.

As a starting point, my paper will form the basis of a College document, which will be co-badged with the GPC and published over the summer. This will at least set out the RCGP official position on the issue. The rise of the salaried GP will also be a major theme of the 2008 RCGP Annual Conference, allowing us to expand the debate.

Whatever our views, I'm sure we all agree that we can't leave the market to decide the future of general practice – we owe it not only to our profession, but also to our patients.



**Dr Clare Gerada, RCGP Vice Chair and a GP Partner in South London, writes in a personal capacity to warn of a 'ticking time bomb' in general practice caused by the lack of partnerships open to young doctors**

## CASE STUDY

**Dr Janet Hall is a GP in Sheffield. Having just taken on two new GPs at her practice, she explains the reasons why she and her colleagues chose to appoint partners rather than salaried doctors:**

- Increased commitment and more likely to engage in the management and maintenance side of things and to contribute ideas to the development of the practice.
- Flexibility with work allocation and more likely to undertake tedious but essential tasks.
- More involvement in decision-making – people are more likely to adhere to policies and decisions if involved in developing and implementing them.
- Due to us being a low-earning practice (for historical reasons), a partner was a better financial option for us – no locum insurance.
- More opportunity to pursue, utilise and develop personal interests that will benefit the whole practice, such as becoming a GP trainer.
- Reduced staff turnover as less likely to leave.
- No two-tier system of doctors.
- Better job protection for the new doctor.

GP services, sometimes being awarded contracts over established GP providers. Surely it can only be a matter of time before dissatisfied salaried GPs feel that they would prefer to work for one of these large conglomerates.

But does this really matter? And if we decide that it does, what can we do?

The reality is that all GPs work under a contract: partners under an increasingly detailed and managed contract with their

## Doctor in the House (of Commons)

RCGP Fellow and Council member Orest Mulka received a personal mention during Prime Minister's Questions in the House of Commons.

Labour MP for North West Leicestershire David Taylor quizzed the Prime Minister on plans for his next visit to the area, saying:

"The Prime Minister will receive a warm welcome, not least from the area's general practition-

ers, who have implemented our government's primary care policies very successfully since 1997. Will he meet those GPs, such as the highly respected Dr Orest Mulka, whose experience with polyclinics abroad indicates that they will be a step too far and that they might lead to a lower regard for generalist doctors, damage the GP-patient relationship and be wasteful and demoralising as a consequence?"



## Top awards for College

The RCGP scooped two awards at the prestigious Members, Marketing and Communications Conference and Awards Ceremony (MemCom).

The Associates in Training (AiT) e-bulletin and the pre-publicity leading up to the College's first-ever national primary care conference *A Fresh Approach* were awarded first prize in their categories.

The AiT bulletin was produced in order to bring together relevant news from Certification, Assessment, Membership and Events. The planning of the first RCGP national conference included market research to determine what members wanted to see on the conference programme – resulting in over 50 plenary and concurrent sessions over the three days and an attendance of nearly 800 delegates.

RCGP Chairman Professor Steve Field said: "These awards are the 'Oscars' of the marketing world. They represent a huge achievement for the College and are hard-earned and very well deserved. I pay tribute to all the staff involved for the hard work and energy they put into the projects."

## DIARY DATES

### APRIL

**22 Business and PBC Study Day**  
**Engineers' House, Clifton, Bristol**  
 Fees: Members/Associates in Training £25; Non-Members £30  
 Organised by: RCGP Severn Faculty  
 Contact: Rachel Smith on 01264 355012 or severn@rcgp.org.uk

**30 RCGP Masterclass: Dr Iona Heath Disease Mongering**  
**RCGP, Princes Gate, London**  
 Fees: Members £175; Non-Members £220  
 Organised by: RCGP Events Department  
 Contact: Emily Soo on 020 7344 3119 or esoo@rcgp.org.uk

### MAY

**13 Quality – Where is the QOF going?**  
**Dr Brian Dunn, GPC Negotiating Lead and Chair of the NI GPC**  
**Holiday Inn, Taunton**  
 Fees: Members/Associates in Training £20; Non-Members £25  
 Organised by: RCGP Severn Faculty  
 Contact: Severn Faculty 01264 355 012 or severn@rcgp.org.uk

### JUNE

**24-25 Minor Surgery Course**  
**RCGP, Princes Gate, London**  
 Fees: Members £400; Non-Members £450  
 Organised by: RCGP Events Department  
 Contact: Camelia Reynolds on 020 7344 3124 or creynolds@rcgp.org.uk  
**Repeated September 24-25**

### JULY

**4 RCGP Masterclass: Dr David Pendleton Personality in Practice**  
**RCGP, Princes Gate, London**  
 Fees: Members £175; Non-Members £220  
 Organised by: RCGP Events Department  
 Contact: Emily Soo on 020 7344 3119 or esoo@rcgp.org.uk

### SEPTEMBER

**26 RCGP Masterclass: Dr Roger Neighbour Consultation Skills**  
**RCGP, Princes Gate, London**  
 Fees: Members £175; Non-Members £220  
 Organised by: RCGP Events Department  
 Contact: Emily Soo on 020 7344 3119 or esoo@rcgp.org.uk

# Question Time

RCGP Chairman quizzes Lord Ara Darzi on the future of the profession, privatisation and polyclinics . . .

When Lord Darzi agreed to be interviewed by Professor Steve Field for *RCGP News*, we were inundated with suggestions for questions. His responses make for some interesting reading.

**SF: What do you believe are the biggest issues facing general practice?**

AD: Primary care in the UK is rightly regarded with pride, and envied around the world. It has formidable strengths: such as the population focus underpinned by continuity of care through long-term registration of patients, care coordination by GPs and nurses, and a high degree of personal public trust in GPs and other primary care professionals.

However, challenges do exist. For example, there is unwarranted variation in both access to and quality of services. This means the system doesn't deliver excellence for everyone, often those living in more deprived communities. Future demographic and health challenges, as well as rising expectations from patients and the public, mean that primary and community care has to evolve and continue to develop to be fit for the future. Integration of care, advice and services is needed to ensure that those with the greatest health needs can better access the support required.

**What do you say to accusations that the government has an agenda to introduce private general practice?**

There is no explicit preference or hidden agenda. There is, however, a long-standing need to tackle under-provision and poor quality where it exists. PCTs should be taking active steps to tackle this.

Where there are gaps in primary care services, identified with local clinicians and the local community, PCTs should run fair and open tendering processes for new providers. These will allow all healthcare providers, including existing GMS or PMS practices, voluntary and independent sector organisations to bid either independently or in conjunction with each other.

We want the best providers to win the open tenders to deliver these services, meaning that they can deliver high-quality primary medical care services, promote better health, improve patient access and develop more personalised care for patients. In this way we can start to address the historical under-provision and variation in quality that affects some general practice.

**Why are you promoting polyclinics as the only future model of general practice?**

I have no wish to impose a fixed model of what primary care should look like or how it should be organised. This must be determined locally. I have always said that it is for local people and clinicians to decide what is best for their community. The overriding objective is to deliver the best possible

service to patients. People want healthcare that is more personalised and convenient, so primary care services need to adapt to respond to this need.

In October's interim *Our NHS, Our Future* report I announced that the £250 million comprehensive spending review (CSR) access fund will be used to establish 152 GP-run health centres (which people called polyclinics, primary care centres, super surgeries or community hospitals) in easily accessible locations, one in each PCT. There are already many health centres around the country.

These centres will offer a wide range of health services, including pre-bookable GP appointments and walk-in services. They will open from 8am to 8pm seven days a week for registered and non-registered patients. Their purpose is to provide improved access to GP services, but also to support better integration with other community-based services (such as diagnostics, pharmacy and social care) and to create a stronger focus on promoting health.

How far to go beyond the core GP services is a matter for local communities and commissioners. What works in one area clearly might not be suitable for another. This is a central principle of my review, which is primarily a locally led process.

