RC GP NEWS

THE NEWSPAPER OF THE ROYAL COLLEGE OF GENERAL PRACTITIONERS

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Triple boost for RCGP Revalidation plans

The RCGP has launched its pilot of the Revalidation ePortfolio for GPs – in tandem with the third edition of its *Guide to the Revalidation of General Practitioners* and a simplified guide to CPD credits.

GPs in urban and rural areas across the UK are taking part in the pilot and, depending on a successful outcome, the College hopes to make the electronic tool widely available later this year – free to RCGP members as part of their overall membership package.

The Revalidation ePortfolio is the first of its kind to be based on the areas of revalidation set out in the *RCGP Guide to Revalidation for General Practitioners*, now in its third iteration and available from the RCGP website.

The ePortfolio is designed to encourage reflection and is centred on a learning activity log with a simple data entry system.

The system categorises information in the learning log in a way that allows users to view a pictorial representation of their progress towards revalidation before annual appraisals and the five-yearly revalidation submission.

It links to the College's new Continuing Professional Development (CPD) credit scheme – which the College has simplified in response to GP feedback – and contains a guide to the system and a means to record and claim the credits earned. It will link with the trainee ePortfolio and members' personal data held by the College will be automatically entered into it.

The ePortfolio will also allow direct links to the College's other e-learning products such as Essential Knowledge Updates, which will autocomplete relevant entries into the Revalidation ePortfolio.

RCGP Chairman, Professor Steve Field, said: "This will be the definitive tool for GPs to use to support them in meeting the requirements of revalidation. It is being designed specifically for GPs in their many and varied roles.

"Frontline GPs are trialling the Revalidation ePortfolio so that we can be sure it meets the needs of all GPs, regardless of their individual working circumstances."

The RCGP *Guide to the Revalidation of General Practitioners* is regularly updated to reflect developments in the systems and processes the College is developing for revalidation – taking into account feedback and suggestions from grassroots GPs across the UK. Key changes between the second and third editions include:

- Adoption of the use of the phrase 'supporting information' in place of 'evidence', in keeping with other relevant organisations
- Adjustment of the timelines to reflect the fact that the Early Adopters programme (in which the first doctors will revalidate) will now start in the year 2011/12
- The possibility of GPs submitting a quality improvement project in the place of a second clinical audit
- Reference to the revalidation of GPs in training
- Simplification of the Learning Credits (Supporting information area 6)
- A refinement of the definition of activities included in extended practice (Supporting information area 13)
- Emphasis of the discretion that will be required by Responsible Officers for assessing supporting information for revalidation.

To accompany the latest version of the Guide, the College has also released Version 2 of the RCGP *Guide to the Credit-Based System for Continuing Professional Development* which has been refined after consultation with GPs and now provides simplified guidance on how many credits should be claimed for different learning activities. The RCGP credit system is not purely based on time spent, but also reflects the impact of learning.

Professor Field said: "We must get into the mindset of seeing revalidation as professional development, making sure that revalidation uses existing systems and that it is not onerous for busy GPs.

"We are using all the feedback and input received from GPs around the country to help us develop a programme for the revalidation of GPs that meets their specific needs. We are actively listening to what GPs are telling us in their emails and when we meet them. We have simplified our proposal relating to learning credits for this reason.

"GP feedback is invaluable to us and I would encourage all our Members and Fellows to give us their views so that our proposals for revalidation are as robust and relevant as they could possibly be."

While the RCGP has the responsibility on behalf of all GPs to propose the standards and methods for the revalidation of GPs, the General Medical Council (GMC) must approve the standards and methods before they are introduced.

■ *Both updated Guides are now available on the RCGP website*:
www.rcgp.org.uk/revalidation www.rcgp.org.uk/cpdcredits

Professor Steve Field: Feedback from members is absolutely crucial to our proposals

Inside this issue...

What members really think of College

The MRCGP qualification and the College's continuing role in maintaining professional standards and training are the benefits most highly valued by RCGP Members and Fellows according to the latest membership survey.

The expanding range of educational and training resources provided by the College was also widely welcomed in the survey. Newly developed services and benefits – particularly those geared around knowledge building and personal development – met with widespread approval from respondents: 93 per cent said they found Essential Knowledge Updates (EKU) very useful, with 90 per cent approval for the portfolio of resources being introduced to support Revalidation.

Trainee ePortfolios and eGP attracted positive feedback and there was wide support for proposed additional resources such as Online Seminars for CPD. *Continued overleaf*

Supporting GPs in the first five years

Dr Clare Taylor, past Chair of the Associates in Training Committee 2008-9, has recently been appointed as First5 Continuing Professional Development Fellow. Here she explains the concept of First5 and the aims and objectives of the First5 CPD project.

First5 is a new initiative being developed by the Royal College of General Practitioners (RCGP) which will support new GPs from completion of training to the first point of revalidation at five years. The RCGP already does excellent work to support all of its members, however the benefits of maintaining membership are not well known to all newly qualified GPs.

The concept of First5 is a way for the RCGP to play a key role in supporting new GPs through those crucial first five years up to the first point of revalidation.

Five Pillars of First5

The First5 concept is currently under development by the First5 task group at the RCGP. Faculties and members will be regularly updated on progress. There are currently five key pillars of First5 which are being developed:

1. **Connecting with College:** Promoting a sense of belonging and appropriate representation for the First5 cohort within the College
2. **Facilitating networks:** Encouraging peer support and mentoring through the development of local networks using the RCGP faculty structure
3. **Supporting revalidation:** Offering tailored support through revalidation for those in the first five years post-CCT.
4. **Career mentorship:** Highlighting the opportunities a career in general practice offers and helping new GPs get the most out of being a GP.
5. **Continuing professional development (CPD):** See below.

The concept will also help to encourage members to consider fellowship and use other RCGP work such as the concept of Federations to help to deliver support to First5 where possible.

Origin of the Concept

The concept of First5 was suggested by Dr James Parsons, AiT representative for Yorkshire

Clare Taylor: Identifying the particular CPD needs of new GPs in their first five years

and developed by the AiT Committee 2008-9. The project is being taken forward by the First5 Task Group led by Dr Clare Gerada, Vice Chair of Council. Dr Clare Taylor, Chair of AiT Committee 2008-9, is the First5 CPD fellow working with the Professional Development Board, led by Professor Nigel Sparrow to address the CPD needs of First5.

Why is First5 needed?

Associates in Training (AiTs) are now a well recognised group within RCGP and establish a relationship with the College during their training through membership benefits such as the trainee journal *InnovAiT* and the annual conference, as well as through MRCGP examinations. AiTs are also supported by their trainer and local peer group at vocational training schemes. However, on completion of training this support ceases. At the end of GP training, AiTs are competent but may lack confidence. The first years after training can be a difficult time for new GPs who find themselves in the ever-changing world of modern general practice and the new independent practitioner may feel vulnerable and isolated.

The RCGP already does excellent work to support all of its membership, However, the benefits of maintaining membership are not well known to all newly qualified GPs. The concept of First5 is a way for the RCGP to play a key role in supporting new GPs through those crucial first five years up to the first point of revalidation.

Where do we want to be?

The RCGP needs to connect with all of its members, including those within the first five years after training. The RCGP should be the first point of access for GPs at all stages of their career – the relationship established with RCGP during time as an AiT should continue throughout the professional lifetime. The regional faculty structure should be the local face of the RCGP and offer opportunities for peer support, educational events and local representation.

Nationally, the RCGP should continue to offer effective leadership and representation within the wider health service which represents the interests of all its members including those in the First5 cohort.

The First5 CPD Project

CPD is an essential part of general practice, which ensures GPs improve their knowledge and skills throughout their careers. CPD activity is currently reviewed during the annual appraisal and will form an essential part of revalidation. Throughout GP training, AiTs are encouraged to develop a personal development plan and use a variety of resources to meet their learning needs.

