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Management of bells palsy in primary care
Lisa Heath1, Hannah Fox2, Stuart Winter1, 1ABM trust, Swansea

002 - Audit
What guides our management of migraine in primary care?
Morag Brothwell1, Immaneni Sudha2, Michelle Gouldie1, Cranham Health Centre, Upminster, Essex

003 - Audit
Audit on letters from psychiatrists to general practitioners following assessment of patients in follow up clinics
Kiki Lam1, Jonathan Van Niekerk, 1Royal Bolton Hospital, Greater Manchester

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An audit of a psychiatric day hospital service for older people
Asiya Maula1, Sarah Justice1, Balamurugan Ganesan1, 1Queens Medical Centre, Nottingham

005 - Audit
The use of antipsychotic drugs for behavioural management in patients with dementia
Alison Eastaugh1, 1University of Birmingham, Birmingham

006 - Audit
Assessing suicidal risk in patients with depression or low mood in general practice
Michaela Janks1, Serena Deller1, 1University of Birmingham, Birmingham

007 - Audit
Evaluation of depression in patients of suburban and rural regions in Western Greece
Konstantina Sereti1, Dimitra Sereti2, Panagiota Zographou1, Maria Petta1, Theodosios Theodosiou1, 1Chalandritsas Health Center, Chalandritsa Achaias, Greece, 2Vardas Health Center, Varda Ilias, Greece

008 - Audit
Alcohol screening in patients with mental health problems
Charlotte Scott1, 1University of Manchester, Manchester

009 - Audit
Modified Paddington alcohol test (PAT) in emergency department (ED)
Suvro Mondal1, Shalini Maini1, 1Royal Berkshire NHS Foundation Trust, Reading, Berkshire

010 - Audit
An audit to identify those known patients using excessive alcohol and evaluate the effect that a GP intervention has on consumption.
Jamie Addlestone1, 1University of Manchester, Manchester

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Dimitra Sereti1, Konstantina Sereti2, Theodosios Theodosiou1, Maria Petta1, Panagiota Zographou1, 1Vardas Health Center, Varda Ilias, Greece, 2Chalandritsas Health Center, Chalandritsa Achaias, Greece

012 - Audit
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Theodosios Theodosiou1, Dimitra Sereti2, Konstantina Sereti1, Maria Petta1, Chalandritsas Health Center, Chalandritsa Achaias, Greece

013 - Audit
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Kerry Lloyd1, Sue McGorry1, Ewan Wilkinson1, Lynda Carey1, John Lucy1, Richard Jones1, Kelly Sophie1, Ruth Hunter1, Jacqui Waterhouse1, Peter John Lucy1, Trish Bennett1, Sandra Davies1, 1Liverpool University, Liverpool, 2Liverpool John Moores University, Liverpool

014 - Audit
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Christopher Mulholland1, Richard Wilson2, Kate Dixon1, 1University of Manchester, Manchester, 2Lorn Medical Centre, Oban

015 - Audit
An audit of the Care of Patients who had not achieved target for QOF domain AF3 – thromboprophylaxis
Benjamin Thurston1, 1Oxford University, Oxford

016 - Audit
An audit investigating whether chest pain referrals from primary care are appropriate according to NICE Guidelines
Holly Pearse1, 1University of Manchester, Manchester

017 - Audit
Depression screening in coronary heart disease (CHD)
Ichheim White1, 1Moordown Medical Practice, Bournemouth, 2University College London, London

018 - Audit
CHADS2 Scoring for GP’s - a cross-surgery audit analysis
Julia Humphreys1, Abbie Walsh2, Susan Harris1, 1Castleton Health Centre, Rochdale, 2North West Deanery, North West

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Are patients being prescribed statins appropriately in general practice?
Holly Pearse1, 1University of Manchester, Manchester

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The co-prescription of non-steroidal anti-inflammatory drugs and aspirin
Carter Singh1, 1The Royal College of General Practitioners, London

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Rabia Hassam1, 1Handsworth Medical Practice, Birmingham

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Melody Tsai1, Zhi En Ernie Tan1, 1University of Manchester, Manchester, 2University of Manchester, Manchester, England

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Moeen Ashraf1, 1Amble Health Centre, Amble, Northumberland

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Ahmed Ibne Saber1, 1Mersey Deanery, Liverpool

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Liam Piggott1, 1Royal Sussex County Hospital, Brighton
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Lucy Allender1, Hannah May2, Pip Fisher1, 1University of Leeds, Yorkshire, 2Whitehouse Centre, Huddersfield

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Oluwatosin Sotubo1, Krishnakant Buch1, 1Lower Broughton Health Centre, Manchester, 2The University Of Manchester, Manchester

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Sarah Mills1, 1University of Edinburgh, Edinburgh

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Johanna Curtis1, Mary O’Brien1, Nick Harvey3, 1Solent Healthcare, Southampton, 2Public Health, NHS Southampton, 3MRC Life Course Epidemiology Unit, University of Southampton

030 - Audit
Are we under-diagnosing vitamin D deficiency?
Deborah Patel1, Richard Darnton2, 1Kirkstall Lane Medical Centre, Leeds

031 - Audit
Characterising emergency admissions of patients with sickle cell crisis in NHS Brent: engaging GPs to improve the care of their patients
Stuart Green1, Carole Amobi2, Ogo Okoye2, Karen Phekoo1, 1Imperial College, London, 2NHS Brent, London

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Ogo Okoye2, Ghida Aljuburi1, Azeem Majeed2, Stuart Green2, AaSah Nkoko2, Comfort Ndive1, Patrick Ojee4, Ricky Banarsee1, Lola Oni1, Karen Phekoo1, 1NHS Brent, London, 2Imperial College, London, 3CLAHRC, London, 4Sickle Cell Society, London, 5NWL Hospitals, London

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Mohammed Choudhury9, Sarah Scrivener1, Nuala Whitehead1, 1Portsmouth Hospitals NHS Trust, Portsmouth

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Musarat Ali9, 1Church Walk Surgery, Nottingham

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Michael Barrett1, 1Manchester University, Manchester

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Emma Fardon1, 1Hawkhill Medical Centre, Dundee

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Lauren Sidon1, 1Manchester University, Manchester

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Fatima Ali1, David Roberts1, 1East and North Hertfordshire NHS Trust, Hertfordshire

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J James Stubbbs1, David Brogelli2, Jenny Allan3, Carolyn Pallister4, Stephen Whybrow1, Amanda Avery1, Jacqueline Lavin1, 1Slimming World, Alfredton, Derbyshire, 2University of Surrey, Guildford, Surrey

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Unal Clancy1, 1Springfield Surgery, Brackley, Northamptonshire

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Jamie Green1, 1Springfield Surgery, Brackley, Northamptonshire

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Claire Hallam1, Gill Mullins2, Jane Mawdsley3, John Broom4, Jackie Cox1, Bar Hewlett1, 1LighterLife UK Ltd, Harlow, 2Victoria Park Health Centre, Wirral

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Claire Hallam1, Gill Mullins2, Jane Mawdsley3, John Broom4, Jackie Cox1, Bar Hewlett1, 1LighterLife UK Ltd, Harlow, 2Victoria Park Health Centre, Wirral

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Anneke Alves1, 1University of Manchester, Manchester

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Ken Courtenay1, 1Barnet Enfield Haringey Mental Health NHS Trust, London

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Emma Brandon1, Johnny Lawrence1, Montasser Mahran1, Jane Preston1, 1James Paget University Hospital, Great Yarmouth