**Have you visited a GP surgery in your capacity as a Minister for Health? If not, do you have plans to do so?**

I have visited around seven GP practices all over the country as part of the Next Stage Review process. I really value visits as they give me an opportunity to meet the people actually delivering the service, get a better appreciation of the work they do and provide a direct opportunity for them to contribute to the debate. The messages I heard on the visits are being fed into work on the Primary and Community care strategy as part of the Next Stage Review.

**Which parts of the RCGP Roadmap would you like to see implemented, and are there parts of the document you disagree with?**

The *Roadmap* describes a compelling vision for the future of general practice, with primary care at the centre of the twenty-first-century NHS. The Primary and Community Care strategy draws on a number of themes from the document: for example, more integrated service delivery across



primary and community services, albeit with local flexibility over how this is organised, an emphasis on care personalised to the patient, and a deeper focus on health promotion and public health. The degree of consensus on the need to help primary care evolve to be fit for the future is very encouraging.

**How will your strategy address health inequalities and improve access for the socially excluded, e.g. the elderly and homeless?**

Tackling health inequalities is a key theme of the strategy. We are considering models of fairer funding for primary and community services that reflect local needs. In addition, another key theme of the strategy – greater personalisation – will help deliver more flexible services that respond to the needs of different individuals, such as those with long-term conditions or BME people.

**There is evidence that personal care leads to better patient satisfaction and improved outcomes in patients with long-term conditions. How are you going to ensure that this valued component of general practice is maintained?**

More personalised care for patients is one of the pillars of the Next Stage Review and another of the key strengths of general practice. The strategy will identify how to give patients more control over their own care and foster a greater partnership between patient and professional, through better information and support for self-care and self-management, the information prescription, established joint health and social care teams and, underpinning this, improved assessment and care planning. Additional investment in assistive technologies will help more patients care for themselves at home, supported by better-integrated health and care services.

**Is the NHS ready to meet the socio-demographic time bomb posed by an increasingly aged population?**

An ageing population is one of the key challenges for primary and community care to respond to, as it evolves to be fit for the future. A greater focus on health promotion, and self-care support for those with long-term conditions, will help people be more informed and active in keeping themselves healthy. Practices and other primary care

professionals will intensify efforts to proactively screen the population, and target at-risk groups to intervene early and diagnose and treat disease where it already exists. As the prevalence of long-term conditions such as dementia increase, primary and community services will need to respond more flexibly and in a more integrated way than before.

Innovative approaches to health and social care delivery hold great promise. The Department is committed to testing new innovations, such as telehealth and telecare, to ensure that they do provide benefit for service users, carers and their health/social care professionals. We need to be sure that new approaches and technologies have a positive impact in respect of improving quality of life, clinical effectiveness and cost-effectiveness.

**Is a tertiary surgeon qualified to understand, and make decisions for, general practice?**

I was personally asked by the Prime Minister to lead the review but that does not mean I have all the answers. The Primary and Community Care strategy is being developed with the help of an external Advisory Board, which includes a number of leading GPs together with representatives from community nursing services, patient organisations, local government, community pharmacy, mental health services and dental services.

We are planning a major stakeholder event with GPs, community nurses, patient representatives and others in April.

**What can you say to reassure GPs – and our patients – that we have a future?**

Primary care has an exciting future at the centre of the twenty-first-century NHS. We want to build on the existing strengths – registered lists, a population focus, a gate-keeping role and high levels of trust – and address some of the weaknesses seen from the patient's perspective – such as variation in quality, lack of access particularly for vulnerable groups and the fragmented nature of some services. No public service can afford to stand still, but GPs have a history of innovation, responding to what their patients and the NHS need and I have every faith this will continue.

By creating an enabling national environment with the Strategy, removing barriers and introducing new incentives that support and reward high performance, we liberate local commissioners and clinicians to develop a primary and community care service fit for the future.

Afterwards, Professor Field said: "I had a very frank and challenging discussion with Lord Darzi during which I put forward members' concerns and offered the RCGP solutions for improving patient care. We must now wait and see how much he has taken on board, but it was a brave move and I thank him for making the time and the effort."



# How should you be approaching CPD in 2008?

By Professor Ruth Chambers, CPD Clinical Lead;

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

Dr John Howard, Medical Director, RCGP International

So you want to be an exemplary GP as regards your clinical practice, and you hope to sail through revalidation when it finally begins. What continuing professional development (CPD) should you be doing now in relation to your clinical practice so that you are well prepared?

Well it all depends ...

## Matching your CPD to your aspirations

Although the primary purpose of revalidation (recertification and relicensing) is to demonstrate that doctors on the GP register continue to meet the standards that apply to the discipline of general practice, two of the secondary purposes are to promote CPD among GPs and to encourage an improvement in the quality of care. The way you approach and record CPD is key to these aims: you will need to show that the CPD you undertake is both relevant to your clinical practice and demonstrate that it has resulted in reflection and perhaps change in practice.

The box opposite lists the issues and priorities that you should take into account when you plan your CPD. Some of these relate to a GP working in one practice, but most are relevant to sessional and locum GPs who may work in different types of practice. The RCGP is establishing a managed CPD scheme that will provide a simple framework for you to record the evidence you will require in your CPD folder each year. That is, the CPD activities that met your expressed needs – and how that learning has or will influence your clinical practice – along with other learning that you undertook along the way. This is

expected to be at least 50 hours of outcome-based learning each year – with a good balance of CPD content across different areas over the five-yearly revalidation cycle.

## How should you prioritise your CPD needs?

So you're now faced with all these learning needs and still have to fit in the day job – seeing patients. Fifty hours of outcome-based learning sounds a lot compared with the old rules on simply attending 30 hours of learning under the previous Postgraduate Education Accreditation (PGEA) system. But remember this includes your practice-based and personal learning, with reflection included, and it seems very little if you are to address the list of needs in the box adequately. And that doesn't allow for you to spoil yourself either by doing some learning just because you enjoy the topic and networking with colleagues.

Try thinking about your PDPs for the next five years. If you have a learning need that will require a significant investment of time, such as a university postgraduate degree in, say, a teaching certificate, why not devote most of your time and capacity for learning next year to that award? Then this year and the third year from now you'll need to fulfil all your basic learning needs in the broad area of clinical practice.

Be aware of the General Medical Council's (GMC's) description of the four revised domains for Good Medical Practice, in which doctors will be expected to demonstrate their competence: *knowledge, skills and performance; safety and quality; communication, partnership and team work; maintaining trust*. The

CPD you undertake should develop your competence in each of these domains.

It is tempting and comfortable to keep on learning about things you're already good at and ignore topics that you are ignorant about

a guide to learning about areas that you usually avoid. The RCGP system will assist you in ensuring you have a broad spread of activities.

Another useful strategy for prioritising your learning needs

## LEARNING NEEDS

### Your learning needs should be priorities emerging from:

- Learning instigated in line with a previous/current personal development plan (PDP) – which may reveal further learning needs.
- Local priorities in your primary care organisation (PCO), e.g. local initiative on getting patients to return to work.
- Your career aspirations, e.g. to become a trainer or to develop a special clinical interest.
- Discussions with colleagues about your clinical practice, e.g. coffee-time discussion with other GPs with whom you work, or with a hospital consultant over the shared care of a patient.
- Direct comments from colleagues about your practice and you personally, e.g. from multisource (360 degree) surveys or less formal feedback.
- Changes in NHS systems or policies, such as new guidelines or procedures.
- Patient population needs, e.g. learning more about elderly care if you have a high proportion of nursing homes.
- Practice complaints or significant events that highlight a learning need for you.
- External indicators of your 'performance' – how your team compares with others in relation to the QOF, prescribing activity, etc.
- New legislation, e.g. mental capacity, equality and diversity.
- Areas you have to look up or feel uncertain about in consultations – either from a diagnostic or therapeutic point of view. It's worth recording these and looking for patterns.
- Think about the importance of networking with colleagues – especially if you are a single-handed GP, based in a remote area, or are without a regular workbase.
- Life events and opportunities – new career directions, e.g. becoming an appraiser or mentor, taking a career break or changing your practice.
- Statutory and mandatory training requirements e.g. fire safety, cardiopulmonary resuscitation training.

or dislike. One way to ensure that your own preferences do not win out over your learning needs is to look at how your CPD activities in the last year or few years map to the GP curriculum – the basis for GP training. You could use the contents of the GP curriculum as

is to discuss what has cropped up from audits, complaints and other activities linked to the needs listed in Box 1 with a peer – your appraiser, your partner or colleague, a GP tutor, or in a small group if you belong to one (and many of us do).