The RCGP curriculum gives an overview of all the areas they should be familiar with and resources such as *InnovAiT* help to ensure the whole curriculum is covered over the three years of training. At the end of training, AiTs should be competent in the main areas of practice but may not feel confident in more complex areas. The CPD needs of First5 may therefore differ from those of the entire membership.

The aim of the project is to identify the CPD needs of those within the first five years of gaining CCT and to develop a suite of CPD material aimed specifically at First5 to ensure they feel supported by the College; are appropriately equipped for their role in the primary healthcare team; and are able to take the profession forward in providing safe, high quality care for patients. The materials developed for the First5 CPD project may also benefit other RCGP members at various stages in their career.

- *A survey will be sent to all College members within the first five years post-CCT shortly and faculties will also be encouraged to discuss the First5 CPD project at their next faculty board meetings.*
  I would also very much welcome any comments or suggestions about the First5 CPD project by e-mail, so please contact me at first5@rcgp.org.uk

College appoints Chief Examiner

Dr Sue Rendel has been appointed as the College's Chief Examiner to take responsibility for the conduct, delivery and quality management of MRCGP assessments.

Dr Rendel, a Fellow of the College, is a GP Principal and trainer in a seven-partner practice in Newbury, Berkshire, and has been involved with the MRCGP examination at a senior level for a number of years, having acted firstly as convenor of the simulated surgery between 2005 and 2007, and more recently as the deputy clinical lead for the CSA. She has also been a leading figure in the development of the CSA, her work in this area being recognised by the award of the College's nMRCGP Foundation Medal in 2007.

Her appointment as Chief Examiner is initially for one year as the future roles within the MRCGP are reviewed. The coming year promises to be a busy one and Sue hopes to make an impact by improving the College's assessment links with the deaneries, refining standard setting and quality assurance processes across MRCGP assessments and contributing to discussions within the College about the development of a permanent leadership structure for the examination after 2010.

RCGP Pandemic Summit heads for Princes Gate

The RCGP swine flu Pandemic Summit on March 18 will now be held at the College headquarters in Princes Gate, London, rather than Leeds.

A variety of GPs and other primary care professionals will be invited to review key aspects of the pandemic, the strategic response and ways to inform planning for future responses to major incidents.

RCGP Pandemic Planning Lead Dr Maureen Baker said: "This Summit is an opportunity for GPs and others to consider the legacy of this pandemic. It is important that GPs analyse this and other aspects because this information will be critical in the future."

Nomination of Members to serve on College Council for 2010 – 2013

Six new nationally-elected members are needed to serve on RCGP College Council for the three-year term 2010-2013. Any Fellow or Member of the College may propose another for election to one of the six vacancies.

Nomination forms and further details may be obtained on application to the Returning Officer, 14 Princes Gate, London SW7 1PU or by email to: jcheong@rcgp.org.uk. Tel: 020 7344 3157
Please note all nomination forms must be returned no later than noon **31 March 2010**.

Ballot of members

In the event there are more nominations than places to be filled, a ballot will be held. Voting papers* for the ballot will be sent to all Fellows and Members during April 2010. A single transferable vote system will be used for the election. The result of the ballot and names of the six successful candidates will be declared at the June 2010 Council meeting and subsequently published in the *British Journal of General Practice*.

(* The ballot of Members & Fellows may be conducted electronically.)

What members really think...

However, significant numbers of members (more than 30 per cent) were unaware that the RCGP provided special and clinical interest support or that it helped practices seeking to improve their delivery of services through initiatives such as the Quality Practice Award (QPA).

Benefits such as reduced rate accommodation, use of meeting rooms and the members' library (providing free literature searches) were also currently underused as they were not widely advertised, said the survey.

Members felt that the College communicated well with them overall – but wanted more explicit information about its objectives, activities and services, and some said that making contact with the College could be improved.

The membership survey – conducted and evaluated by independent consultants – was the first full quantitative survey of RCGP members and was designed to determine levels of satisfaction, as well as identifying areas in which improvements to the membership package could be made. The survey will become a regular activity enabling the College to understand how well it serves its membership – and what it could do better.

Members were also questioned on issues of concern currently facing the profession, with the majority of respondents citing revalidation and registration, privatisation, polyclinics and funding. While membership of the College delivers a variety of tangible benefits, including access to educational materials and professional development tools, the survey results also reveal the strong personal benefit that members derive from being part of the College – 85 per cent said that membership of the RCGP made a positive statement about them as a person and a professional.

The RCGP won praise for its continuing work to promote awareness of general practice and for ensuring that standards of care were maintained at individual practice level, benefiting grassroots GPs and patients.

When asked what would improve their experience of College and of membership, over 50 per cent said the College could be more active in encouraging greater involvement from younger GPs, women and ethnic groups.

RCGP Chairman Professor Steve Field said: "The survey has revealed so much about what our members want, need and expect from the RCGP in terms of education, guidance and support. It's most encouraging that the results have highlighted the value our members attribute to being part of College.

"The views of members and fellows are invaluable in determining what steps College can take to ensure that we deliver the most relevant and useful resources available, particularly in the run-up to revalidation and supporting our members through the process.

"They can be reassured that we are listening and responding by introducing new initiatives and services that they want and need for the benefit of their own professional development and for the benefit of patient care across the UK."

Creating a paradigm shift in renal care

Dr Donal J O'Donoghue, National Clinical Director for Kidney Services addresses RCGP members' concerns about diagnosis, treatment and care

What do you see as the key issues for primary care in the diagnosis and treatment of renal disease? What works well and what improvements could be made?

The challenges for primary care are to recognise those at risk of kidney disease; to ensure surveillance systems are in place for early identification of kidney damage and kidney dysfunction – by a routine measurement of urinary albumin creatinine ratio and serum creatinine in the at risk groups; to know when a more precise diagnosis than chronic kidney disease is warranted; and to optimise outcomes by treatment of proteinuria, control of hypertension and aggressive management of vascular risk factors.

Identification and treatment of kidney disease requires a systematic approach to risk assessment and a holistic approach to management. The principles do not differ from other long-term conditions like hypertension and diabetes. Kidney disease is silent but deadly. Symptoms are non-specific and only develop late in the course of CKD.

What is surprising is the variation in primary care. When you look at the number of people on the CKD register by practice, there's up to a 50-fold variation in each PCT. There is also a significant shortfall in many practices versus the expected prevalence. Those with CKD rates of less than two or three per cent need to examine their electronic records to improve their systems of CKD recording. But let's not forget that primary care as a whole has done incredibly well given the short lead time from when the CKD domain was announced and introduced into the Quality and Outcomes Framework.

What is important now is that everyone with CKD has a formal laboratory-based assessment of proteinuria. Treatment of blood pressure and raised albumin creatinine ratios would save lives, prevent strokes and reduce the burden of ESRF.

Organ donation – if the Welsh Assembly Government adopts an 'opt-out' system, what would happen if English patients died in Wales or vice-versa?

The Human Tissue Act 2004 and the Human Tissue (Scotland) Act 2006 requires donors or their families to give their consent to organ donation. However, any donation procedures would follow the legislation of the country of donation. For example, we sometimes import an organ from France, which has opted out legislation. Allocation of the organ, as now, is on the basis of clinical need.

What can GPs do to improve the availability of organs for transplantation?

GPs are leaders in their communities and so have a hugely influential role in a range of medical, ethical and societal matters, including transplantation. As individual practitioners most will have encountered people who have benefited from transplantation and almost certainly have managed patients and families who have been devastated by illnesses that have destroyed organs that can be replaced by transplantation – not only kidneys but also livers, lungs and hearts.

In addition, they can take simple steps to encourage individuals to register as an organ donor. One GP, a good friend of mine, Ian Wilkinson from Chadderton Town Health Centre in Oldham, simply added the question about organ donation to the registration of people joining the practice. In a year they had increased take up of that option from 10 to 60 per cent. It's so simple and takes very little time – why not adopt something similar in your practice?

What are your views on the validity of the prevalence figures from QOF data? GPs are experiencing over- and under-coding – how concerned are you and should there be an audit?