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Ronald Mak1, Bushera Choudry2, 1University of Manchester, Manchester, 2Walken Medical Centre, Bolton
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George Gavriel1, Claire Stewart1, Akin Osakua1, Sarah Egan1, Greg Simons1, 1Milton Keynes VTS, Oxford Deanery

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Greg Simons1, Claire Stewart1, Sarah Egan1, Akin Osakua1, 1Milton Keynes VTS, Oxford Deanery

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Rachel Handscombe1, 1Moss Valley Medical Practice, Sheffield

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Kristian Mears, Rhys Davies1, Jamie Martin1, Richard Deferrars2, 1Hartley Corner Surgery, Camberley, 2Frimley Green Medical Centre, Frimley

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Alexandra Watts1, Aarti Jivanji1, Nitesh Singh1, Karin Kadlecikova1, Sumit Gokani1, 1UHL, Leicestershire

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Lucy Loveday1, 1University of Bristol, Bristol

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Chris Smith1, 1Imperial College, London

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Soleman Begg1, Sandeep Geeranavar1, Madeleine Ginn1, Luisa Pettigrew1, Vikesh Sharma1, 1RCGP Junior International Committee, London

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Rachael Pagnamenta1, 1Severn Deanery, Bath, 2St. Mary's Surgery, Timsbury, Bath

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Lindsay Moran1, Diarma Treece1, Wan Ley Yeung1, 1Yorkshire and Humber Deanery, West Yorkshire

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Lindsay Moran1, Brian Nicholson1, Wan Ley Yeung1, 1Yorkshire and Humber Deanery, West Yorkshire

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James Tanner1, Ann Boyle1, Tim Millward1, Brandon Unit, Leicester, 2Bradgate Unit, Leicester, 3Evington Centre, Leicester

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Sandy Giles1, Samantha Scallan1, 1Hartley Corner Surgery, Camberley, 2Frimley Green Medical Centre, Frimley

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Lindsay Moran1, Wan Ley Yeung1, Joanna Reynolds1, 1Yorkshire and Humber Deanery, West Yorkshire

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Ann Smalldridge1, Duncan Cross1, 1REACHE North West, Salford Royal Foundation Trust, 2RLC Surgery, Radcliffe, Bury

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Lindsay Moran1, Hussain Gandhi2, Gary Howsam1, 1Yorkshire and Humber Deanery, West Yorkshire, 2East Anglia Deanery, Cambridgeshire

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Samantha Scallan1, 1Hartley Corner Surgery, Camberley, 2Frimley Green Medical Centre, Frimley

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Alethea Peters1, Susi Caesars1, Samantha Scallan1, 1Wessex School of General Practice, Winchester, Hampshire

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Tabitha Smith1, Mark Taylor1, Ian Wye2, 1GP Education Unit, Southampton University Hospital Trust

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Aurelia Butcher1, Peter Perkins1, Ian Wye1, Samantha Scallan1, 1Wessex Deanery, Wessex, 2Southbourne Surgery, Bournemouth
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Alison Callaway¹, ²The Meridian, Coventry

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Waqar Shah¹, Anita Lightstone¹, Phil Ambler⁴, ³Royal College of GPs, London/Nationwide, ²UK Vision Strategy, London/Nationwide

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Mandeep Singh Baveja¹, ³Shafsbury Medical Centre, Leeds

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Aws Alfahad¹, Paul Malcolm¹, ²Norwich Radiology Academy, Norwich, ³Norfolk and Norwich University Hospital, Norwich

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Yusrah Shweikh¹, Emma Donaldson¹, Peter Paine¹, Jeremy Tankel¹, ²Salford Royal NHS Foundation Trust, Manchester

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Yusrah Shweikh¹, Marie Clayton², Sheila McCorkindale³, ¹Salford Royal Foundation Trust, Manchester, ²NHS Salford, Manchester, ³Salford PCT, Manchester

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Joseph Adele¹, Sheena McHugh¹, Claire Buckley¹, Katie Murphy¹, Sue Doherty¹, Gabrielle O’Keeffe¹, Elizabeth Keane³, Mark James¹, Ciara Coughlan¹, John Traynor¹, Ivan Perry¹, Diarmuid Quinlan¹, ²Department of Epidemiology and Public Health, UCC, Cork, Ireland, ³Diabetes in General Practice (DiGP) Ltd, UCC, Cork, Ireland, ⁴Diabetes Services Implementation Group (DSIG) Cork & Kerry Retinopathy Subgroup, HSE, Cork, Ireland, ⁵Association of Optometrists Ireland, (AOI), Ireland

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Kristian Mears, Rhys Davies¹, Jamie Martin¹, Kate Grady¹, Richard Deferrars², ³Hartley Corner Surgery, Camberley, ⁴Frimley Green Medical Centre, Frimley

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Abdul Mohammed¹, Rebecca Pareker¹, Sylvia Miles¹, Saliman Hassoun¹, Iskander Idris¹, Devaka Fernando¹, ²Diabetes and Endocrinology Department, Sherwood Forest Hospitals NHS Hospitals, Sutton in Ashfield

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Anna Gerrard Hughes¹, Chris Cooper¹, ²University of Manchester, Manchester

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Kirsty Pope¹, Bonnie Miller¹, ²The University of Salford, Salford

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Ceri Lumb¹, ²St James's University Hospital, Leeds

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Gemma Armstrong¹, Jennifer Black², Pip Fisher², ³University of Manchester Undergraduate Medical Education, Manchester, ⁴Oswald Medical Practice, Chorlton-Cum-Hardy, Manchester, ⁵University of Manchester; Community Based Medical Education, Manchester

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Uzma Sarwar¹, Ruth Hutt¹, ²Public Health, Lewisham

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Jonathan Mills¹, Mark Hage¹, Marcus Bicknell¹, Kirran Bilkhu¹, ²University of Nottingham, Medical School, Nottingham, ³Beechdale Practice, Nottingham

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Judy Shakespeare¹, ²Summertown Group Practice, Oxford

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Elizabeth Smithson¹, Linda Parsons¹, Henry Smithson¹, ²Liverpool University, Liverpool, Merseyside, ³Luton and Dunstable Hospital Trust, Luton, Bedfordshire, ⁴Academic Unit of Primary Medical Care, Sheffield, South Yorkshire

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Simon Gowda¹, ²Ashfield Primary Care Centre, Sandbach, Cheshire

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Christine Slater¹, ²The Children’s Society, London

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Sarah Allum¹, ²J o Bucanan¹, Anne Baird¹, Janice Ellis¹, ³Porter Brook Medical Centre, Sheffield
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<td>Mick Serpell, Paul Schofield, Anna Taylor, Meena Jain, Napp Pharmaceuticals Limited, Cambridge, Gartnavel General Hospital, Glasgow</td>
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<td>Alexandra Rolfe, Christopher Burton, University of Edinburgh, Edinburgh</td>
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Nadiya Hassan1, Elizabeth England2, 1University of Birmingham, Birmingham

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Anaemia, cardiovascular disease and chronic kidney disease (CKD): a cross sectional study of the QICKD (Quality Improvement in CKD) trial data
Simon de Lusignan1, Olga Dmitrieva1, Hugh Gallagher1, Kevin Harris2, Charles Tomson1, David Goldsmith1, 1University of Surrey, Guildford, 2South West Thames Renal Unit, St Helier, 1University Hospitals of Leicester, Leicester, 1Southmead Hospital, Bristol, 1Guy’s and St Thomas’, London