Some priorities will be obvious – such as the critical learning you need to complete following a significant event analysis or patient complaint; updating your CPR training; or a new clinical lead role in your practice team.

## What level of learning will fulfil your need?

You may just need to be *aware* of what is best practice, and not necessarily competent to carry it out. Then you would know when to refer a patient and who to refer to – within your practice team, or to a colleague in secondary care, or maybe to the voluntary sector.

You might need to be *competent* in the clinical area or the aspect for which you have an identified learning need – at the level that could be expected of an 'ordinary' GP. For instance, you may need to gain knowledge and skills in secondary prevention for patients who have suffered a myocardial infarction – to be able to optimise their follow-up care and motivate them to improve their lifestyles.

You could have a clinical lead role that requires you to be an *expert* in a clinical field – if you lead on diabetes in your practice team, or are a GP with special interest or a clinical champion for your PCO, say.

So your purpose helps to define the nature of your learning needs, which in turn dictates the depth and breadth of the CPD you will need to undertake to meet those needs and enhance your practice. When you self-accredit your learning via the CPD scheme that the RCGP will be introducing to support GPs' recertification, you will be able to record the outcomes of your CPD as learning credits, counting the time taken as part of your 50 hours.

## What kind of CPD then?

You'll choose the sort of learning activities that are appropriate for

your needs, your learning style(s) and what CPD opportunities are available to you. It should help that the RCGP is developing a scheme to accredit educational providers – drawing on the experience of the EPASS scheme in Scotland – which should be piloted in England later this year. This will create a simple system for the quality assurance of an organisation providing CPD – so that you know what to expect with respect to the scope and level of the learning you will receive. As part of this process the RCGP will publish the expected standards for providers of CPD.

You might prefer to do the bulk of your CPD online, or you might favour workshops or learning sets or in-practice learning events. The choice is yours: it's all about self-directed learning as long as you can show that you have met your learning needs and applied what you have learned in practice. The managed CPD scheme will include structured templates to record your CPD, indicating how you identified what learning you needed to do, how you met your needs and how your practice has changed as a result. Your portfolio will explain how you prioritised those learning needs and built your PDP so that you have an ongoing record of your development as a GP throughout your career.

## Did you get it right?

It's tricky predicting what your learning priorities are when new learning needs are turning up in every surgery you do. You do your best to prioritise and follow your PDP through, reserving learning time for unexpected needs. Preparing for your annual appraisal will give you an opportunity to reflect on the balance and range of CPD you've logged, and the ensuing discussion with your appraiser should give you another perspective on it. And then, there'll be the next PDP ...

## Essential General Practice

A new resource to support GPs' Continuing Professional Development (CPD) is being developed by the RCGP.

The self-assessment e-Learning educational outputs – known as Essential General Practice (EGP) Updates – will help GPs keep abreast of important new and changing knowledge and information relevant to general practice.

Currently being piloted, the EGP Updates will focus on key clinical areas of national significance, for example NICE guidelines. They will also include the latest information about changes to legislation or new ways of working.

EGP Updates will be available to all GPs and can be used as part of their CPD portfolio for annual appraisal and, in due course, recertification. The Updates will also be useful for GPs taking career breaks to help them keep up to date.

Two EGP Updates will be produced per year, each including up to 20 items of information with links to the original source and references to supporting material.

Each Update will take around 2–3 hours to complete, longer if the GP decides to undertake the optional exercises that will enable them to apply their new knowledge to their own practice and

identify specific learning and service needs.

An initial pilot will take place in April, followed by a second pilot in October. After the pilots are assessed, a rolling programme will be developed and it is envisaged that the Updates will be available in 2009.

The RCGP is also developing a Knowledge Hub – an online database that will provide a constantly updated core knowledge base structured under the headings of the GP curriculum. As well as being a key resource in the production of the Updates, the Knowledge Hub will also allow GPs to search for specific information.

Professor Nigel Sparrow, Chair of the RCGP Professional Development Board, says: "The EGP Updates and Knowledge Hub will be an invaluable resource and will make it much easier for GPs to demonstrate that they have kept up to date with new and changing information."

"By undertaking the EGP Updates, GPs can be assured that they have covered the essential knowledge needed to keep up to date for their clinical practice."

For more information about EGP Updates and the Knowledge Hub, please email: [education@rcgp.org.uk](mailto:education@rcgp.org.uk)

## New Members' Ceremony

More than 100 GPs were welcomed into the College during the latest New Members' Ceremony held at Kensington Town Hall in London. A variety of GPs from all over the country were presented with their membership certificates by Honorary Treasurer of the College, Dr Colin Hunter.

A number of the new Members represented are currently practising in the armed forces, including Dr Yousuf Uzair Siddiqui, who recently flew out to work with a medical team supporting troops in Helmand Province, Afghanistan.

The ceremonies are now a regular fixture in the College calendar and are organised across the UK to give College 'newcomers' a chance to celebrate their achievement officially, network with other Members and College Officers, and find out more about what the College can do for them throughout their careers.



# Just think about it

By Derek Beeston, Principal Lecturer, Centre for Ageing and Mental Health at Staffordshire University

The 78-year-old developmental biologist, author and broadcaster Lewis Wolpert, when writing about his depression in the 1990s, described it thus: "It was the worst experience of my life, more terrible even than watching my wife die of cancer. I am ashamed to admit that my depression felt worse than her death but it is true."

Speaking at a conference in 2007, he said that the only reason he did not take his own life was that he was too much of a coward. He went on to say that his wife, Jill Neville, offered him a deal. "Give it one year," she said, "And if you are not better by then I will help you die." He agreed and recovered, but sadly it was Jill who died.

Wolpert also said: "For anyone who treats depression . . . and who has not themselves been depressed it is like a dentist who has had no experience of toothache."

Such descriptions of depression, although deeply personal, are incredibly common in older people, but their problems are often unrecognised, untreated, or poorly managed.

Depression is the most common mental health problem in the over-65s. The recent Age Concern report *Promoting mental health and well being in later life* indicates that there are up to 2.4 million older people with depressive illness severe enough to impair their quality of life. Demographic trends indicate that this figure will rise to just under 4 million by 2015.

Research reveals that whilst a range of effective treatments exist for depression in older people, many of our older citizens are simply falling through the net. This can and does lead to the most terrible of consequences – suicide.

A couple of years ago I first came across the suicide statistics for older people and discovered that across the Western world rates increased with age for both men and women. I knew that there was a national suicide prevention strategy but was dismayed to find that it was principally concerned with suicide amongst the young, with not a single mention of suicide in older people.

Interestingly, the National Service Framework (NSF) for Older People has as its first standard 'to root out age discrimination', but the NSF for Mental Health is aimed primarily at adults 'of working age'. After the NSF for adults was published, none of the additional £1 billion in funding

went into services for older people. If central policy itself discriminates, what chance is there for our older citizens?

There is a wealth of research on suicide in older people and we have a good grasp about what needs to be done but it simply isn't happening. Given that in the over 65s one suicide attempt in three will result in a death and in males over 80 years old the completion rate is one death for every 1.5 attempts, it's a worrying picture.

In primary care, for example, we know that unmanaged or untreated depression in older people is a very significant factor in completed suicides. Psychological autopsy studies repeatedly show us that depressive illness in older people is often identified but then ignored in subsequent treatment plans.



For GPs there is the added pressure of time. With typical consultations lasting less than 10 minutes and an older person presenting typically with somatic rather than psychological symptoms, how does one recognise depression or suicidality?