GPs have a central role in diagnosis, explanation to patients and agreeing treatment goals, and practice nurses can educate and encourage achievement of those goals and of the lifestyle changes needed to reduce patients' risks. We do publish estimates of prevalence for every practice, so it is possible for GPs to compare themselves against colleagues in similar practices and the national figures. This data underscores the need for education and support to a proportion of practices. The variability makes CKD a hot topic for local audit and a good candidate for locally enhanced service agreements – the benefits are extraordinary.

I am encouraged by the rapidity by which primary care has engaged in the process of identification and management of kidney disease. The reporting of estimated GFR was introduced without very much notice, which made things difficult for GPs in 2006. We now have about four per cent of the adult population on the primary care CKD Stage 3-5 registers, which is about half the number we know have kidney disease.

Given the fact that kidney disease is so common, so harmful because of its association with premature vascular disease, and the fact that it is so eminently treatable, it's also an ideal candidate for a more detailed, national audit of quality management.

What plans are in place for improving access to dialysis – particularly home units – for patients?

A constant challenge is to maximise transplantation which, for those who are suitable, is the best form of renal replacement therapy if the underlying kidney disease cannot be halted. We have plans to increase the number of deceased organs by 50 per cent over the next few years. Looking at other European countries and copying some of their methods, this should be achievable. Live kidney donor transplantation is also a recent success.

Looking at the Renal Registry data on home therapies, some units have many more patients than others. This almost certainly reflects clinical bias by both doctors and nurses who, often inadvertently, promote one dialysis modality over another. Supporting patients in shared decision making to achieve the best possible outcomes is one of the main goals of the Renal NSF. The NSF therefore recommends access to and management by a multiprofessional renal team for at least one year before renal replacement therapy is needed.

Developing tools to support shared decision making in kidney failure and measuring the quality of the choice is one of my goals as Renal Tsar. The DH is incentivising home haemodialysis by recommending payment for individual dialysis sessions, and we are strongly promoting care planning for all people with advanced kidney disease. A central part of that care planning is to support individuals in shared decision making so that people know what the options are, know the pros and cons of various options and are supported in whichever choice they make.

Patients dialysing at home can feel isolated. The support of enthusiastic and committed GPs is greatly appreciated. Home dialysis is another area where good primary and secondary care communications and team working improves our patient experience and outcome of care.

How can the education and training needs of both professionals and patients be addressed?

GPs and practice nurses are quick to learn and CKD isn't rocket science. Since the introduction of eGFR reporting and the CKD domain into the QOF we have seen kidney disease become the number one topic GPs want more information on. It has figured in lots of local and national meetings. Now that primary care and secondary care are singing from the same hymn sheet – using the same words and classification system, the emphasis is shifting from 'what is eGFR and why does it matter' to 'how do we treat proteinuria', 'what to do when GFR falls' and 'medicines management in CKD'.

NHS Kidney Care, the improvement organisation recently established to support the Renal NSF, is also working with the RCGP in the development of a range of packages such as e-learning and to integrate kidney care into the vascular sections of the curriculum of doctors, nurses, pharmacists and other therapists.

For patients we are also developing educational packages and information prescriptions. For those with advanced kidney disease and for people with progressive kidney disease who are likely to end up on dialysis or requiring a transplant there is very good material on the National Kidney Federation website: www.kidney.org.uk

What do you feel has been your biggest achievement as renal 'tsar'?

My job is to promote high quality care for all people with kidney disease, to listen to healthcare professionals and patients and to challenge the system – people in policy, people in commissioning and clinicians. The biggest achievement has been working with primary care to raise the profile of kidney disease and achieving the visibility that now gives us a platform for real improvements in peoples' experience and outcomes of kidney care.

In the UK we are already seeing a reduction in people arriving as 'crash landers', those requiring dialysis as an emergency; we have even seen a levelling in terms of the number of people requiring dialysis. That is remarkable. That's down to good quality primary care. Good quality primary care of people with kidney disease is also delivering significant reductions in strokes, heart attacks and other vascular events.

As a clinician working in the DH, what frustrates you?

In fact it's a privilege to work in the Department of Health and with colleagues across primary and secondary care to help improve things for people with kidney disease. I do miss direct patient contact and it's true that policy development takes longer to formulate and implement than individual patient care plans.

Prevention is better than cure but it's not got the immediate buzz that I found so much fun as a junior doctor. It is as fulfilling and if I had my time again I might well choose primary care as my speciality.

With so many other competing priorities for Government investment – cancer, dementia, mental health etc – what guarantees can you give to GPs that their renal patients are receiving a fair deal?

I think our front line staff – no one more so than in primary care – are the custodians of quality; and front line staff are the only people who can deliver improvements in patient experience and outcomes. We have to move from a 20th century 'cure paradigm' to a 21st century 'long-term conditions' approach to kidney care and we have to look for synergies.

Many of the antecedents of cancer are the same as those that cause kidney disease – smoking, obesity and exposure to environmental toxins – so tackling the route causes of kidney disease will improve cancer and vascular outcomes.

The NHS is its people. Our values and behaviour are the system. I see kidney disease not as a brand new condition for primary care, not as the straw that might break the camel's back, but rather as a condition whose recognition could bring the vascular triad of CKD, that's Cardiac, Kidney and Diabetes, together. Primary care in the UK is proving me right.

■ *If you have a question or would like to contact me, you can email me on* Donal.o'donoghue@srft.nhs.uk

A longer version of this interview can be seen at **www.rcgp.org.uk/rcgp news**

Updating the Protection of Children Toolkit

Dr Janice Allister
RCGP Fellow and Chair, PCCSF

CHILDREN AND YOUNG PEOPLE are some of the most vulnerable people, and every member of society has a responsibility to keep them safe. Health Service workers, especially those working in the front line of primary care, have a duty to care and protect. General practitioners and our teams have a key position in the NHS which allows us to recognise and act upon concerns for the well-being of children.

Professor Steve Field, the RCGP Chairman, in response to the publication of the NICE Guidance *When to Suspect Child Maltreatment* (2009), emphasised the important role GPs have to play: "Child maltreatment can include neglect and emotional abuse as well as sexual and physical abuse, and often has long lasting effects into adulthood. The GP's role is crucial. We are often the first port of call for children and their families."

Origins of the Toolkit

The need for resources to help inform GPs and their teams of the role they could play in safeguarding children was acknowledged in 2003. Professor Yvonne Carter and Dr Michael Bannon produced a guidance booklet for the RCGP, entitled *The Role of Primary Care in the Protection of Children from Abuse and Neglect*. It emphasised how the primary care role is uniquely placed to identify potential markers of abuse, and makes a series of recommendations.

The official RCGP response to Lord Laming's report into the death of Victoria Climbie was published the following year. *Grasping the Nettle: the GP, the child and information sharing* was followed by the *Keep me Safe Strategy for Child Protection* in 2005, both produced for the RCGP by Ruth Bastable. The Strategy set out to examine child protection as it relates to general practice, and proposed a unified and consistent approach to safeguarding issues.

These documents were important and showed the need for a collection of comprehensive and coherent educational tools that could be disseminated to all GPs for use in practicetraining and development. The *Safeguarding Children and Young People Toolkit* was born out of this vision.

Led by Dr Andrew Mowat, the former RCGP Child Health Lead and Chair of the Primary Care Child Safeguarding Forum (PCCSF), the RCGP and the National Society for the Prevention of Cruelty to Children (NSPCC) worked collaboratively to produce the first full version of the Toolkit.

They produced the original Toolkit in 2007 to provide GPs and practice teams with clear and effective guidance that could be easily used in daily practice. The Toolkit contains a template for policy and procedures which can be adapted with local guidance, a legal framework for all seven jurisdictions in the British Isles (including the Channel Islands), an audit tool and training modules.

The Toolkit was published on the RCGP website (www.rcgp.org.uk/circ) with free public access and specific training modules available to RCGP members. It has proved to be very popular, with over 3,000 views in the last six months alone. It is now well established as a useful support for GPs.