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Trends in admissions for diabetes and diabetes-related lower extremity amputations in the Republic of Ireland over a five year study period
Diarmuid Quinnlan, Claire Buckley1, Anne O’Farrell1, Tony Lynch1, Davida De la Harpe2, Nurdiana Basharuddin1, Howard Johnson2, Ronan Cavanagh1, Ivan Perry1, Colin Bradley1, 1University College Cork, Ireland, 1Health Intelligence Unit, Dublin, Ireland, 1St Vincent’s Hospital, Dublin, Ireland

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How useful is a patient decision aid for patients with T2DM when making a decision about starting insulin. Patient opinions from the PANDAs (Patients And Decision Aids) study - a quantitative analysis
Brigitte Colwell1, Nigel Mathers1, Alastair Bradley1, Chirck-jenn Ng1, Ian Brown1, 1University of Sheffield, Sheffield, 2University of Malaya, Kuala Lumpur, Malaysia, 3Sheffield Hallam University, Sheffield

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Results from screening for pre-diabetes & diabetes among patients with hypertension from a primary-care outpatient clinic in Singapore.
Teck Yee Wong1, Kim Kiat Tan1, Wern Ee Tang1, Seng Kwong Cheong1, Fong Seng Lim1, 1Tan Tock Seng Hospital, Singapore, 2National Healthcare Group Polyclinics, Singapore, 3National University Health System, Singapore

148 - Research
Young women with diabetes on teratogenic drugs have suboptimal contraception: results from a UK multi-ethnic cohort
Shiraz Makda1, Emma Wiimoto1, Melanie Davies1, Kamlesh Khunti1, John Bankart1, Aresh Anvari1, 1Department of Cardiovascular Sciences, University of Leicester, Leicester, 2Department of Health Science, University of Leicester, Leicester, 3East Midlands Deanery, Leicester

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Which women are having a hysterectomy and why? A national observational cohort study
Helen Stokes-Lampard1, Zara Llewellyn1, Sue Wilson1, 1University of Birmingham, Birmingham

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A preliminary report on knowledge on breast cancer and screening practices for breast and cervical cancers, among female patients attending Family Practice clinics in Sri Lanka
R.E Ediriweera de Silva1, E.D.P.S Fernando1, L.D.S Liyanage1, E.W.Premaratne1, W.D.D de Silva1, K Maddumabandara1, 1University of Colombo, Colombo, Sri Lanka, 2University of Kelaniya, Ragama, Sri Lanka, 3District General Hospital, Nawalapitiya, Sri Lanka, 4Lady Ridgeway Hospital, Colombo, Sri Lanka, 5Colombo South Teaching Hospital, Kalubowila, Sri Lanka

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GP input following cancer diagnosis: lessons learned from the development of a structured cancer care review
Una Macleod1, Pat Quinn2, David Linden3, Susan Brown1, Elizabeth Mitchell2, 1Hull York Medical School, Hull, 2University of Glasgow, Glasgow, 3The Scottish Government, Edinburgh

152 - Research
Logical decision-making? Health care professionals’ perceptions of the use of unscheduled care by people with long term conditions: a qualitative study
Jessica Drinkwater1, Susanne Langer1, Cheryl Hunter1, Peter Salmon2, Elise Guthrie1, Carolyn Chew-Graham1, 1University of Manchester, Manchester, 2University of Liverpool, Liverpool, 3Manchester Mental Health and Social Care Trust, Manchester

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Benedict Hayhoe1, Amanda Howe1, 1University of East Anglia, Norwich

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A lone mother’s decision-making when her child is unwell during the out-of-hours period
Lizzy Bernthal1, 1Army, Southampton

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The hospital as a place of safety - the use of unscheduled care in patients with long-term conditions: a qualitative study
Carolyn Chew-Graham1, Cheryl Hunter1, Susanne Langer1, Jessica Drinkwater1, Elise Guthrie1, Peter Salmon2, 1University of Manchester, Manchester, 2University of Liverpool, Liverpool, 3Manchester Mental Health and Social Care Trust, Manchester

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Visible impact and experiences of health professional consultation: a qualitative study of people with psoriasis
Pauline A Nelson1, Lis Cordingley1, Christopher EM Griffiths1, Carolyn A Chew-Graham1, 1University of Manchester, Health Sciences Research Group, Manchester, 2University of Manchester, Manchester Academic Health Science Centre (MAHSC), Manchester, 3University of Manchester, Primary Care Research Group and National School of Primary Care Research (NSPCR), Manchester

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Joanna Clark1, Harry Smallwood1, Graham Fergusson1, Rebecca Mann2, 1Taunton Rd Medical Centre, Bridgwater, Somerset, 2Musgrove Park Hospital, Taunton, Somerset

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A pilot study investigating the prevalence of asthma symptoms and high blood pressure in primary school children attending selected schools in Wakiso district, Uganda
Farah Kidy1, Diana Rutebawika1, Moses Kizza2, Emily Webb2, Alison Elliott1, 1London School of Hygiene and Tropical Medicine, London, 2MRC/UVRI Uganda Research Unit on AIDS, Entebbe, Uganda
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Craig Leaper1, Lena Barrera1, Utz J. Pape1, Azeem Majeed1, Christopher Millet1, Imperial College London, London

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Lewis Beake1, Jackie Davidson1, Junaid Bajwa1, Simon Hussain1, Richard Sekula1, Chima Olughu2, MSD, Hoddesdon, 1NHS Greenwich, Greenwich

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Carolyn Deighan1, Wendy Armitage1, Louise Taylor1, Michelle Clark1, 1Heart Manual, NHS Lothian, Edinburgh

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Lucy Salmons1, Sally Kerry1, Barts and the London, School of Medicine and Dentistry, London

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Jacqueline Harris1, Derbarl Yerrigan Aboriginal Health Service, Western Australia, Australia

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Katy Gardner1, William Fraser1, Kate Mccadden1, Topping Joanne1, Qassim Taher1, Michelle Cox6, Lynne Garforth1, James Bunn1, Liverpool Community Health NHS Trust, 1Royal Liverpool and Broadgreen University Hospitals NHS Trust, 1Liverpool Primary Care Trust, 1Liverpool Women's NHS Foundation Trust, 1Liverpool Primary Care Trust, 1Liverpool Community Health NHS Trust,

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Colum Farrelly1, John Purvis1, Altnagelvin Area Hospital, Londonderry

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Aysia Maula1, Mohammed Faisal Malik1, Balamurugan Ganesan1, Queen's Medical Centre, Nottingham University Hospitals NHS Trust, 1Nottingham, Queen's Hospital, BHR NHS Trust, Romford

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Psychiatric co-morbidity in autistic spectrum disorder: a role for routine specialist referral
Mohammed Faisal Malik1, Aysia Maula1, Queen's Medical Centre, Nottingham University Hospitals NHS Trust, 1Nottingham, Queen's Hospital, BHR NHS Trust, Romford

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Multidisciplinary consensus for the future development of ADHD Services
Hani Ayyash1, Honor Merriman2, Sachin Sankar3, Carsten Vogt4, Prudence Allington-Smith1, Tina Earl1, Kiran Shah5, 1Doncaster Royal Infirmary, Doncaster, 1NHs Oxfordshire, Oxford, 1CAMHS, Northampton, 1CAMHS, Reading, 1Brooklands Hospital, Birmingham, 1Demford Hospital, Plymouth, 1Redbridge PCT, Ilford

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Vandita Chisholm1, Peggy Frost1, College of Occupational Therapists, London

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Sarah Mills1, University of Edinburgh, Edinburgh

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Farshad Shaddel1, Marjan Ghazirad1, Oxford University, School of Psychiatry, Oxford

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Louise Dubras1, Anya Farnbrough1, Pamela Campbell1, Ann Spooner1, Solent NHs Trust, Southampton