A GP friend of mine explained his approach to older patients. He made a point of walking to the consulting room door so that he could watch the older patient approach – for him the consultation had

already started. On greeting the patient he would take in as much information as possible and before starting the discussion proper would show them a card printed on which were five signs of depression. A range of very quick depression-screening tools are available for use with older patients but are rarely used.

Identifying depression in older patients is one thing and we know effective chemical treatments are available, but here we meet the problem of access to the wider range of services. Work is currently ongoing nationally to improve access to psychological therapies, but we have yet to see if this is to be fully inclusive regardless of age. Sadly, the likelihood is that once again money for improving access will largely be aimed at younger people.

Improving the mental health of our older citizens is a problem that cannot be tackled by primary

Primary care and GPs in particular have a key role to play in revolutionising services for depressed older people. The vast majority of older people with depression do initially go to their GP who has an enormous responsibility to recognise and respond to it. It is the GP who can make things happen and who can shake up the co-ordination of the service-wide response to the older person's despair.

In a recent study 90 per cent of GPs said it was important to detect early signs of depression and make a diagnosis; they also had high levels of confidence in treating depression in older people. In reality, however, mental health problems in older people are vastly under-diagnosed and under-treated.

The writer Andy Solomon, in an article about his depression for the *New Yorker*, describes how one day he lay in his bed too frightened even to take a shower. In his mind he could clearly rehearse each thing he would have to do and to him they became "like the 14 Stations of the Cross". He knew that he had showered every day for years, but as a one-time sky-diver he said that it would have been easier to make his way to the tip of a plane's wing against a powerful wind at 6,000 feet than it was now to take a shower. Can you begin to imagine what that must have been like?

Just think about it: for about a third of our lives you are asleep. Your first ten years are spent in childhood and your last twenty years are likely to be characterised at some point by declining physical and mental health. Of course you may be one of the lucky ones and live a long, happy and healthy life, surrounded by secure and loving relationships, continuing to develop and grow to the very end, but I wouldn't bet on it.

As a GP you can make a real difference right now and join the growing numbers of health and social care professionals and older people themselves who want to be heard and who most of all want to see services for depression in older people improved now.

## Resource

The Centre for Ageing and Mental Health at Staffordshire University, in association with the RCGP Mental Health Group and the Royal College of Nursing, has produced a crib sheet for GPs on this topic: [www.westmidlands.csip.org.uk/silo/files/practitioner-guidance-suicide-in-elders.doc](http://www.westmidlands.csip.org.uk/silo/files/practitioner-guidance-suicide-in-elders.doc)

# Just think about it in *your practice*

By Dr Carolyn Chew-Graham, Senior Lecturer in Primary Care, School of Community Based Medicine, University of Manchester and National School for Primary Care Research, National Institute of Health Research. Carolyn is also RCGP Clinical Champion, Mental Health, and

Dr David Shiers, GP advisor to CSIP, West Midlands

Depressive disorders are common, affecting one in seven older people, a prevalence rate that is consistent across countries and cultures.<sup>1</sup> Depression in older people is associated with serious morbidity and mortality, including, as Derek Beeston reflects, suicide.<sup>2</sup>

Two-thirds of older people with serious depression do not have symptoms that fit current classifications of mood disorders,<sup>1</sup> which have been generated to reflect symptoms in younger people, and presentation may differ from younger people because of ageing, physical illness, or both. Thus, older people may present with malaise, tiredness, insomnia or pain, which the primary care clinician may feel represents organic disease, or forgetfulness, which leads to concern that this patient has cognitive impairment and early dementia.

Detection of depression is poor,<sup>3</sup> and primary care clinicians may lack the necessary consultation skills or confidence to diagnose late-life depression correctly. They may be wary of opening a Pandora's box in time-limited consultations, collude with the patient that feeling miserable is normal considering all the physical problems the patient has, have limited expectations of treatment, and share therapeutic nihilism with the patient.<sup>4</sup> Older people may be

distrustful of tablets, not take them, may prefer psychological interventions which have been shown to be effective in people with late-life depression and anxiety,<sup>5</sup> but such therapeutic options may be unavailable in primary care.<sup>6,7</sup>

Evidence suggests that models using multifaceted interventions and principles of collaborative care are effective.<sup>8</sup> These models vary, but generally include the deployment of care managers and flexible collaboration between primary and specialist care, to improve access to the psychiatrist and mental health teams for members of the primary care team.<sup>9,10</sup>

Derek Beeston's article highlights the important role of primary care in the detection and management of depression in older people, as 90 per cent of older people with depression are managed in primary care. The task of the GP must be to move away from the old model of relying on the passive prescription of pills.<sup>11</sup> The primary care clinician (GP, practice nurse, district nurse or active case manager) needs to have an awareness of the possibility of depression in any older person consulting, particularly those with chronic disease where depressive disorder will be more common.

The Quality and Outcomes Framework (QOF) of the new General Medical Services (GMS) Contract (Department of Health, 2006)<sup>12</sup> requires that GPs and practice nurses use two screening questions (Box 1) within the previous 15 months with patients with chronic disease. These could usefully be asked of all older people in primary care consultations, or, if worried about time, selected patients (Box 2).

continued on page 7 ►

## BOX 1

### Screening questions for depression

- During the past month, have you often been bothered by feeling down, depressed or hopeless?
- During the past month, have you often been bothered by having little interest or pleasure in doing things?

A 'yes' to either question is considered a positive test.

A 'no' response to both questions makes depression highly unlikely.

## BOX 2

### Suggestions for targeted screening in primary care

- recent (<3 months) major physical illness or hospital admission
- chronic illness (physical comorbidity and, particularly, chronic pain)
- in receipt of high levels of home care
- carers
- recent bereavement
- social isolation
- patients complaining of persistent sleep problems

## BOX 3

### Areas to cover in a primary care evaluation of depression

#### History

- sensitive exploration of symptoms
- identification of triggers
- previous history of depression
- recent bereavement
- maintaining factors – drugs, alcohol
- review of medications (including benzodiazepines and self-medication)

Substantiating the history by talking with a carer or family member (with the patient's consent) can help to clarify aspects of the history.

#### Mental state assessment

- evidence of psychotic symptoms
- thoughts of self-harm
- use of Mini-Mental State Examination (MMSE) where cognitive impairment is suspected

#### Risk assessment

- thoughts of self-harm
- previous self-harm
- explore whether plans have been made
- ask what prevents the patient acting on thoughts or plans

#### Focused physical examination

- focused neurological examination
- BP and pulse

May help identify contraindications to certain classes of antidepressants.

#### Appropriate investigations

- blood tests (including full blood count), biochemistry (including calcium), glucose, liver and thyroid function, haematinics (B12 and folate).

# Asthma in children

By Peter Burrill, Specialist Pharmaceutical Adviser for Public Health, Derbyshire County PCT

Children presenting with wheeze are likely to have either atopic asthma or episodic viral wheeze; distinguishing between these has important implications for management. A recent review of diagnosing asthma in children is helpful.<sup>1</sup>

If one feature consistently points to a diagnosis of asthma, it is wheeze. Wheeze is the end result of narrowing of small airways due to processes that include oedema of the airway wall, contraction of smooth muscle, and mucus plugging. A study of parents of children with wheeze found that some thought that wheeze was a sound such as whistling, squeaking or gasping, whereas others defined it as a different rate, style or timbre of breathing, and some thought it was the same as coughing. This is an important reminder that reported wheeze might not be wheezing after all.

One area of diagnostic difficulty in childhood asthma is chronic cough. Cough is a common complaint in childhood; up to 10 per cent of pre-school and early-school-aged children have chronic cough without wheeze at some time. Although childhood asthma may present with cough, most children who cough without wheeze do not have asthma. Isolated chronic cough is a poor marker of asthma and without other typical features of asthma, should always raise the strong possibility of an alternative cause.