2009 Update

The Toolkit was always intended as a resource that would evolve over time with new developments. In 2009 it was agreed that it should be revised with the full collaboration of the RCGP and NSPCC. The revision was led by Dr Andrew Mowat with a group including myself as the current chair of the PCCSF and named safeguarding GPs actively engaged in training. It accommodated substantial feedback from practising GPs.

The aim of the revised Toolkit remains the same: to be a collection of tools that can be used in training and patient care, with many features that tailor it specifically to the needs of general practice.

For example, the GP may recognise a pattern of neglect through poor personal care, missed immunisations and scheduled appointments, behavioural and mental health issues or difficulty in managing chronic long-term conditions such as asthma or diabetes, knowing parental factors such as drug and alcohol abuse, mental health issues or domestic violence.

Key contents include:

- **Introduction:** This covers the range of different child protection issues that may be encountered in primary care, and how to identify and approach them.
- **Policies and procedures:** This is a practical guide covering all primary care policies and procedures relating to safeguarding and child protection. It can be used as a template for individual practice policies and procedures.
- **Case scenarios:** These are based on recent cases which can provide a crucial team-building and discussion exercise *(Appendix 8)*.
- **Training modules:** Updated for 2009, these present user-friendly training material for use in practices.
- **Audit tool:** This has been completely redesigned in response to Serious Case Review feedback, and is up-to-date, fresh and entirely specific to the professional and contractual needs of general practice *(Appendix 9)*.
- **External links:** A helpful catalogue of resources for GPs and their teams regarding child protection issues *(Annex C)*.

The complete toolkit is worthy of attention and study, but it can be dipped into for specific information. Sections are short enough to consider in a lunchtime meeting. It keeps GPs and other practice staff up to date with current guidelines and legislation and encourages active participation with a cognitive, pre-emptive approach. It recognises that child safeguarding must not be considered in isolation, and promotes in-house practice-based training with real child health scenarios as part of the training modules. It acknowledges that all members of staff have roles and responsibilities in safeguarding. Use of the toolkit will help to ensure that general practices across the United Kingdom operate a safe environment, in which staff are comfortable working with young people.

We also hope it will reassure patients and our multi-agency partners that general practices are committed to safeguarding and promoting the welfare of children and young people.

Access and feedback

The 2009 revision of the RCGP and NSPCC *Safeguarding Children Toolkit for General Practice* is available on the RCGP website at www.rcgp.org.uk/circ

It can be downloaded as a whole or in sections for easy access. As the Toolkit was created with the intention of allowing practices to adapt the guidance to their local needs, it is also available as a Word document to make this easier.

■ *Members of the Primary Care Child Safeguarding Forum (PCCSF) are GPs and Community Paediatricians involved in safeguarding consultations, teaching and audit. We welcome feedback and ideas for further updates:* www.pccsf.co.uk

GPs campaign to end the scandal of children in detention

The RCGP has joined forces with the Royal College of Paediatrics and Child Health (RCPCH) and the Royal College of Psychiatrists (RCP) to launch a position paper opposing the practice of detaining children and young people in immigration centres. **Dr Les Ashton** (Primary Care Mental Health Forum) and **Dr Jane Roberts** (RCGP Adolescent Health Group) contributed to the position paper. Here, they explain why this 'unethical' and 'unacceptable' practice must stop.

IT IS RARE that a cause raises such concern that it finds unanimous inter-collegiate support, but the treatment of children and young people who face deportation is one such cause. The position paper is supported by the Faculty of Public Health, with endorsement from the official bodies of Social Work, Psychology and Child Psychotherapy.

The launch event attracted official representation from RCGP Chair of Council Professor Steve Field and RCPCH Chairman Professor Terence Stephenson, with a compelling opening address from Sir Al Aynsley-Green, the Children's Commissioner, who referred to his personal observations made on visits to Yarl's Wood, the main detention centre for families.

A thorough review of case notes – conducted with a paediatrician, Dr Nick Lessof – found widespread inadequate medical care at the centre, which resulted in the Commissioner judging clinical governance at Yarl's Wood as 'unacceptably poor' [(1)].

At least 1,000 children each year are detained in one of three prison-like detention centres for indefinite periods, often extending beyond 30 days. Detention usually begins with a dawn raid at the family's home; a home in which many of the families will have lived for a number of years.

Many of the children detained, too, will have actually been born in the UK. Once detained, often without explanation or any idea of the length they will be held for, the children have only limited access to primary care services through a privately contracted provider which was found to be below standards expected of the NHS elsewhere [(1)]. More than 50 per cent of those detained will ultimately be released, often due to 'eleventh hour' intervention, and sent back either to their original homes or relocated to being the process of rebuilding their lives once again.

Children seeking asylum in the UK are among the most vulnerable in our community, with high rates of significant physical and psychological harm that reflect their life experiences before arriving in the UK, the dislocation of their families, and the challenges of poverty and integration that they face on arrival. These are compounded by the harmful effects of arrest and detention which, studies have found, in and of themselves cause significant harm[(2)].

The paper makes a number of recommendations, the most important being the immediate cessation of the administrative detention of children, young people and their families, now recognized as harmful and unacceptable, and calls on Government to address this issue as a matter of priority.

It also calls for children detained to be recognised as Children in Need and immediately referred to Local Authority children's social care as 'children at risk of significant harm', expecting initial assessment to be completed within seven days as described in *Working Together to Safeguard Children* [(3)].

■ *If you would like to give your support to the campaign to end the detention of children please look at the Medical Justice website for further information:* www.medicaljustice.org.uk *and sign the petition at* petitions.no10.gov.uk/NoChildDetention/

Child care: Professors Steve Field and Terence Stephenson with Sir Al Aynsley-Green at the launch

RCGP Chairman Professor Steve Field said:

It is so important that this outrageous practice is brought to an immediate end. It horrifies me that in a civilised society we allow children to be subjected to terrifying, dehumanising experiences which can have a lifelong, negative impact on their lives.

The testimony of children in detention centres is heartbreaking. One girl asked: "Why do they have to put us in cages?" The confusion, embarrassment, discomfort and worry they experience as a result of their detention is hard enough for an adult to deal with – yet for a young person the impact of these experiences can be far worse.

Mental health problems are already disproportionately high in refugee populations, problems which evidence agrees are exacerbated by detention. In addition to this, children detained often experience poor physical health, as they cannot access immunisation and preventative services.

Detention is by no means an appropriate setting for treating people with mental or physical conditions, regardless of their age. It is extremely difficult to provide adequate mental healthcare to young people when they are being held in the very environment that is causing them distress.

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Improving hospital discharge summaries

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PATIENT RECORDS serve two purposes. The first is to enhance direct patient care by acting as an aide-mémoire, a support for clinical decision making and communication between clinicians caring for a patient.

The second is to provide a legal record of that care to support clinical audit, research, resource allocation and performance planning. It is the primary mechanism for providing continuity of safe and effective patient care and ensuring that the right patient information is delivered to the clinicians caring for that patient at the right time. This is particularly true of discharge summaries where GPs need accurate, relevant and timely information when patients are discharged from hospital.

The NHS Alliance's second survey of discharge summaries in 650 practices in 2007 reported that: 'Respondent after respondent told the NHS Alliance that it is not just delays in receiving discharge information that put patient care at risk, it is lack of critical detail. In some cases, even the patient's name was missing'. (www.ehiprimarycare.com/news/2580/e-discharge_summaries_ needed_says_gps)

The third NHS Alliance survey in 2008 focussed on delayed discharge summaries which remained a persistent problem, in spite of implementation of electronic summaries in many trusts and the secondary care contract requirement for discharge summaries to be sent within 72 hours of discharge.

The quality of medical record keeping in the UK is highly variable across the NHS (Carpenter et al, 2007). The layout and content of hospital admission, handover and discharge proformas are very different between hospitals and clinical departments, with some not using a proforma at all. This variability is mainly due to the fact that doctors largely learn how and what to write in the medical notes by apprenticeship rather than the application of a standard record structure. The research literature shows improved quality and safety of care when medical records have a standardised structure.