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Caroline Thurlow1, Wymondham Medical Practice, Wymondham, Norfolk

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Angela Kirby1, Yorkshire and Humber postgraduate Deanery, Sheffield

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Gagandeep Bola1, Rachael Fear1, Ewan Barron1, Natasha Lovell1, 1University of Leeds, Leeds

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Philippa Cockman1, Luise Dawson1, Rohini Mathur1, Sally Hull1, 1St. Stephen's Health Centre, Bow, London, 2Department of Public Health NHS Tower Hamlets, London, 3Queen Mary University of London, London

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Kieran Dinwoodie1, Graeme Bingham1, 1Calderside Medical Centre, Blantyre

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Sally Aston1, 1French Weir Health Centre, Taunton

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Sharing GP electronic health records with a UK nursing home
Benjamin Brown1, Amir Hannan1, Sarah Thew1, Iain Buchan1, 1The University of Manchester, Manchester, 2Haughton Thornley Medical Centres, Manchester

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Peter Toon1, 1Barts and the London Medical School, London

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Geoff Riley1, 1The University of Western Australia, Australia

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Jeff Dienhart1, Jessica Daniels1, Miriam Kingsley1, 1Map of Medicine, London

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Pauline Cooper1, 1Oxleas NHS Foundation Trust, Dartford Kent, 2University of Sussex, East Sussex, 3King's College London, London, 4British College of Occupational Therapists, London

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Juanita Convill1, 1Cardiff University, Cardiff

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Joanne Simpson1, Gukaran Singh Samra1, Thomas Warburton1, 1Blackpool Teaching Hospital, Lancashire

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Carter Singh1, 1Royal College of General Practitioners, London

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Alice Lee1, 1University of Manchester, Manchester

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Donna Evans1, Tina Atkins1, Dawn Brayford1, 1Brownlow Medical, Liverpool

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Outreach: primary care and public health in partnership
Richard Jenkins1, Permjeet Dhoot1, 1OneMedicare Ltd, Yorkshire, 2NHS Sheffield, Yorkshire

228 – Practice
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Mohammed Amin1, Imad Ahmed1, Naeem Ahmed1, Faheem Ahmed1, Shafiuul Amin1, Anne Stephenson1, 1King's College London, London

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Santosh Ghokikar1, Florence Mukuna1, 1City Health Centre, Manchester, 2University of Manchester

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James Kerrigan1, Seema Bhatt1, Timothy Evans1, Sonia Taneja1, Sara Kahrobaei1, Suneetha Siripurapu1, Jason Fitchett1, 1Swansea Bay GP Training Scheme, Swansea

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What patients want: a patient questionnaire on general practice opening times
Matthew Tabinor1, 1The University of Nottingham, Nottingham

232 – Practice
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Aruna Sanikop1, Peter Thomas1, 1Aneurin Bevan HealthBoard, Newport, 2Cardiff University, Cardiff
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<td>Ryan Ewbank², Simon Horne¹, ¹British Army, ²NHS Forth Valley, Stirlingshire</td>
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<td>Agnelo Fernandes³, ¹LMC in Croydon, Croydon, ²NHS Direct, ³NHS Pathways, ⁴Intercollegiate Clinical Governance Board for NHS Pathways, ⁵Croydon Federation of General Practices, ⁶Chair of the Croydon Healthcare Consortium, ⁷DH Urgent and Emergency Care Governance Board, ⁸DH Programme Board for NHS 111, ⁹Emergencies Services Committee, ¹⁰Royal College of Paediatricians</td>
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<td>Anne Talbot¹, ¹NHS Bolton, Bolton, Greater Manchester</td>
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<td>Shueh Hao Lim¹, Satvinder Chauhan¹, Paul Fisher¹, ¹University of Aberdeen, Aberdeen</td>
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001 - Audit
Management of bells palsy in primary care
Lisa Heath¹, Hannah Fox¹, Stuart Winter¹, ¹ABM trust, II

Introduction: Guidelines issued to referring GPs from the local ENT department suggest Bells Palsy should be managed with Aciclovir 400mg x5/day for 7 days within 3 days of onset and Prednisolone 1mg/kg, (Maximum 60mg/day) for 7 days within 3 weeks of onset. Ocular protection is recommended for those unable to close their eye unaided. This audit analysed whether patients referred to ENT casualty clinic were managed in accordance with these guidelines or whether the ENT department changed the GPs management.

Method: Of 27 cases of Bells Palsy referred to ENT during a 6 month period, 18 sets of data were available for analysis. Treatment commenced in Primary care and any changes to management made by the ENT department were recorded.

Results: (Within Primary care:)

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<td>Was aciclovir started if seen within 3 days</td>
<td>79%</td>
<td>21%</td>
<td>0%</td>
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<tr>
<td>Was Aciclovir started if seen after 3 days</td>
<td>75%</td>
<td>25%</td>
<td>0%</td>
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<tr>
<td>Was 400mg x 5/day of Aciclovir started</td>
<td>57%</td>
<td>29%</td>
<td>14%</td>
</tr>
<tr>
<td>Was Prednisolone started if seen within 3 weeks</td>
<td>83%</td>
<td>17%</td>
<td>0%</td>
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<tr>
<td>Was 1mg/Kg Prednisolone started</td>
<td>73%</td>
<td>7%</td>
<td>20%</td>
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Eye care given:

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Discussion: In 50% of cases the ENT department amended the management, mostly in the form of eye care. Having written to GPs in the local area with the results, offering advice regarding dosing and timing of starting anti-virals and emphasising eye care, we plan to re-audit in 6 months time.

002 - Audit
What guides our management of migraine in primary care?
Morag Brothwell¹, Immaneni Sudha¹, Michelle Gouldie¹, ¹Cranham Health Centre, Upminster, Essex

Introduction: Headaches represent a significant economic, social and personal burden in the UK. They are the subject of at least 4% consultations in primary care, and constitute a significant proportion of referrals to secondary care. 7.6% of males and 18.3% of females in the UK are affected by migraine. In spite of this, studies suggest that migraine remains underdiagnosed and undertreated. There are a number of guidelines about the management of migraines, the most recent being the British Association of the Study of Headache (BASH) guidelines (2010). There are currently no NICE guidelines, which are expected in 2012.

Aim and method: The aim of this audit was to assess resources used in primary care to guide management of migraine, focusing on the BASH guidelines. 41 general practitioners at a meeting in February 2011 in the Havering PCT, Essex, completed a questionnaire.

Results: Few clinicians used any of the three featured guidelines (MIPCA, SIGN and BASH) and over half of clinicians were not familiar with the BASH guidelines. Consequently, awareness of the most recent advice regarding acute management and prophylaxis according to the BASH guidelines was limited.

Discussion: This audit does not reflect quality of practice, but it is probable that further training and active promotion of guidelines would lead to better, more cost-effective management. The known risks of aspirin may have dissuaded clinicians from using the higher, recommended doses. GPSI headache walk-in clinics and a study of the effect of guideline use on referrals to secondary care are recommended.

003 - Audit
Audit on letters from psychiatrists to general practitioners following assessment of patients in follow up clinics
Kiki Lam¹, Jonathan Van Niekerk, ¹Royal Bolton Hospital, Greater Manchester

Background: General Practitioners and psychiatrists mainly communicate via letters. The quality of care of patients with mental health illnesses is determined by the effectiveness of this communication. Previous literature has identified key elements that should be included in follow up letters.

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Audit Poster Presentations

004 - Audit
An audit of a psychiatric day hospital service for older people
Asiya Maula1, Sarah Justice1, Balamurugan Ganesan1, 1Queens Medical Centre, Nottingham

Aim: To review the functioning of the Parkside day hospital in relation to 'good practice' standards, recommended by the Royal College of Psychiatrists.