## Summary points from the diagnosis review article:<sup>1</sup>

- 'Childhood asthma' describes several different clinical phenotypes with different management strategies.
- The two most common phenotypes are atopic asthma, more common in school-aged children, and episodic viral wheeze, more common in pre-school children.
- Wheeze is a poorly understood symptom, and parents should be asked to clarify what they understand it to be.
- Wheeze is commonly associated with asthma, but several other conditions can result in recurrent wheezing and should be considered before a diagnosis is made.

- Isolated chronic cough is unlikely to be due to asthma.

A second review article discussed the management of asthma in children.<sup>2</sup> The authors comment that the management of episodic viral wheeze is controversial. Little evidence exists in the literature to support the use of regular bronchodilators and corticosteroids. A Cochrane review of eight studies involving 229 patients found no benefit associated with short-acting beta-2 agonists in episodic viral wheeze and persistent wheeze in children under the age of two years.

The benefit of anticholinergics in the management of episodic viral wheeze is similarly unclear. A Cochrane review of six studies involving 321 infants under the age of two years showed no impact on symptoms or clinical course of the acute illness. The studies were heterogeneous, however, leaving the possibility of a subgroup that may benefit. Currently, the indiscriminate use of anticholinergics and short-acting beta-2 agonists in the management of acute episodic viral wheeze is not recommended. Although these agents are still used for young children with wheeze, the doctor should ensure that a clear clinical benefit is achieved before they are regularly prescribed.

## Summary points from the management review article:<sup>2</sup>

- Inhaled corticosteroids, although safe if given at the recommended dose, can have important adverse effects if given above it, including adrenal suppression.
- Long-acting beta-2 agonists (LABAs) can be used as add-on treatment to avoid further increases in the dose of inhaled corticosteroid but can be associated with increased risk of exacerbations and hospital admission.
- LABAs should therefore be continued only if a demonstrable response to treatment occurs.
- Inhaled corticosteroids do not prevent the development of asthma.

- Low-dose inhaled corticosteroid should not be used as preventive treatment for episodic viral wheeze.
- Referral to a specialist centre should be considered when a child reaches step 4 of the British Thoracic Society (BTS) guideline or earlier, depending on the expertise of the GP and the resources available.

Current UK prescribing trends for asthma medication in children do not follow the BTS guidelines, according to the results of a recent study.<sup>3</sup> Researchers assessed the trends of paediatric asthma prescribing in the UK, and compared them with current BTS guidance. Data from the NHS Information Centre for Health and Social Care were used to estimate community paediatric prescribing figures for asthma medications between the years 2000 and 2006.

## The following results were reported:

- The number of prescriptions for bronchodilator syrups decreased by 60 per cent from 2000 to 2006, but this still represents 121,000 prescriptions in 2006 despite minimal recommendations for their use.
- The percentage of steroid inhalers prescribed as combination inhalers of a steroid and a LABA increased from 2.7 per cent in 2000 to 25.3 per cent in 2006. This trend is not consistent with the BTS recommendations that combination inhalers should only be used in patients not controlled on adequate doses of inhaled steroids.
- The prescribing of steroid-alone inhalers gradually declined from 2000 to 2006 although they should be the mainstay for the vast majority of patients with asthma who require controller medications.

The authors conclude "we believe that these numbers point to an overuse of oral beta agonists and LABA/steroid combination preparations in children as a group". They comment "there is a trend towards less prescribing of beta agonist syrups, but the increase in combination products is not guideline driven".

In an internal memorandum, drug safety staff at the FDA in the USA have commented that salmeterol "may have an unfavourable risk-benefit ratio in the treatment of paediatric asthma" and recommend a "more thoroughgoing, formal risk-benefit analysis of salmeterol" for this indication.

The authors of the memorandum state that "adult trial data show an increase in asthma mortality and severe asthma events with salmeterol; available data do not provide any reason to believe that the paediatric population does not share the same risk; and definitive evidence of a protective effect of inhaled corticosteroids is lacking for LABAs, and in fact there is evidence that inhaled corticosteroids are not protective in paediatric patients receiving formoterol (another LABA)".<sup>4</sup>

The current advice from the Commission on Human Medicines (CHM) appears to apply to patients of all ages. The CHM advise that salmeterol and formoterol should:

- Be added to therapy **only** if regular use of standard-dose inhaled steroids has failed to control asthma adequately.
- **Not be initiated in patients with rapidly deteriorating asthma.**
- Be introduced at a low dose and the effect properly monitored before an increase in dose is considered.
- Be discontinued in the absence of benefit.
- Be reviewed as clinically appropriate: stepping down therapy should be considered when good long-term asthma control has been achieved.
- Patients should be asked to report any deterioration in symptoms following initiation of a LABA.

## References

1. *BMJ* 2007; 335:198-202.
2. *BMJ* 2007; 335:253-7.
3. *Arch Dis Child* 2007; doi:10.1136/adc.2007.119834
4. NPCi Blog: www.npci.org.uk/blog/?p=43.

# Allergic rhinitis – the season is nigh

By Dr Alex Elliot, Primary Care Scientist, RCGP Birmingham Research Unit

Winter is officially over. We breathe a collective sigh of relief as this marks the cessation of the influx of patients to the surgery presenting with acute respiratory infections. However, the onset of spring brings with it the imminence of the allergic rhinitis (hay fever) season. This is an often trivialised condition. It is true, however, that although the majority may self-treat with over-the-counter (OTC) remedies, for a proportion of these sufferers a GP consultation is prompted due to either the severity of symptoms, the adverse effects of symptoms on everyday activities and performance at work/school, or simply because medication prescribed by a GP is free or less costly than OTC remedies.

## Trend and seasonality

The RCGP Weekly Returns Service (WRS) is a sentinel general practitioner surveillance scheme that routinely monitors the incidence of a range of infectious and communicable diseases in the community.<sup>1</sup> In addition, the WRS tracks a number of non-infectious conditions such as allergic rhinitis and asthma, both of which have links to environmental causes. The WRS has monitored allergic rhinitis since 1981; figure 1 presents the weekly incidence rate of allergic rhinitis per 100,000 population recorded over 27 years of surveillance. Although there is a relatively constant trend over time, it is clear that the severity of the allergic rhinitis season can differ: for example, the highest rates recorded in the WRS occurred in 1992, when the peak value (for all ages) was 336 per 100,000; the lowest was recorded during the summer of 1990, when rates only reached a peak value of 82. Interestingly, last summer (2007) ranks as the second lowest recorded year in the WRS, possibly a reflection of the poor weather that we experienced over the summer months.

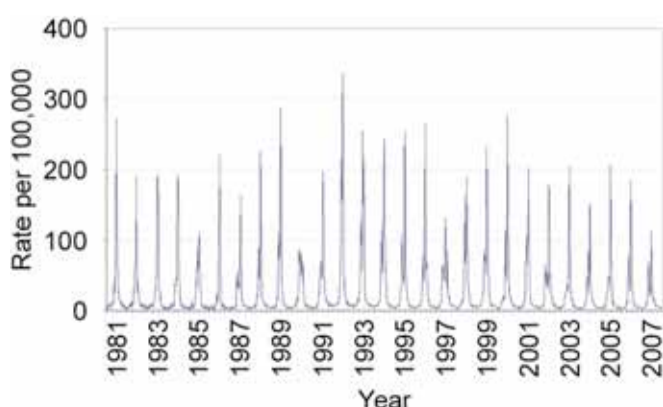


Figure 1. Weekly incidence of allergic rhinitis 1981-2007.

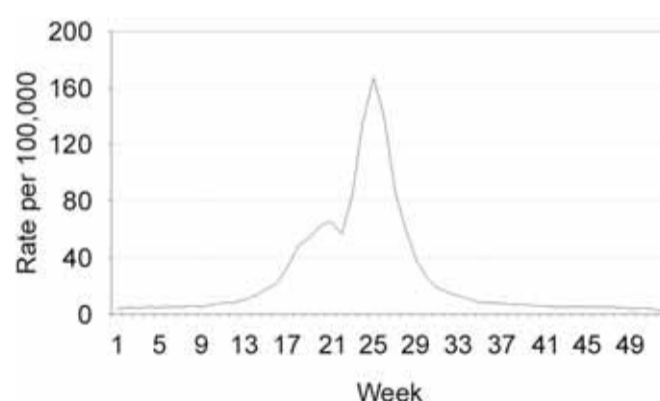


Figure 2. The mean weekly incidence of allergic rhinitis (all ages) 1981-2007.