The introduction of the Electronic Patient Record makes the need to have a standard structure for the recording of clinical content absolutely critical, preferably reflecting professional best practice rather than the structures of IT systems. This ensures that the information recorded about patients can be easily and reliably retrieved and communicated to those caring for the patient in a timely manner.

The Medical Record Keeping Standards project

The Health Informatics Unit of the Royal College of Physicians collaborated with the other Medical Royal Colleges and Specialist Societies to develop evidence and consensus-based standards for the hospital admission, handover and discharge documents.

In principle they are applicable to the records for patients who are admitted to and discharged from the care of most hospital disciplines. They were published in October 2008 (www.rcplondon.ac.uk/clinical-standards/hiu/medical-records/Pages/clinicians-guides.aspx).

The process of developing the standards included:

- Analysing proformas used by different hospitals
- Reviewing the literature
- Holding workshops with junior and senior hospital doctors, GPs and patients
- Sending online questions with the proposed clinical content
- Piloting of the standards using proformas based on the standards in hospitals
- Working with nominated individuals from Medical Royal Colleges and Specialist Societies to ensure these are generic across the different specialties
- Sign-off of the standards by the Academy of Medical Royal Colleges as fit for purpose on behalf of the medical profession

GPs who took part in our consultations on discharge summaries included representatives from the RCGP, representatives from the RCGP Informatics Group and representatives from the JGPIT group. In addition, contributions came from members of the RCP GP Committee, GPs who received the discharge summary during the hospital pilots, and members of the BMA who received an email with a link to the online questionnaire.

The findings

The online questionnaire proposed 36 headings and sub-headings for the discharge record. It was completed by 1,454 clinicians – over 80 per cent of these agreed that 31 of the 36 headings were useful, 28 were clear and unambiguous, and 24 and 25 should be mandatory in a paper and electronic environment respectively.

The headings least likely to be considered useful (name known as, responsible trust and source of admission) were nonetheless considered useful by 47 per cent, 65 per cent and 71 per cent of clinicians respectively. The headings document was updated and a discharge summary designed and piloted in eight hospitals. Patients wanted to ensure that their concerns and information shared with them were also consistently recorded.

A total of 67 discharge proformas were completed and commented on by 86 doctors. The majority of doctors completing the proformas felt the proposed headings were appropriate (90 per cent). A few hospital respondents struggled with completing some of the headings, including functional measures, clinical narrative and information given to patients.

In terms of face validity, GPs receiving the patient felt the proforma (n=20) had provided them with appropriate (100 per cent) and sufficient (89 per cent) information respectively on the reason for admission and had given them a clear indication of the tasks required (79 per cent). Almost all consultants (96 per cent) felt that the information was pertinent and was what they expected to be in a discharge summary.

The standards

The standards were signed off as fit for purpose by the Academy of Medical Royal Colleges in April 2008 and were submitted to Connecting for Health. They were published by the NHS Digital and Health Information Directorate in October 2008.

We hope that implementation of the new standards in both the paper and electronic environments will increase the quality and safety of patient care and clinical communications between secondary and primary care, particularly when they are implemented in electronic systems.

They will form the basis for a common approach to record keeping across England, Wales and Scotland and will be incorporated into undergraduate and postgraduate curricula and all electronic patient record systems. The latter must still deliver the relevant information from hospital to primary care efficiently and in good time in order to minimise risk to patient safety.

The two documents that have been published are:

1. *A Clinician's Guide to Record Standards – Part 1: Why standardise the structure and content of medical records?*
2. *A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital.*

Standards for the content of discharge summaries are in Part 2.

■ *For downloadable versions of the guides and to order free hard copies go to:* www.rcplondon.ac.uk/clinical-standards/hiu/medical-records/Pages/clinicians-guides.aspx

Update on psychological therapies and the management of depression in primary care

Alan Cohen FRCGP
National Primary Care Advisor to the IAPT programme and Director of Primary Care, West London Mental Health Trust

Alan Cohen: Training programme is central to the successful implementation of the guidelines

IN NOVEMBER 2009, the National Institute of Health and Clinical Excellence (NICE) published updated guidelines for the management of depression in adults. At the same time NICE also published a separate guideline for the management of depression in those adults who also have a long-term condition.

The guideline for the management of depression is broadly unchanged from the original 2004 guideline. There are, however, a number of amendments: the advice on the assessment of severity of depression recommends a broader based approach rather than just a 'symptom count'. The changes to the Depression QOF domain presaged the change in the NICE guideline. A stepped care approach is still advocated for the system of care (even though the steps are slightly different to the 2004 version), and a wider range of psychological therapies are recommended for the management of moderate and severe depression.

The guideline makes clear that psychological therapies are central to the management of people with depression. Unlike the earlier guideline, psychological therapies other than cognitive behaviour therapy (CBT) are recommended for people with moderate or severe depression. These other therapies include interpersonal therapy, and behavioural couples therapy. Mindfulness-based CBT is also recommended for relapse prevention and for those with recurrent depression. Counselling can also be recommended, but it is clear from the guideline that the evidence is weaker than for other talking therapies. Finally the new guideline for people with depression, and a long term physical health problem, recommends a new intervention called 'collaborative care' for those who do not respond to other treatment options.

The difficulty for the busy general practitioner is knowing how best to advise their patients as to which treatment option is most appropriate. The second problem is having provided the most up-to-date advice, ensuring that the wider range of recommended therapies are available locally.

The RCGP has launched an e-learning programme Improving Access to Psychological Therapies (IAPT). The programme is part of the College's increasing library of training programmes for GPs – this programme can be found at www.e-GP.org.

The interactive training programme takes the learner through the various stages of managing people with common mental health problems. It uses clinical scenarios and vignettes, together with video material, to help the learner understand the presentation of people with anxiety or depression and to assess the severity of disorder in order to help the GP match an appropriate intervention to the needs and choices of the patient. Psychological interventions are succinctly described to equip practitioners with the understanding and skills required to explain and discuss these with patients. The importance of choice is emphasised, together with the need for continuing support for patients in primary care. The stepped care model of care and the Improving Access to Psychological Therapies (IAPT) programme is also fully explained.

The learning programme, authored by Oxford GP Dr Karen Kearley, will be invaluable to training general practitioners, and experienced doctors. It will also be of value to other members of the PHCT who may wish to know more about psychological disorders, their treatment and the IAPT service.

Access to psychological therapies is vital to the implementation of the guidelines. In the past access has been poor, with typically unacceptably long waits for evidence-based interventions such as CBT.

On 10 October 2007 – World Mental Health Day – the Secretary of State for Health announced new recurrent funding to develop improved access to psychological therapies. The announcement made available £300m that would provide treatment for 900,000 people over three years, of which half would move to recovery, and the appointment of 3,600 new therapists to deliver the recommended treatments.

This programme, and funding, was intended to be half of a six-year programme, so that – at the end of 2011 – half the PCTs in the country would have a new Improving Access to Psychological Therapies (IAPT) service.

Progress has been rapid and exceeded the planned roll-out of the new service. By the end of 2010, there will be new services in 115 PCTs. 35 were set up in 2008, and 80 were commissioned from April 2009. In each site, a new service is being created, with the appointment of new staff who need to be trained to deliver the NICE recommended evidence-based interventions.

The result is a greatly improved access to psychological therapy service even though, in the early stages, sometimes access is slower than anticipated. New services are also coping with historically long waiting lists so that, in the very new sites, it often takes some months to see the benefit of the new funding and service. More information about the new services can be found at www.iapt.nhs.uk

There is a clear link between the development of guidelines based on latest best practice, the implementation of those guidelines through a national implementation programme, and the delivery of training by the RCGP to understand how most appropriately to use the guidelines. The training programme is central to the successful implementation of the guidelines.

Celebrate general practice in Scotland

National General Practice Week in Scotland takes place from 8-14 February on the theme of Celebrating the Best of NHS General Practice.