Methods: Assessment of domain 1 (Standards Relating to Day Hospital Organisation) and 2 (Standards Relating to Clinical Functions) were carried out. Domain 1 compliance was assessed through a verbal discussion and analysis of the service with the day hospital manager. For domain 2, 29 notes were randomly selected and manually analysed using a proforma undertaken by a single person.

Results: (n) = 29, 38% male, mean age 79.6 years. The commonest diagnosis of patients attending the day hospital was Alzheimer's dementia (24%), anxiety & depression (13.8%) and vascular dementia (13.8%). 38% of patients had attended the day hospital for up to six months, which meant the majority of patients had been attending the hospital for more than 6 months, with 21% attending for more than 4 years. The commonest use of the day hospital was day-care (48%) with the next most common use the 6 week assessment with 13.8% of patients.

Discussion: Good documentation was one of the main failings reported, as well as inappropriate use of the facility as a day-care provider as opposed to an acute assessment unit.

Awareness for community based treatments amongst GPs should be increased about the services available for patients and their carers coping with long term psychiatric conditions such as dementia and depression such as multidisciplinary team assessments and information workshops held at day centres.

005 - Audit
The use of antipsychotic drugs for behavioural management in patients with dementia
Alison Eastaugh1, 1University Hospital Birmingham, Birmingham

Dementia is common in the elderly. An estimated 25 million people suffer worldwide. A large proportion of these develop behavioural and psychosocial symptoms.

Following the report by the All-Party Parliamentary Group on Dementia entitled ‘Always a last resort’ the use of antipsychotics for behavioural management has become more pertinent. It concluded that they cause an estimated 1800 deaths per year and increase the risk of stroke 3 fold.

A retrospective audit was undertaken to identify current practice at Wake Green GP Surgery versus NICE guidelines.

It identified 38 patients on the Dementia Register of which 26% of the patients with dementia were also prescribed antipsychotics.

Unsurprisingly 70% lived in residential or nursing homes with the majority started and followed up by the psychiatrist. 30% were started by the GP and had no follow up. In all cases there was no evidence that any non-pharmacological management had been used prior to starting treatment. Only 50% had clear evidence of a full assessment being carried out prior to starting treatment.

50% were on treatment with antipsychotics for 1-3 years and only 20% had ever had a trial off antipsychotics.

The recommendation from this study is to use a template when starting an antipsychotic in a patient with dementia. This should incorporate an automatic follow-up reminder that prompts the prescriber to think these drugs should be used only as last resort.

006 - Audit
Assessing suicidal risk in patients with depression or low mood in general practice
Michaela Janks1, Serena Deller1, 1University of Birmingham, Birmingham

Over 80% of patients with depression are managed in the primary care setting and suicide rates amongst the depressed are much higher than in the general population.[1] It has recently been highlighted that many people who attempt or commit suicide, have often consulted their GP leading up to this.[2] NICE guidance on depression states that doctors must ‘Always ask people with depression directly about suicidal ideation and intent’[3] It then advises on
the management of suicidal risk to include appropriate referral, increasing support and advising about side effects of antidepressants which might confer an increased risk of suicide[4][5]. This Audit aims to evaluate whether GP’s are adequately assessing risk of suicide in patients with depression and to inform on how to improve practice. A random sample of 70 patients with diagnoses of depression or low mood will be selected from an inner city General Practice. Looking at the EMIS notes of the first assessment when presenting with depression, the areas of NICE guidance mentioned above will be audited. According to guidance, suicidal risk should always be assessed and is extremely important in the safety of these patients. It is also vital that the GP carefully documents the consultation.

3. 1.1.4.6NICE-Guidance-on-depression-CG90-October2009
4. 1.3.2.1NICE-Guidance-on-depression-CG90-October2009
5. 1.3.2.2NICE-Guidance-on-depression-CG90-October2009

007 - Audit
Evaluation of depression in patients of suburban and rural regions in Western Greece
Konstantina Sereti1, Dimitra Sereti1, Panagiota Zographou1, Maria Petta1, Theodosios Theodosiou1, 1Chalandritsas Health Center, Chalandritsa Achaias, Greece, 2Vardas Health Center, Varda Ilias, Greece

Aim: To estimate the existence of subjacent diseases in patients suffering from depression.

Method: The survey included a total of 1167 adults patients who visited two Health Centers in a suburban and a rural region in Western Greece during the years 2007-2009. The presence of other diseases was recorded down.

Results: 57% of depressed patients suffered from diabetes, also. 25% from strokes, 43% from cardiovascular diseases, 37% from chronic obstructive pulmonary disease. 28% appeared without disease. From those who didn’t suffer from other disease, 92% was under 50 years old. 85% of depressed patients with subjacent diseases were over 50 years old.

Conclusion: It is expected patients with chronic diseases suffer from depression, too. In this survey, it was noticed down that there is a significant percentage among depressed patients without subjacent diseases and in early ages. Social, economic factors and the modern way of life should be examined as probable causes for the increase of depression in these cases.

008 - Audit
Alcohol screening in patients with mental health problems
Charlotte Scott1, 1University of Manchester, Manchester

Background: Chronic health problems from alcohol use disorder cost the NHS £2.7 billion a year which has lead to the introduction of government policies within primary care to prevent and reduce alcohol use disorder. NICE guidelines recommend that those who are high risk such as patients with mental health problems should be screened for alcohol use.

Aims: To determine whether GP’s are reaching the gold standard of screening patients with mental health problems for alcohol use.

Method: Consultations of patients with a new diagnosis or relapse within the previous 6 weeks of mood affective disorder, anxiety state, low mood or neurotic disorder were reviewed. Information on their age, gender, diagnosis and who diagnosed them was recorded. Whether an alcohol history was taken, any screening method or alcohol advice given was noted.

Results: 35 patients were reviewed with only 5 of them having documentation of an alcohol history. There was no documentation of the use of alcohol screening questionnaire’s or alcohol advice given in any consultation.

Discussion: Documentation of alcohol screening is not reaching gold standards.

Conclusion: Evidence suggests that the Alcohol use disorder identification test (AUDIT) questionnaire is the most specific and sensitive questionnaire in identifying alcohol use disorder and NICE recommends its use. An action plan has been suggested involving the use of AUDIT-PC in high risk patients during consultations, AUDIT at new patient registration and to carry out a similar audit for other high risk patient groups.

009 - Audit
Modified Paddington alcohol test (PAT) in emergency department (ED)
Suvro Mondal1, Shalini Maini1, 1Royal Berkshire NHS Foundation Trust, Reading, Berkshire

The PAT is an evolving screening tool for identifying hazardous and harmful drinkers in ED. It introduction has undergone a number of improvements since its development in 1996 (London).

Methods: 44 random patients were screened by using PAT tool over 2 months period in ED. It was derived from the revised PAT screening tool 2009. Patients were screened on basis of top 10 conditions associated with alcohol related ED attendances. A leaflet with helpful contact details has been given to all PAT positive patients.

Results: Mean age of 52.1 years, 61% male and 39% were female patients. 73% patients accepted to be drinking alcohol. 50% were safe drinker, 22% were dependent and 28% were hazardous drinker. 31% patients felt that their attendance was related to alcohol.
39% were PAT positive. 48% of male compared to 24% of female patients were PAT positive.