We can further analyse the seasonality of allergic rhinitis by calculating a mean weekly incidence rate from the years 1981-2007. Figure 2 presents these data and illustrates the presence of two distinct peaks of activity; the first peaking across weeks 18-21 (late-April/early-May) and the second peaking across weeks 24-26 (mid-June).

Age-specific rates demonstrate that the greatest burden lies in the 5-14 years age group, with a decreasing burden through sequentially older age bands (figure 3A) suggesting that tolerance to pollens and/or other allergens is acquired as age advances. Analysis by gender reveals that females are more likely to consult with new episodes than males (figure 3B). This trend is seen across a range of diagnoses made in general practice but has not yet been fully explained. Geographical analysis across the three WRS "super-regions" (North, Central and South) demonstrates no discernible difference in timing of activity across England and Wales, although on average the Central region is subject to higher rates of activity during the midsummer peak (figure 3C).

We can assess the total burden of allergic rhinitis on general practice using WRS data: based upon the national England and Wales population, we estimate approximately 950,000 consultations for this condition each year of which over 535,000 are diagnosed as new episodes.<sup>2</sup> In completing our analyses we must acknowledge that the cohort of patients who present to GPs with symptoms of allergic rhinitis are probably at the more severe end of the spectrum of symptoms. We must also accept that a confounding factor influencing the age specific incidence might be the availability of "free" prescriptions (or lower cost than OTC remedies) in the 5-14 years age group, which might influence the differences in consulting behaviour between children and adults.

continued on page 7 ➤

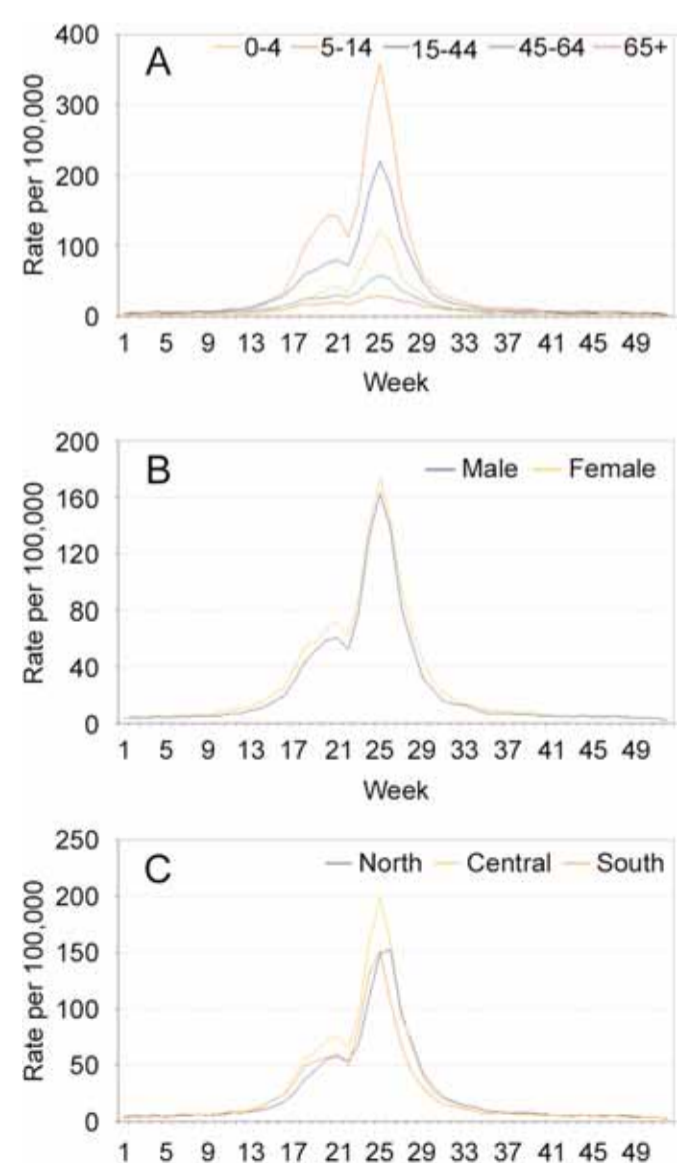


Figure 3. Mean weekly incidence (1981-2007) of allergic rhinitis incidence A) by age group; B) by gender C) by region.

### The role of pollens

Allergic rhinitis may present with either perennial or seasonal frequency; the latter is the more common cause of consultation for 'hay fever'. Causes of perennial cases might include house dust mites and animal dander. The seasonal condition can be triggered by many different allergens, including a wide range of pollens and spores. Both are dependent on season and geographical location. Previous work at the RCGP Birmingham Research Unit has focused on determining the causes of the two main peaks that occur in late spring and midsummer. A paper by Ross et al. (1996) showed that the minor peak was highly correlated with levels of tree pollens, more specifically pollens originating from oak and birch species, or pollens shed contemporaneously with them.<sup>3</sup> The main peak of allergic rhinitis was (perhaps unsurprisingly) related to elevated levels of grass pollens that occurred during the summer months.

### Symptoms

Allergic rhinitis is an atopic disease, defined as increased production of IgE as a response to allergens. Presentation is commonly associated with nasal congestion, serious nasal secretion, sneezing and conjunc-

tivitis. Anterior rhinoscopy can reveal a varying degree of mucosal oedema, rubor and water secretion.

### Treatment and prevention

Treatment of cases can include a variety of medications, including antihistamines, steroids, cromoglycates, adrenergics and antileukotrienes. Antihistamines and topical steroids are commonly used as the mainstay of treatment against allergic rhinitis in adults and children over 12 years old.<sup>4</sup>

General allergen avoidance advice can be implemented into a sufferer's daily routine. Measures can include: wearing wrap-around sunglasses when outdoors; staying indoors during the height of pollen season, or when grass is being cut; keeping windows closed during the day; keeping car windows closed when driving; fitting a pollen filter to air-conditioning units; showering in the evening to remove pollens; and changing clothes when returning from work in the evening.<sup>5</sup>

### Further work

We are currently interested in continuing our research into the possible range of allergens that can cause allergic rhinitis. Fungal spores have been implicated as potential causes and we are currently planning a programme of work investigating their role. Peaks of asthma incidence

in children and young adults have been described and are synchronous with allergic rhinitis.<sup>6</sup> The reporting system at the RCGP Birmingham Research Unit is undergoing an upgrade that will enable us to link patient specific disease episodes; we will therefore be able to analyse specifically the occurrence of allergic rhinitis and asthma together to further examine this relationship and the predisposition of one condition to the other.

**Acknowledgment** – Michele Barley of the Birmingham Research Unit for analysing the regional allergic rhinitis data.

### References

1. RCGP Birmingham Research Unit. Weekly Data on Communicable and Respiratory Diseases. [www.rcgp.org.uk/continuing\\_the\\_gp\\_journey/bru/weekly\\_data.aspx](http://www.rcgp.org.uk/continuing_the_gp_journey/bru/weekly_data.aspx)
2. RCGP Birmingham Research Unit. Weekly Returns Service Annual Report 2006. [www.rcgp.org.uk/continuing\\_the\\_gp\\_journey/bru/annual\\_reports.aspx](http://www.rcgp.org.uk/continuing_the_gp_journey/bru/annual_reports.aspx).
3. *BJGP* 1996; 46:451–55.
4. *BMJ* 1998; 317:1624–29.
5. *BJGP* 2004; 54:412–14.
6. *Thorax* 2000; 55:662–65.