Organised by the BMA's Scottish General Practitioners Committee (SGPC) in partnership with RCGP Scotland, events include an exhibition and reception in the Scottish Parliament, a members' debate in the Parliament Chamber and a special 'pull-out' feature in The Scotsman newspaper.

The week also sees the launch of the BMA's new policy document, General Practice in Scotland: The Way Ahead developed with RCGP Scotland and the Scottish General Practitioners' Committee.

■ *For further information or if you would like to be involved, please contact Josie Westley, RCGP Scotland, at* jwestley@rcpg-scotland.org.uk *or on 0131 260 6801.*

Suicide awareness in primary care: How making the right connection can save lives

Alys Cole-King is a Consultant Liaison Psychiatrist based in North Wales and has a longstanding interest in the treatment of patients with suicidal thoughts or self-harm. She is currently developing a number of e-learning sessions for the Care of People with Mental Health Problems module, as part of the e-GP e-learning programme (www.e-GP.org). Here, she describes the development of a new collaborative approach to suicide and self-harm awareness training.

EVERY YEAR approximately 5,000 people in the UK die by suicide. This is twice the number of deaths from road traffic accidents.[1] Suicide is the most common cause of death in young people in the UK. While only 25 per cent of those who die by suicide are known to specialist mental health services, the majority of the remaining 75 per cent have contact with front-line services including primary care, a significant proportion of these in the weeks before their death [2].

Every contact a suicidal individual has with someone represents an opportunity to intervene and prevent a suicide. If suicide prevention is seen as the preserve of specialist mental health services, opportunities for intervention will be missed [3]. Doctors can be educated to enhance their ability to detect suicidal ideas but this may not result in any change in their management of suicidal patients [4]. Even brief training can significantly improve attitudes towards suicidal patients [5]. Sudack et al suggest that more robust training could reduce morbidity and mortality [6].

A new training package on suicide and self-harm has been developed, called *Connecting with People*, targeted at busy frontline professionals and others [7]. *Connecting with People* [8] aims to increase understanding and empathy, reduce the stigma associated with self-harm and enable participants to talk to someone who has suicidal thoughts or following self-harm. It equips participants with simple distress-reducing techniques and safe ways of responding to a suicidal individual. In particular, it aims to demystify the process of suicide risk assessment and response to suicide risk.

It has previously been suggested[9] that suicide can be mitigated and this should start in community settings such as primary care. *Connecting with People* aims to contribute to community suicide prevention by both changing the hearts and minds of attendees and providing them with the relevant skills to engage with a distressed suicidal individual in a collaborative, therapeutic way. Participants in the training have reported that they feel 'empowered' and now want to make a difference and engage with suicidal individuals.

Connecting with People has a flexible, modular form enabling it to be tailored to the needs of healthcare, non-NHS and a wide range of third sector organisations. It is firmly evidence-based and uses a mixture of lecture-style and facilitated discussion sessions, and can be continuously updated to incorporate new research. But its key characteristic is that it is concise.

The shorter version only takes two hours and can be delivered to the target audience on their own premises, reducing the time commitment and cost. This helps to increase uptake, especially by those who are otherwise unlikely to attend training in suicide and self-harm awareness because they do not feel they can justify taking the time to attend a one- or two-day programme, although they will be encouraged to do so.

Training method and target audience

There are two types of training session, each of which is adapted for different audiences:

Two-hour Suicide Awareness Training aims to:

- **Create empathy and challenge stigma** by helping participants develop their understanding of suicidal behaviour;
- **Promote understanding** of the ambivalence of suicidal individuals
- **Develop an empathic, therapeutic relationship** in a demanding and time pressured environment
- **Introduce the user friendly 'Cole-King Continuum'** [10], a framework designed to demystify the process of talking about suicidal thoughts
- **Promote the role** of a professional or carer in suicide prevention

One–day Suicide Response Training aims to:

- **Increase understanding and skills** in order to contribute to a community-based suicide prevention approach
- **Make assessing individuals with suicidal thoughts more transparent** by using the mitigation framework[11] which promotes a collaborative assessment and response to an identified suicide risk. This approach is recommended in the Department of Health National Risk Management Programme *Best practice in managing risk*. London: Department of Health; 2007.
- **Promote realistic ways** for dealing with very distressed suicidal individuals in a busy morning surgery
- **Teach professionals to 'speak the language'** of an effective referral to Mental Health colleagues. Prioritising referrals.

Domains of the 'Cole-King Continuum' of suicidal thoughts

- Nature of the suicidal thoughts, *ie* frequency, intensity etc
- Perception of the future and hopelessness
- Planning and preparation
- Ability to resist acting on their thoughts of suicide or self harm

Central to the development, evaluation and delivery of *Connecting with People* is a groundbreaking collaboration between statutory health services, the voluntary sector, business and government.

The Welsh Assembly Government Health Minister, Edwina Hart, has recognised that GPs are at the front line of suicide prevention. The Welsh Assembly has therefore provided funding specifically to develop further the primary care version of the training. To ensure clinical relevance and increase its impact, this will be done in consultation with primary care professionals.

As a psychiatry SHO in 1993, I started running short suicide and self-harm awareness training sessions for A&E and general hospital staff, after becoming concerned by the seeming lack of empathy towards patients with suicidal thoughts or following self-harm. The training sessions have gradually been evolving ever since. After attending one of the sessions in 2002, RCGP Fellow Dr Huw Lloyd, Chair of Wales Mental Health in Primary Care (WaMH in PC), invited me to deliver a session specifically for GPs in North Wales and he and the WaMH in PC Core group have been particularly supportive of the training

With only a limited number of Liaison Consultants, I approached Gavin Peake-Jones, a management consultant with a business background and particular expertise in organisational learning and change management, to help develop short suicide and self-harm awareness training sessions further by improving its focus and impact and facilitating its dissemination.

I initially collaborated with Gordon Hunter, Director of Services of Wrexham Mind (the national mental health charity), and Phill Chick, from the National Leadership and Innovation Agency for Healthcare in Wales, who further encouraged and facilitated the development and dissemination of the training. It is now intended that this training should become a part of the WaMH (Wales Mental Health in Primary Care)in PC Gold Standards programme and will be incorporated into the programme as it is rolled out across Wales.

Gavin and I are now formal partners in Mind Cymru's *Positive Choices* Project. This five-year Wales-wide project is funded by the Big Lottery and aims to train 13,000 people across Wales in Applied Suicide Intervention Skills Training (ASIST). *Positive Choices* is a central strand of the Welsh Assembly Government's National Suicide and Self Harm Reduction Action Plan. Together with ASIST, *Connecting with People* will be a central part of a comprehensive suite of training for all sectors in suicide and self-harm, evaluated by the NPHS. Alan Briscoe, *Positive Choices* project manager, has worked closely with Gavin and Alys to ensure the consistency of key messages across both programs.

The ASIST/*Connecting with People* suite of training is the first example of an integrated suicide awareness training programme with different versions tailored to the needs of different sectors. It is a testament to what can be achieved by collaboration between the statutory services, third sector, private sector and Government.

Through this work, Wales could lead the way in establishing a common language and understanding of suicide prevention and the role that all sectors of society can play. It has the potential to have a significant impact on the way in which suicidal individuals are responded to by the people they come into contact with.

Dr Tony Jewell, Chief Medical Officer for Wales, said: "Although suicide intervention training is already in practice in Wales, the public consultation on the *Talk to Me* action plan identified the need for a bite-sized course for health professionals to help them recognise signs of mental distress.

"The responses indicated that many professionals felt they had some of the necessary skills, but they would find it difficult to take enough time out of their daily schedules to complete a longer course. This training programme, *Connecting with People*, has been developed to increase understanding among frontline staff and health professionals with the overarching aim of reducing suicide and self-harm in Wales."

Participants' Feedback

Following the training sessions participants are asked to complete anonymous feedback forms. The results to date for different versions of the training are set out below. Note that many participants were already working in mental health.