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<th>Percentage</th>
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<td>Fall</td>
<td>18</td>
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<tr>
<td>Collapse</td>
<td>16</td>
<td>29</td>
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<tr>
<td>Head Injury</td>
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<td>67</td>
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<tr>
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<tr>
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<td>67</td>
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<td>Other</td>
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Discussion: The study has highlighted that PAT positive results were related to top 10 presentations. PAT positivity was found to be doubled in male patients compared to females.

PAT screening and two minute brief advice by ED staff could have a positive impact on drinking behaviours. We could compare the statistics of alcohol related admissions and repeat attendances as a separate column while re-auditing.

010 - Audit
An audit to identify those known patients using excessive alcohol and evaluate the effect that a GP intervention has on consumption.
Jamie Addlestone\(^1\), \(^{1}\)University of Manchester, Manchester

Background: Alcohol misuse leads to physical, mental and social harm, costing the NHS £2.7 billion a year. 28% of adult men and 21% of adult women drink over the recommended limit. This study aims to determine whether identified problem drinkers were intervened, the effect on alcohol consumption, and whether success of intervention correlates with lower Alcohol-Use Disorder Identification Test (AUDIT) scores.

Methods: A computerised search identified documented problem drinkers between 31st March ‘09 until the 1st April ‘10. AUDIT score, number of units drank per week, and whether advice or a referral was documented were recorded.

Results: 65 patients fulfilled the criteria for audit (n=65). 66% of patients presenting over the limit were intervened. 82% of patients reported a reduction in alcohol consumption at follow-up. A 2-way chi squared analysis between intervention and reduction rendered a p value of 0.00075 and an NNT of 3. The relationship between AUDIT scores before intervention and reduction at follow-up rendered a p value of 0.276.

Conclusions: Based on these results, a GP intervention was statistically significant in reducing alcohol consumption and there was no relationship between high AUDIT scores and a lesser chance of reduction, indicating benefits in providing interventions even to dependent drinkers. Training in motivational interviewing could standardise and improve intervention effectiveness.

011 - Audit
Management of anaphylactic reactions in primary care
Dimitra Sereti\(^1\), Konstantina Sereti\(^2\), Theodosios Theodosiou\(^2\), Maria Petta\(^2\), Panagiota Zographou\(^1\), \(^1\)Vardas Health Center, Varda Ilias, Greece, \(^2\)Chalandritsas Health Center, Chalandritsa Achaias, Greece

Aim: To estimate the management of anaphylactic reactions in primary care

Method: Retrospective recording of 472 patients with anaphylactic reactions, (from mild to life-threatening), which appeared for five contiguous years, mostly between May - September in the Emergency Department of two Health Centers. They were an average of 40 years old.

Results: Mucocutaneous symptoms were appeared in a percentage of 97%, respiratory symptoms in a 35%, gastrointestinal in a 22%, cardiovascular symptoms in a percentage of 11%. The causes were drugs, insect bites, food or unknown. Epinephrine, corticosteroids, H1 and H2 histamine receptor antagonists, bronchodilators were used for treatment according to the judge of general practitioner and the severity of the case. Transport to hospital was needed in a 5%. Intramuscular epinephrine was used in cases with shock (2%). Histamine-1 (H1) blockers were used in 93%, histamine-2 blockers in 9%, corticosteroids in 75%, inhaled beta-2-agonists in 14%. Training for epinephrine self-injection took place at 0%. The epinephrine demanding cases were referred to allergist for long term monitoring and education.

Conclusion: Doctors in primary care seem to avoid epinephrine in all cases of anaphylaxis, using it only in shock cases. Also, they should be able to educate and train the patients treat themselves, especially in life-threatening cases, by avoiding the allergen and use the self-injectable epinephrine.
Audit Poster Presentations

012 - Audit

The detection of abdominal aortic aneurysm in population with cardiovascular risk profile or morbidity in primary care in a rural area in Western Greece

Theodosios Theodosiou1, Dimitra Sereti2, Konstantina Sereti1, Maria Petta1, 1Chalandritisas Health Center, Chalandritsa Achaia, Greece; 2Vardas Health Center, Vardas Illias, Greece

Aim: To correlate the cardiovascular morbidity and the related risk factors with the abdominal aortic aneurysm existence among male population over 65 years old.

Method: 92 male patients (mean age: 73 years old) with at least one risk factor were checked for AAA by ultrasound scan.

Results: 34,8% of the patients appeared with hyperlipidemia, 42,4% were smokers (active or no), 45,6% were suffered from hypertension, 18,4% with coronary artery disease, 22,8% with diabetes type II and 4% were suffered from peripheral artery disease.

7 (7,6%) patients were detected having AAA ≥3 cm in diameter. The 6 (85,7%) of them appeared with ≥3 risk factors at the same time (mainly smoking and hyperlipidemia).

From the rest 85 patients, 77 (90,6%) had <3 risk factors and 8 (9,4%) had >3 risk factors.

Conclusion: The male sex, age > 65 and the presence >3 risk factors are probably correlated with increased percentage of AAA. These specific characteristics could be taken into account and lead to targeted control in population, in order to decrease the AAA related mortality.

013 - Audit

Cardio-vascular disease in Liverpool - modelling techniques to reduce variation in care

Kerry Lloyd1, Sue McGorry1, Ewan Wilkinson1, Lynda Carey2, J. John Lucy1, Richard Jones3, Kelly Sophie3, Ruth Hunter4, Jacqui Waterhouse1, Peter Johnstone1, Trish Bennett1, Sandra Davies1, 1Liverpool University, Liverpool, 2Liverpool John Moores University, Liverpool

Background: Cardio-Vascular Disease (CVD) is the biggest cause of preventable, premature death in Liverpool. Monitoring of trends in premature mortality from CVD had previously shown steady decline. However, most recent trends appeared to be showing signs of levelling off in the rate of decline, prompting the need to review outcomes in relation to all CVD related work programmes.

Introduction: Risk reduction in CVD offers benefits in reducing morbidity and mortality. As a result of local trends in mortality, Liverpool Primary Care Trust developed a work plan in relation to all aspects of CVD management. The work plan aimed to offer a strategic overview of all CVD services, their current impact and potential future impact on local trends in CVD mortality and morbidity.

Methods: A variety of methods were employed to model the current and future impact on mortality and morbidity of local performance measures. This included the use of population based software tools to assess the impact of the local NHS Health Check Programme and Locally Enhanced Service. Other techniques included the application of national guidance to local data, performance in areas such as management of Stroke and Heart Failure.

Results: The work demonstrated the programmes of work which would achieve maximal effect at population level, with much of the focus being in those areas relating to primary care.

Conclusion: When cost-effectiveness and efficiency is paramount, this work highlighted, in tangible terms, the local impact of the application of best practice guidance. The work also assisted in strategic planning, as to where investment and resources would be best placed to achieve maximum health gains for the local population.

014 - Audit

An audit to see if patients at Lorn Medical Centre, receiving Clopidogrel have been appropriately prescribed the treatment in accordance to the current 2008 NHS Greater Glasgow and Clyde NHS Antiplaletate guideline for secondary - prevention of CHD and Stroke

Christopher Mulholland1, Richard Wilson1, Kate Dixon1, 1Raigmore Hospital, Inverness, 2Lorn Medical Centre, Oban

Continuity of care between secondary and primary centres can be challenging and can have an effect on polypharmacy in the community, which can be costly for practices. Clopidogrel is being increasingly used in secondary care as per the 2008 NHS Antiplaletate guideline for secondary prevention of CHD.

A database of patients on Clopidogrel was created on Microsoft Excel. Each patient was reviewed to identify the indication for Clopidogrel and adherence to guidelines. Interventions prior to Cycle 2 included discussion with senior partners and distribution of guidelines. Patients identified as no longer requiring Clopidogrel were informed. Six weeks later the audit was repeated the presence of stop dates were documented.