# New treatments for asthma and hay fever

By Dr Rupal Shah, Clinical Editor, RCGP News

## 1. New add-on treatment for asthma

### What is omalizumab?

Omalizumab (Xolair) is a recombinant monoclonal antibody that stops IgE from binding to receptors on the surface of mast cells and basophils. It therefore prevents the release of inflammatory mediators and reduces allergen-induced bronchospasm.

### Who is it licensed for?

Omalizumab is licensed as add-on therapy for adults and children aged 12 and older with severe persistent allergic asthma who have reduced lung function (FEV1 < 80 per cent) as well as frequent symptoms and who have had multiple documented severe asthma exacerbations despite daily high-dose inhaled corticosteroids, plus long-acting inhaled beta-2 agonists.

### How is it administered and how much does it cost?

Omalizumab is administered subcutaneously every 2–4 weeks. The dose depends on baseline IgE before the start of treatment and on the patient's body weight. The cost of a year's treatment varies from £3,100 to £15,400 depending on the dose and frequency of injections.

### What are its most common side effects?

Omalizumab is usually well tolerated and the most common adverse effects are local reactions at the injection site such as bruising, erythema and pain.

Rare side effects include the possibility of anaphylaxis; if this is going to happen, it usually occurs within 2 hours of the first dose, but may happen even beyond 24 hours after the drug is administered. Patients need to be warned about the symptoms of anaphylaxis and what to do if it occurs.

There is a possibility that drug-induced malignancies may be associated with Omalizumab – in

clinical trials, 0.5 per cent of patients receiving Omalizumab developed malignancies, compared to 0.2 per cent of patients receiving placebo. Further research is needed to clarify the exact risks.

### What does NICE recommend?

2007 NICE guidance recommends that Omalizumab may be tried in patients aged 12 and older with severe, unstable, persistent allergic (IgE mediated) asthma as add-on therapy.

Patients being considered for Omalizumab must have had a full trial of inhaled high-dose corticosteroids and long-acting beta-2 agonists as well as leukotriene receptor antagonists, theophyllines, oral corticosteroids, beta-2 agonist tablets and smoking cessation where clinically appropriate.

Patients must have been shown to be compliant with the above treatment.

Patients must also fulfil the following criteria:

- Confirmation of IgE mediated allergy to a perennial allergen by clinical history and allergy skin testing.
- Either two or more severe exacerbations of asthma requiring hospital admission within the previous year, or three or more severe exacerbations of asthma within the previous year, at least one of which required admission to hospital, and a further two which required additional treatment or monitoring in A&E.

Omalizumab should only be initiated and monitored by a specialist in allergy and respiratory medicine. It should be discontinued at 16 weeks in patients who have not shown an adequate response to therapy.

## 2. Sublingual hay fever vaccine

Approximately 26 per cent of people in the UK suffer from allergic rhinitis, half of whom are allergic to grass pollen. For those with severe symptoms who do not respond to traditional treatments such

as antihistamines and nasal steroids, allergen immunotherapy has been tried, using subcutaneous injections of allergen extracts. The injections may need to be used for 3–4 years to produce remission and because of the possibility of anaphylaxis, they must be administered in a hospital setting, where full cardiopulmonary resuscitation facilities are available.

### What is Grazax?

Grazax is a new sublingual hay fever vaccine, containing a small quantity of grass pollen allergen extract. It can be used as an alternative to injection immunotherapy and has the advantage that it doesn't need to be given in hospital.

### How long does it need to be taken for?

Grazax should be taken daily for at least 16 weeks before and also during the hay fever season (which runs from late May to August). There is less clinical benefit if Grazax is not initiated at least four months before the start of the hay fever season; in one trial where it was started eight weeks prior to the start of the grass pollen season, it did not lead to a reduction in symptoms of rhinoconjunctivitis, although patients treated with Grazax used less rescue medication than those given placebo (*J Allergy Clin Immunol* 2006; 117:802–9).

The Summary of Product characteristics for Grazax recommends a daily dose of one tablet.

### Which patients might benefit from Grazax?

Grazax is suitable only for patients who have been shown to have a positive skin prick test and/or specific IgE blood test to grass pollen. It should only be initiated by a specialist and the first dose should be taken under medical supervision.

### How effective is Grazax?

A Cochrane review addressed the safety and efficacy of sublingual immunotherapy for allergic

rhinitis (*Cochrane Database of Systematic Reviews* 2003; 2(Art. No.: CD002893) DOI: 10.1002/14651858.CD002893). The authors concluded that sublingual immunotherapy significantly reduces symptoms and medication requirements in allergic rhinitis. However, the size of the effect in comparison to other treatments is not clear.

A *MeReC* bulletin (Supplement to Issue No 27; March 2007) concluded that in clinical trials, Grazax has been shown to produce a statistically significant reduction in symptoms and rescue medication compared to placebo. However, absolute benefits appear modest, and the clinical significance is uncertain.

The *Drug and Therapeutics Bulletin* could not recommend Grazax due to its expense and the lack of trial data comparing it against subcutaneous immunotherapy or symptomatic treatments (*DTB* 2008; 46(2):9–10).

### What are the most common side effects?

Oral pruritis is the most common side effect of Grazax and may affect up to 46 per cent of patients. Local angioedema/swelling is a less common side effect.

Grazax is contraindicated in patients with malignancy or systemic disorders affecting the immune system, severe inflammatory conditions affecting the mouth, or uncontrolled or severe asthma.

### How much does Grazax cost?

Grazax costs more than injection immunotherapy. If taken for four months before and three months during the hay fever season, the annual cost would be approximately £472.50. No direct comparisons have been made with subcutaneous immunotherapy in terms of efficacy.

If it is taken every day, Grazax costs £821 per year.

In primary care, time is at a premium, so rating scales are rarely used. They can, however, provide an additional more objective measure of severity and progress, which can inform treatment decisions, and clinicians may wish to try the GDS 4-item scale to screen for depression in at-risk older people, or use the PHQ-9 to quantify the severity of depressive symptoms.

The GP should cover five areas in the primary care consultation when suspecting depression in the older person (Box 3).

Most older people who succeed in killing themselves have consulted a GP in the month prior to suicide and many will have had a previous episode of self-harm. It is sometimes forgotten that older people may harm themselves through self-neglect, and the primary care professional should be aware of the risk of a patient becoming physically compromised through dietary self-neglect as a result of a depressive illness.

Keeping the patient well is just as important as initial treatment. A combination of antidepressants – both tricyclics and selective serotonin re-uptake inhibitors – and psychological interventions prevent relapse, and some patients

may benefit particularly from combining these modalities.<sup>13</sup>

In addition, new challenges arise from evidence showing that a proportion of late-onset depression arises because of age-associated cerebrovascular disease.<sup>14</sup> So treatments of the future may include those not usually regarded as part of the mental health treatment toolkit – for example, drugs to halt vascular damage.

There is a need for primary care clinicians, GPs and practice nurses, district nurses and active case managers to develop alertness to the possibility of depression in older people. Skills needed are the ability to develop an empathic relationship with the person and not to normalise the symptoms, to assess risk, particularly of suicide, and an increased confidence in managing older people with depression, referring to other team members, the voluntary sector, other statutory services and secondary care when appropriate.<sup>15</sup> The work of primary care clinicians in the management of older people with depression could be supported by some imaginative commissioning at the primary–secondary interface.

### References

1. *Br J Psychiatry* 1999; 174:307–11.
2. *Guidelines for depressive disorder of later life: practising the evidence*. London: Martin Dunitz, 2002.
3. *J Clin Psychiatry* 1999; 60:45–51.
4. *Fam Pract* 2006; 23:369–77.
5. *J Consult Clinical Psychol* 2001; 69:756–2.
6. *Fam Pract* 2002; 19:632–7.
7. The Layard Report: *Increasing Access to Evidence Based Psychological Treatment*.
8. *BMJ* 2004; 329:181–2.
9. *JAMA* 2002; 288:2836–45.
10. *BJGP* 2007; 57:538:364–9.
11. *PLoS Medicine* 2008; 5(2):260–268.
12. BMA and NHS Employers. *Revisions to the GMS contract, 2006/7. Delivering investment in General Practice*. London: British Medical Association, 2006.
13. *JAMA* 1996; 281:39–45.
14. *J Affect Dis* 2004; 79: 81–95.
15. National Institute for Clinical Excellence. *Depression: management of depression in primary and secondary care. Clinical guideline 23*. London: NICE, 2004.