- 99% (376/380) rated the quality of the presentation as 'very good' or 'good'
- 93% (324/350) increased their understanding of self-harm and suicidal thoughts
- 93% (232/249) increased self-reported empathy
- 94% (187/198) now believed, following the session, that they had a role in suicide prevention

Responses to 'What have you learnt during this session that you plan to use in the future?'

'I plan to ask more questions about suicidal thoughts, *ie* nature, frequency.'

'How to assess the risk of a person who presented with suicidal thoughts and confidence to use the knowledge!'

'Understanding how to assess risk. Knowing what I can do that could make a difference to someone'

'Potential therapeutic measures that can be taken'

'Framework for assessing patients, including instilling hope'

'Never judge those who have self harmed'

'To always remember you can make a difference to their ambivalence'

'That giving just a few minutes of kindness can save someone's life'

'The benefit of intervention and the impact that I can have'

'How a little effort on our behalf can make a big difference'

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Helping the newly-bereaved

Anne Wadey
Head of the Bereavement Advice Centre

Many practices have expressed appreciation for the Bereavement Advice Centre A5 leaflet or wallet card which they give to newly bereaved families. These have been designed specifically for use by health sector professionals who meet families around the time of the death. One side of the leaflet summarises the information, advice and signposting that Bereavement Advice Centre provides. The other side features a grid in which the bereaved can enter the names, phone numbers and appointment details of key contacts in the immediate post-death period, such as the registrar, funeral director and bank. There is also space for details about the funeral for answering queries at this stressful time.

Bereavement Advice Centre is committed not just to the direct support of the bereaved by providing information, advice and signposting but also to working in partnership with professionals who provide direct care. We provide an overview of the entire jigsaw so we can direct the bereaved to the right service, at the right time and in the best sequence.

■ *For a sample or supply of the leaflet, please call 0800 634 9494, specifying Health Sector Leaflet. A4 posters, credit card-sized cards and clear acrylic stands for both A5 and card-sized literature are also available. All Bereavement Advice Centre literature is free. See our website* www.bereavementadvice.org *under Contact Us – For Professionals for details.*

New support for general practice research

The importance of general practice research has been underlined in a report by the Academy of Medical Sciences, one of the most prestigious scientific bodies in the UK, writes **Martin Roland** FRCGP FMedSci, *(right)* Professor of Health Services Research at the University of Cambridge.

The workshop report, *Research in general practice: bringing innovation into patient care*, argues that general practice and primary care are fundamental to the success of a healthcare system and that UK expertise in research in these areas is world leading.

The values of general practice underpin a challenging research agenda. This spans preventive medicine, early diagnosis, acute and chronic disease management, personalised care, and understanding of beliefs and behaviours relating to health and illness, areas which are of increasing importance to the UK's healthcare agenda. In addition, general practice is uniquely placed to deliver research of international importance. Key strengths include universal registration, well established research networks, extensive general practice research databases, and long-standing university departments of general practice. The UK has particular expertise in conducting clinical research including large-scale randomised trials in general practice, and in health services research.

Key research priorities

The report identified a number of priority areas for future research. These included:

- Research addressing the 'second translational gap', ie the gap between clinical research and healthcare delivery is a key priority. General practice research has a major role in bridging this gap – evaluating new healthcare interventions in realistic clinical settings, and facilitating the implementation of new knowledge in clinical practice.
- Research is needed on the role of the general practitioner in clinical care and as a gatekeeper to secondary care. A key role of the general practitioner is to coordinate and integrate patient care. The stage at which a diagnosis is made in primary care is often the key determinant of clinical outcome. The report draws attention to the need for further research to strengthen the evidence base for decision-making in diagnosis, treatment and patient care pathways. The impact of the patient's context on their illness, especially in terms of comorbid conditions and adverse or enabling social settings also require more attention. There is also an important broader role for research evidence in evaluating new models of team care for both clinical and cost effectiveness.
- While UK primary healthcare has important strengths, the report argues that there remain important opportunities to learn from other European systems. Innovative approaches originating in different settings, such as the changing roles and responsibilities in primary care in developing countries, should not be overlooked.

Professor Nigel Mathers, Chair of Clinical and Research, RCGP and Professor of Primary Medical Care, University of Sheffield, said: 'The Academy's report is very timely. With the creation of the national primary care research networks [PCRN] and the support provided by research design services and comprehensive local research networks [CLRNs], there's now good infrastructure to support GP research. It's a good time to get involved in research.'

The need to develop research capacity

Although academic general practice is better developed than in many countries, the report draws attention to the need to build and sustain research capacity. The UK's research capacity in primary care needs to be expanded, with particular attention given to the development of the next generation of academic leaders.

Only one in 225 general practitioners in the UK are clinical academics (compared to approximately one in 16 consultants in all hospital specialties) and the current number of academic general practice training posts is insufficient to sustain existing capacity.

Greater emphasis on research in the general practice training curriculum, clear and well resourced career pathways, and an increased number of role models for aspiring academic researchers will be vital for the future of the discipline.

Future needs of general practice research

The report argues that potential of UK funding for research in general practice could be maximised by:

- **Promoting** funding opportunities to the research community
- **Encouraging** interdisciplinary working, eg collaboration with molecular scientists and biomedical engineers around diagnosis and monitoring, and with social scientists about more effective delivery of primary care
- **Ensuring** that funding streams cover opportunities at the interface of medicine, public health and social care (eg patient experience, infection-control in nursing homes)
- **Supporting** emerging research groups, new models and methodologies to increase diversity and strengthen the discipline

The report also argues that the NHS will benefit from closer alignment between policymakers, academics and clinicians in developing a wider culture of evidence use in healthcare. UK general practice research merits greater recognition as a first-class research discipline from Government and increased support from funders.

■ *See the report at* www.acmedsci.ac.uk/index.php?pid=101

Get involved with moves to improve teaching around health inequalities

Angela Jones MRCGP
Chair, RCGP Health Inequalities Standing Group

Members of the RCGP Health Inequalities Standing Group (HISG) were among those invited by Professor Ian Gilmore, President of the Royal College of Physicians, to a high-level policy dialogue to discuss the teaching of the medical profession around the issue of health inequalities.

The aim of the meeting was to look at making public health and epidemiology teaching to undergraduates more engaging, with more direct involvement with socially disadvantaged groups, as well as embedding public health and the social determinants of health within the postgraduate training and continuing professional development of all doctors.

Professor Jane Dacre, Vice Dean of UCL, contextualised the discussion in the context of the WHO report on *Social Determinants of Health*, the upcoming publication of the Marmot Review and the GMC's recommendations in *Tomorrow's Doctors 2009*. Her contributions were followed by talks from the perspective of medical students, general practice and public health.

Mustafa Abbas, Vice President of the medical student organisation Medsin-UK, gave an inspirational address outlining the potential for harnessing the innate interest of medical students in social justice and advocacy, illustrated by many of the initiatives undertaken by Medsin-UK.

Dr Fiona Head, recently appointed Consultant in Public Health in Bedford, spoke about her personal training journey, through MRCP, via MRCGP to a CCT in public health, describing the areas of learning involved at each stage and the importance of flexibility of training in allowing doctors from a range of disciplines to participate in and contribute to public health.

Dr Joseph O'Neill, GP and Honorary Lecturer at Liverpool University, presented the Cheshire and Merseyside Health Inequalities Programme for Students (CHIPS), a pioneering experiential undergraduate teaching programme, which he has been developing for a number of years.

The CHIPS programme offers four-week special study modules focussing on five key areas: urban deprived populations (incorporating substance misuse), homelessness and travellers, refugees and asylum seekers, offenders and global health.

Two weeks are spent 'immersed' in a local NGO serving one of these groups, followed by a two-week period during which the student familiarises him or herself with the literature and reflects on the causes of health inequality, their role as a future health professional in addressing these issues and the best ways to provide medical care to the study group, presenting this as a 3,000 word essay.

Dr O'Neill stressed that his programme is non-copyright and easily replicable in other universities.