A total of 43 patients were included in Cycle 1. 67% (29 patients) were appropriately prescribed Clopidogrel. 33% (14 patients) were out with the guidelines, due to clinical judgement. 7 were considered appropriate for Clopidogrel therapy.

16% (7 patients) were informed to discontinue Clopidogrel therapy. In cycle 2, 36 patients were on Clopidogrel. 7 of these were out with the guideline. 39% (14 patients) had stop dates documented. 80% (29 patients) were appropriately prescribed Clopidogrel according to the guideline in cycle 2.

We observed an initial poor adherence to guidelines. Our audit showed an improvement in adherence to guidelines within six weeks. The next step would be to ensure clinicians should receive a copy of the current guidelines, keep the database updated and when prescribing Clopidogrel an indication and stop date should be documented.
**015 - Audit**

An audit of the Care of Patients who had not achieved target for QOF domain AF3 - thromboprophylaxis

Benjamin Thurston1, 1Oxford University, Oxford

Stroke is a major cause of mortality and morbidity. Atrial fibrillation (AF) is a significant risk factor for stroke, but appropriate thromboprophylaxis can dramatically reduce that risk. Improvement of AF care is currently an NHS National Priority Project. We undertook an audit of the AF patients in one teaching practice to establish if patients not meeting QOF-target AF3-thromboprophylaxis had significant unmet clinical need.

From 305 patients on the AF register, a list of those not achieving AF3 was generated. Their records were reviewed. Patients possibly receiving suboptimal thromboprophylaxis were contacted and medication changes were made where appropriate. After 3 months, records of non AF3 achieving patients were reassessed.

The results indicate that sub-optimal care was rare. There were coding issues, particularly of cardioverted patients keeping active AF Read codes. Clinicians were reluctant to implement anticoagulation years after an AF diagnosis if patients were asymptomatic and in sinus rhythm whenever seen. Yet guidance suggests these patients should receive thromboprophylaxis. Clinicians were averse to using QOF-exclusion codes and tended to free-text clinical justifications.

This audit was reassuring; there was little unmet clinical need in AF3 not-to-target patients. Clinical focus should remain upon the rigorous application of CHADS2 in all cases of AF. Better use of QOF-exclusion codes should be encouraged.

There is need for consensus regarding best practice in patients whose historical AF seems clinically to have resolved.

**016 - Audit**

An audit investigating whether chest pain referrals from primary care are appropriate according to NICE Guidelines

Tina M Tian1, Andy Carson-Stevens1, Adesh Ramsewak1, Nick Ossei-Gerning1, 1University Hospital Wales, Cardiff

Background: Chest pain is a common presentation for General Practice consultations. NICE guidelines on stable chest pain published in 2010 indicate: those with non-cardiac pain and calculated coronary artery disease (CAD) risk of <10% do not need further investigation; those with risk >90% should be treated for angina without further diagnostic tests. We sought to determine whether patients were appropriately referred from primary care for investigation.

Methods: All cardiologists at University Hospital of Wales (tertiary referral centre) were invited to complete forms for patients referred from GP for stable chest pain; the first 100 forms were analysed. Patient symptoms were coded using the Diamond Forrester symptom criteria; heart disease risk factors were noted and percentage risk of CAD was calculated according to NICE guidelines, and the investigation arranged was also recorded.

Results: 100 forms were analysed. Patients consisted of 49% men and 51% women aged between 24 and 91 years (median, 61 years). 39% of referrals from GPs to the chest pain clinic were inappropriate against the NICE guidelines: (1) 17 patients presented with non-anginal chest pain with 6 patients undergoing non-invasive testing. (2) 7 patients had a calculated CAD risk of <10%, 5 underwent Exercise Tolerance Test (ETT). (3) 15 patients with CAD risk >90% had unnecessary non-invasive investigations.

Discussion & conclusion: This audit identifies inappropriate referrals from general practice. We will propose a chest pain proforma, based on NICE guidelines to be completed by referring general practitioners and a re-audit will be completed in one year.

**017 - Audit**

Depression screening in coronary heart disease (CHD)

Ichechim White1, 1Moordown Medical Practice, Bournemouth, 2University College London, London

Introduction: NICE recommends case finding for patients at risk of depression. Depression is both common and disabling, contributing to 12 percent of the total burden of non-fatal global disease. In particular, 15-25% of people with chronic physical health problems, such as CHD, meet diagnostic criteria for depression.

Aim: To identify whether patients with CHD have a depression screening questionnaire documented every 15 months.

Methods: A sample group of all patients with CHD was identified (267 in total). Two clinical reports were created identifying screened and unscreened populations. Incorrect codes and patients receiving palliative care were identified. The number of patients screened was then compared to a standard of 40-90%.

Results: 80 percent of patients in the CHD cohort had received screening. Of the 20 percent of patients unscreened, two were incorrectly coded as having CHD and one patient was receiving palliative care. 54 patients were not screened.

Discussion: In accordance with NICE the majority of patients with CHD were being correctly screened for depression. However, in light of the significant burden of depression in this cohort, a standard of 100 percent screening should be considered achievable.

Further recommendations from this audit included the creation of a documented pathway for the continuing care of patients post detection of depression. Furthermore, all staff were educated about the significance of depression in those with CHD. A reminder system to prompt doctors at the practice was also suggested.

**018 - Audit**

CHADS2 Scoring for GPs - a cross-surgery audit analysis

Julia Humphreys1, Abbie Walsh2, Susan Harris2, 1Castleton Health Centre, Rochdale, 2North West Deanery, North West

The CHADS2 score was designed to provide a simple approach to assessing stroke risk in primary care. The score was validated by a study on people 65–95 years of age with non-rheumatic AF who were not prescribed warfarin [Gage et al,
The CHADS2 criteria have been assessed against risk factors refined to form the NICE criteria, and both were found to be similar for predicting event rates in a cohort prospectively followed up for stroke and vascular events [Lip et al, 2006]. This audit poster presentation was completed by three GP ST3 trainees working within the Greater Manchester region. The study was completed across 3 different practices, with a wide range of patient demographics. Results analysis examined whether patients with a diagnosis of atrial fibrillation were appropriately anti-coagulated, according to their assessment using the CHADS2 scoring system. The overall management of each patient was therefore analysed according to NICE Guidelines.

**019 - Audit**

**Are patients being prescribed statins appropriately in general practice?**

Holly Pearse1, 1University of Manchester, Manchester

**Introduction:** Statins are one of the most commonly prescribed drugs, it is therefore important that statin prescribing is carried out in a cost effective manner, as recommended by NICE.

**Methods:** The notes of 742 patients currently on a statin at one practice were assessed. The proportion of patients on a low cost statin, defined as simvastatin or pravastin, was calculated. The notes of a sample of 100 patients on a higher cost were analysed to calculate the proportion that had a clinical indication for this, and to find by whom this statin was first prescribed.

**Results:** Out of 742 patients on a statin, 68% were on a low cost type. Out of 100 patients on a higher cost statin, 48% had first been prescribed by the practice, 25% by a hospital and the remainder had joined the practice already on them. Out of those patients that were prescribed a higher cost statin from the practice, 67% did not have a documented clinical reason. However, none of these was first prescribed in the last three years.

**Discussion:** If those patients unnecessarily on a higher cost statin were switched to a low cost statin, an estimated saving would be made of £3,686 per month. The literature was reviewed which suggests that all statins are effective with comparable adverse effects. Additionally, patient interviews indicated that the majority of patients would not mind switching statin. It was therefore proposed that patients already on higher cost statins should be changed to simvastatin.