# A day in the life of the curriculum

GP trainers and trainees around the country were invited to take part in an RCGP 'Diary Project' to share and record their thoughts and experiences of learning and training within the new GP curriculum.

Contributors were asked to choose a day between 7–17 March and write about the tasks and challenges they faced, and how it felt to be part of GP training.

As well as providing a valuable historical record, the information submitted will provide important feedback for the review process of the curriculum.

The diaries are now being analysed and the preliminary results will be presented in June at a UKCEA workshop 'Narratives of training within the new RCGP curriculum'.

Dr Charlotte Tulinius, Medical Director of the RCGP Curriculum and creator of the Diary Project, said: "At the moment, we have very little literature on how a GP curriculum influences the daily work of those involved in GP training.

"The Diary Project is a unique and exciting opportunity to follow a major development in GP training primarily as it is perceived by the College's own members."

# Dates for your diary!

## 2-4 OCTOBER 2008



### Annual National Primary Care Conference 2008



## Dynamic practice

### Creating Solutions for the Future

Bournemouth International Centre  
[www.rcgpannualconference.org.uk](http://www.rcgpannualconference.org.uk)

## Call for Papers

Principal Sponsor



## Scotland launch of GP Learning Tools

A new set of GP Learning Tools was officially launched by Chair of NHS Education Scotland, Ann Markham, at an event held at RCGP Scotland offices in Edinburgh on 22 February. The tools complement the RCGP's new training curriculum and MRCGP examination.

The Learning Tools comprise a set of GP Prompt Cards, a booklet explaining the essence of the general practice initiative, plus an optional poster.

The aim is to support GP trainees, who can look at the cards and pick those which reflect their own views on the important elements of general practice. The cards have been created to prompt original thought and discussion.

Ann Markham said: "The event was a great success and we're hoping the new GP Tools will be popular."

"The new GP Learning Tools have the potential to have a huge impact not only on undergraduate medical education but also continued professional development. NHS Education for Scotland is delighted to be a partner in this initiative."

RCGP Scotland Chair Dr Ken Lawton, Ann Markham and Professor Trevor Gibbs, RCGP Scotland Deputy Chair of Policy

## Stormont launch for new Northern Ireland patient group

Northern Ireland's 'Patients in Practice Group (PiP)' was launched at the Stormont Parliament building.

Comprising six lay members and two GPs, the 'voice of the patient' group aims to develop activities that encourage GPs to work more effectively with patients.

It will encourage Northern Ireland practices to include patient views in all their decision-making, as well as ensuring that College activities correspond with patients' needs.

Hosted by Dr Alasdair McDonnell MLA, the launch was attended by the Permanent Secretary for the Department of Health Dr Andrew McCormick, several Members of Legislative Assembly (MLAs), and representatives from health boards and local commissioning groups.

Dr McDonnell, said: "Having worked as a GP for many years, I know how important it is for GPs to work in partnership with patients to improve services. PiP provides a vital platform for patients in Northern Ireland to make their valuable contribution to the development and delivery of primary care."

RCGP Northern Ireland Project Manager and PiP lead Nuala Foley said: "I am delighted to be involved with this group and look forward

to seeing it develop. The group will provide the local College Council with a channel to engage in a two-way dialogue with patients and to share best practice and information."

Paul Archer, Patient Co-chair of Patients in Practice (PiP), said: "The establishment of a patient representative group within the NI

Council of RCGP is a very welcome initiative which follows very successful patient representation on the respective Councils of the College in Great Britain."

Dr Alasdair McDonnell MLA at the launch of the patient group with NI Chair Dr David Johnston



## Obituary

### Dr A. Akram Sayeed

OBE, FRCP Edin, FRCGP Leicester Faculty

Dr Akram Sayeed, who died on 18 January 2008 aged 72, was a highly respected Leicester GP and a pioneering and influential figure in the medical communities of both the UK and Bangladesh. During his 40 years of general practice, he also worked tirelessly for improved community relations in the UK.

Akram was born and brought up in what is now Bangladesh. After graduating from the University of Dhaka in 1958, he undertook further medical training in the USA before settling in the UK in 1961. He entered general practice in 1963, becoming one of the first Asian GPs in Leicester. In 1964, he established his own general practice from scratch, which he then developed into a successful three-doctor practice.

From 1968 to 1977, Akram served as one of the 12 statutory members of the Community Relations Commission, and in 1976 received an OBE for his long and distinguished services to community relations. From 1983 to 1988, he served as an advisor to the Home Secretary on community and race relations. Akram was also a founding member of the Overseas Doctors' Association (now the British International Doctors' Association), and served as its national chairman from 1993 to 1996. He also helped to establish the Standing Conference of Asian Organisations in 1970.

Akram maintained strong professional links with his country of birth and was appointed by the Bangladeshi government as an honorary advisor to the Bangladeshi Ministry of Health and Family Welfare. From 1980 onwards, he was instrumental in helping medical colleges in Bangladesh to secure recognition by the General Medical Council. In honour of this work in promoting medical education and training in Bangladesh, he was awarded honorary fellowships of the Bangladesh College of General Practitioners and the Bangladesh College of Physicians and Surgeons. Akram also helped to raise large sums of money to help victims of natural disasters in Bangladesh. After the cyclone that affected that country in 1991, he helped to establish a major community self-help project in the Pekua district of Cox's Bazar, Bangladesh, which was funded by donations from the people of Leicester.

He was president of the Leicester Division of the British Medical Association from 1994 to 1995, and president of the Leicester Medical Society from 2001 to 2002. The BMA honoured him with a fellowship in 1995. He served on the General Optical Council from 1994 to 1998, and in 1999 he was elected to the General Medical Council, on which he served until 2003.



Akram retired from general practice in 2003. In 2005, the Eastern Leicester Primary Care Trust decided to rename his former practice premises as the Sayeed Medical Centre in honour of his long and dedicated contribution to general practice. During his retirement, Akram sadly suffered the loss of his eyesight, but despite this he took up writing and published his memoir (*In the Shadow of My Taqdir* [2006]), three volumes of essays (*Letters from Leicester, Volumes 1-3* [2004-2007]) and two Bengali novels (*Shesher Adhaya* [2005]; *Rahu Grash* [2006]).

Akram leaves a wife, Hosneara, three children and six grandchildren.

Contributed by his son, Reza Sayeed

## Reflections from general practice

Have you had a memorable experience in your everyday practice that young doctors could learn from?

Could you write it up in a readable style to share with rest of the profession?

Following the success of the recent RCGP writing competition in GP magazine, the College is seeking more contributions from College members to share key learning points from the everyday lives of GPs that can be used to educate future generations.

Your stories will help young doctors to see reflective learning in a real-life context, and also to appreciate the rich variety of life as a GP.

All submissions, to be received before 30th April, will be considered for inclusion in a potential book to be published by the RCGP.

For further information please contact the Publications Manager by email: [hfarrelly@rcgp.org.uk](mailto:hfarrelly@rcgp.org.uk)

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

Please write to:  
 The Editor, RCGP News,  
 Royal College of General Practitioners  
 14 Princes Gate, Hyde Park, London SW7 1PU

Or email:  
[rcgpnews@rcgp.org.uk](mailto:rcgpnews@rcgp.org.uk)



ISSN 1755-7720

© 2008 Royal College of General Practitioners. All rights reserved.

Published monthly by the Royal College of General Practitioners  
 14 Princes Gate, Hyde Park, London SW7 1PU  
 Email: [rcgpnews@rcgp.org.uk](mailto:rcgpnews@rcgp.org.uk)  
 Website: [www.rcgp.org.uk](http://www.rcgp.org.uk)