Since 2008, HISG has earmarked *Health Inequalities in the Curriculum* as our annual theme for 2010. The timing has turned out to be excellent, coinciding with the imminent publication of the Marmot Review, due in February.

The HISG feels that primary care practitioners already play a key role in teaching medical students around the issues of health inequalities, through their provision of community attachments for undergraduates and their involvement in communications skills training. However, it is possible that this teaching would benefit from being formalised in some way, perhaps through the identification of the necessary competences required by health professionals to address health inequalities.

In addition, more integration of public health teaching within primary care, with a more experiential and practical approach would have the potential to bring public health alive and to excite students by its potential for making a real difference to people's lives We look forward to seeing the official report the policy dialogue at the RCP and hope to contribute to any recommendations which evolve.

HISG are undertaking a range of activities during the coming year to address the issue of training around health inequalities and we have seconded Dr O'Neill to the group for 2009 to lead in the area of undergraduate teaching.

HISG have also recruited an Associate in Training to join the group for a year to lead on embedding teaching around health inequalities in the postgraduate training of general practitioners.

Finally, HISG will be considering how the issue of tackling health inequalities can be covered within the continuing professional development of the primary care profession.

It is vital that the importance of addressing the social determinants of health and an understanding of how this can be done within our day to day work is part of every doctor's professional practice and CPD, if we are to make the UK a fairer and healthier place for all.

■ **Forthcoming event:**
Health Inequalities in the Undergraduate Curriculum
27 April 2010
www.rcgp.org.uk/PDF/Health_Inequalities_Conference_Liverpool_April_2010_v3.pdf

■ *Current GP teachers, AiTs and others who are interested in assisting HISG are encouraged to contact RCGP Senior Policy Officer, Jonathan Hamston:* jhamston@rcgp.org.uk

Revalidation: video podcasts for busy GPs

Professor Mike Pringle, RCGP Medical Director for Revalidation, has recorded a video podcast for the College website explaining recent changes and decisions on the Revalidation of GPs.

In the six-minute film, Professor Pringle provides an update on recent work with the BMA on remediation and future projects lined up with the BMA and the Department of Health. The film is part of an occasional RCGP series to keep GPs and stakeholders in the loop on developments in Revalidation. The series is introduced by RCGP Chairman, Professor Steve Field.

■ *The films can be viewed at* www.rcgp.org.uk/revalidation

Consultation on chronic heart failure

The National Institute of Clinical Excellence (NICE) is updating its clinical guideline on the management of chronic heart failure in adults and has published its draft recommendations for public consultation. Since the original guideline was published in 2003, new high-quality evidence from randomised controlled trials in diagnosis, treatment and monitoring have been published. The partial update will ensure that the recommendations take into account the new evidence available.
Deadline for submissions is 10 March 2010.

■ *Find out more at*
www.nice.org.uk/guidance/index.jsp?action=folder&o=46793


Professor Helen Smith


Professor Aziz Sheikh


Dr Anthony Harnden


Dr Matt Hoghton


Dr Jonathan Botting

New clinical priorities – and faces – at CIRC

Five new Clinical Champions have been appointed by the RCGP Clinical Innovation and Research Centre (CIRC).

The new Clinical Champions are:
Professor Helen Smith and **Professor Aziz Sheikh**, joint champions for Allergy
Dr Anthony Harnden for Child Health
Dr Matt Hoghton for Learning Disabilities
Dr Jonathan Botting for Minor Surgery

These appointments bring the number of clinical champions to 14, working across 12 clinical priority areas. The other areas and champions are:

End of Life Care: Professor Keri Thomas
Mental Health:
Professor Carolyn Chew-Graham
Prescribing: Dr David Milson
Urgent and Emergency Care:
Dr Agnelo Fernandes
Ageing and Older People's Health and Wellbeing: Professor Louise Robinson
Headache: Dr David Kernick
Musculoskeletal Medicine: Osteoarthritis – Dr Mark Porcheret
Musculoskeletal Medicine: Osteoporosis – Dr Graham Davenport
Respiratory Care – Dr Kevin Gruffydd-Jones

Professor Nigel Mathers, Chair of the Clinical Innovation and Research Centre, said: "I'm absolutely delighted with the College's choice of new clinical priorities. What particularly impresses me is not only the quality of our new clinical champions but also the opportunity it gives us for ensuring our clinical work remains at the heart of what we do."

■ *For more information on the Clinical Champions, Expert Resource database and other Clinical Innovation and Research Centre initiatives, please visit* www.rcgp.org.uk/circ *and follow the relevant links*

THE FIVE NEW CLINICAL CHAMPIONS

ALLERGY	**Professor Helen Smith** is an academic GP with 15 years experience in general practice and the foundation chair in Primary Care at Brighton & Sussex Medical School. She has clinical expertise in allergy and an interest in developing primary care allergy services to meet the needs of her patients. A salaried GP in a small practice in a deprived part of Brighton & Hove, she developed a Locally Enhanced Service for the PCT in 2005.
	Professor Aziz Sheikh is Professor of Primary Care Research & Development at the University of Edinburgh where he also chairs the Allergy & Respiratory Research Group. He is interested in epidemiology and the clinical management of asthma and allergic disorders; medical errors and exploring the interface between cultures (ethnicity and religion). He is Assistant Editor of *Primary Care Respiratory Journal*; Associate Editor of the *Journal of the Royal Society of Medicine* and a GP Editorial Adviser to the *British Medical Journal*.
CHILD HEALTH	**Dr Anthony Harnden** is a GP in Wheatley, Oxfordshire and a lecturer in General Practice at the University of Oxford. He worked to help the RCGP become a member of the consortium of Royal Colleges responsible for the Confidential Enquiry into Maternal and Child Health (CEMACH) which was awarded charitable status in 2009. He has been a member of the Joint Committee of Vaccination and Immunisation (JCVI) since 2006 and was a signatory to the 'Elliman' letter dismissing the link between the MMR vaccine and autism.
LEARNING DIFFICULTIES	**Dr Matt Hoghton** is a GP in Bristol and a GPwSI in Physical Health in Adults with Learning Disabilities. He has been involved in RCGP initiatives on learning disabilities for over ten years. He was a member of the Department of Health Taskforce for Learning Disabilities and also helped to develop Communication Passports for people with Learning Disabilities in the Avon area.
MINOR SURGERY	**Dr Jonathan Botting** practises in Barnes, South West London. He became interested in minor surgery while undertaking a clinical assistant post at the major burns and plastic surgery centre of Queen Mary's Hospital, Roehampton. He is passionate about training for GPs providing minor surgery services, as well as running courses in minor surgery through the London Deanery for the past eight years. He provides weekly minor surgery clinics for patients at his practice.

Fellowship Committee Observers required

Two positions are available on the Fellowship Committee for Observers. Observers have an important role in ensuring that protocols for Fellowship are being followed and that decisions are fair and just. Observers are entitled to contribute to discussion but not to vote (though decisions are usually made by consensus).

The Fellowship Committee is particularly keen that the interests of younger members and those from atypical or sessional career backgrounds are represented. Applications are therefore being sought from Members within the first five years following completion of training (in line with a new initiative to provide support to these members known as 'First5') and those with a sessional career background. The Fellowship Committee meets twice a year at Princes Gate. Travel, subsistence and locum expenses may be claimed.

Applicants must be Members of the College in good standing. If you would like more information on the role (including a closing date for applications), please visit www.rcgp.org.uk/news_and_events.aspx or contact Laura Summers on 020 7344 3061 or email fellowship@rcgp.org.uk

Queen's birthday honour is in order for Dr Harland

Dr Robin Harland from Queen's University, Belfast, collected an OBE from the Queen for Services to Sport and Exercise Medicine in Northern Ireland. Dr Harland, who also received the prestigious Rose Prize from the RCGP and the Worshipful Society of Apothecaries of London in 2005, said: "I am thrilled to have had my name put forward for this huge honour. This award is not just for me personally, it is recognition of the importance of Sport and Exercise Medicine (SEM) in modern times. It's not widely known that SEM has been a single NHS Specialty since February 2005."

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