**020 - Audit**

**The co-prescription of non-steroidal anti-inflammatory drugs and aspirin**

Carter Singh1, 1The Royal College of General Practitioners, London

**Introduction:** The co-prescription of non-steroidal anti-inflammatory drugs (NSAIDS) and Aspirin can increase the risks of various side effects including gastrointestinal haemorrhage. In view of the regular widespread use of the abovementioned drugs in the general practice setting, the potential accumulative dangers are significant.

**Aims:** To audit the use of the commonest NSAIDS and Aspirin in a given practice population and to risk-stratify and minimise risk to patients.

**Methods:** Search the practice database and analyse the results using manual statistical methods. To identify individual patients and perform a pharmacist-lead medication review and by doing so - improve patient care.

**Results:** A significant minority of patients were on repeat prescriptions of NSAIDS and Aspirin.

**Discussion:** This audit revealed a significant minority of patients were on repeat prescription of NSAIDS and Aspirin and through a concerted medication review tailored for individual patients, the potential risks of co-prescription were reduced. The audit loop was closed successfully and thus patient care and safety were improved.

**021 - Audit**

**Aspirin use in primary prevention: a general practice in Handsworth, Birmingham**

Rabia Hassam1, 1Handsworth Medical Practice, Birmingham

**Introduction:** Recent evidence suggests that aspirin should not be used in the primary prevention of cardiovascular disease as there is no evidence of a clear mortality benefit, even in people with risk factors such as raised blood pressure or diabetes mellitus. There are however serious risks such as an association with serious bleeds. Aspirin is not licensed for primary prevention in the United Kingdom. The aim of this audit was to see if we were following this guidance. Ideally, no patients should be on aspirin for primary prevention only unless there is a strong patient preference and risks and benefits have been weighed up by the patient and doctor.

**Method:** All patients on a repeat prescription of aspirin and not on a TIA or IHD disease register were identified. I reviewed the records of these patients (n=153).

**Results:** 142 patient were on aspirin for primary prevention only. However, 11 patients were on it for an appropriate reason e.g angina, peripheral ischaemia, renovascular disease. Therefore, the majority of patients were inappropriately on aspirin for primary prevention.

**Discussion:** We are not following local guidelines regarding aspirin in primary prevention of cardiovascular disease. Patients who were inappropriately on aspirin had it stopped, either with discussion with the doctor or with the option to do so when collecting a repeat prescription. New diabetics should not automatically be started on aspirin and inappropriate aspirin use should be stopped in an opportunistic way, after discussion with the patient. Individual factors must be taken into account.
022 – Audit

Prescribing dipeptidyl peptidase-4 inhibitors in primary care
Melody Tsai1, Zhi En Ernie Tan1, University of Manchester, Manchester, England

Introduction: Type 2 Diabetes Mellitus (T2DM) is a global problem that is increasingly prevalent in the United Kingdom. Newer pharmacological agents are continuously explored to target T2DM. Dipeptidyl peptidase-4 inhibitor (DPP-4 inhibitor) is one of these promising discoveries, found to reduce HbA1c levels without producing hypoglycaemic effects, nor increasing patients’ weight.

Aim: Our aim was to examine the effectiveness of DPP-4 inhibitors and whether they were prescribed accordingly to the National Institute for Health and Clinical Excellence (NICE) guidelines.

Method: This is a retrospective audit carried out in two primary care centers of all patients with T2DM and on a DPP-4 inhibitor. Data extracted from a computer system were then analyzed through a list of criteria and set standard using the NICE guidelines.

Result: A total of 55 patients were included for analysis. Sixty-five percent of the patients did not benefit from the commencement of DPP-4 inhibitors. Interestingly, 40% had worse diabetic control after six months. The lack of follow-up at six months time was the most common reason for not meeting the NICE guidelines. Other reasons include prescribing DPP-4 inhibitors before using first line agents and without combining other medications when HbA1c ≥7.5%.

Conclusion: Although there is evidence to support the efficacy of DPP-4 inhibitors, our study does not evidently display their beneficial effects. Therefore, it is essential to prescribe this medication prudently and accordingly to the NICE guidelines. To complete the audit cycle, medication adjustments for identified patients and recommendations to improve prescribing practices would be implemented.

023 – Audit

CDAD risk: use of PPIs and antibiotics in nursing homes
Moeen Ashraf1, Amble Health Centre, Amble, Northumberland

Background: Concurrent administration of proton pump inhibitors (PPIs) and antibiotics increase risk of Clostridium Difficile associated diarrhoea (CDAD) approximately three folds. While prescribing antibiotics, risk of individual patients developing CDAD should be considered which is mostly high for hospital patients hence PPIs are stopped to reduce risk. This audit aims to identify CDAD risk, while reviewing antibiotic and PPI prescription in three local nursing homes with view to change practice and reduce CDAD risk.

Criteria & standard: Withhold proton pump inhibitors for the duration of the course +7 days in identified high risk patients to reduce CDAD risk. Standard of stopping PPIs in 60% of high risk patient was to be achieved.

Methods /Results: Prescription charts for patients in all three nursing homes were reviewed for recent three months and high risk patients identified. Out of 84, 82 (97.6%) patients were above 65 years of age and 10 (11.9%) palliative. 4 (4.7%) patients were prescribed more than one antibiotics at the same time. There were no patients with liver cirrhoses, inflammatory bowel disease or on chemotherapy. 65 (77.3%) patients received antibiotics out of which 20 (23.8%) were on PPIs. In the identified high risk patients none had PPIs withheld during the antibiotic treatment.

Recommendations to achieve set standards and re-audit to complete the audit cycle were made.

024 – Audit

An audit of benzodiazepine prescribing practice as hypnotics & anxiolytics in an inner city general practice
Ahmed Ibne Saber1, Mersey Deanery, Liverpool

Aim: To compare benzodiazepine (BZD) prescribing practice to local PCT guidelines and NICE guidance:
1. Type, frequency, indications for use and length of BZD prescriptions
2. Use of non-pharmacological strategies pre BZD prescription.
3. Completeness of documentation regarding addiction potential
4. Frequency of attempts to stop/reduce BZD prescriptions.
5. Reasons for lengthy repeat prescriptions.

Method: The audit was carried out at an inner city general practice, with a study period of two years. Both acute & repeat BZD prescription were included. Data gathered: length of BZD prescription and previous non-pharmacological intervention had been used, attempts of stopping or reducing BZD dose/frequency and nature of advice given to patient at the time of BZD prescription.

Key Results:
- N=75 patients.
- 17% (n=13) were receiving an acute and 83% (n=62) a repeat prescription of BZD.
- Documentation regarding addictive nature of BZD given to patients (47%).
- 4% of patients on BZD were offered non-pharmacological intervention prior to BZD prescribing.
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- In 84% of cases, no consideration or attempt at medically initiated reduction
- Varied clinical and non-clinical reasons for failure to stop.

**Conclusions:** The number of patients on repeat prescription is disproportionately larger than those on acute prescriptions. Use of alternatives is poor as is the completeness of documentation. Attempts to reduce the number of repeat prescriptions is infrequent, explained by both clinical (withdrawal) and non-clinical reasons (non-compliance with services). Therefore adherence to guidelines is encouraged in this practice.

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**025 - Audit**

**Reconciliation of hospital discharge summaries and changes in patient medications**

Liam Piggott, 1Royal Sussex County Hospital, Brighton

A significant proportion of a GP's patients at some point will be admitted to hospital on either an emergency or elective basis. Some of these will have management plans formulated by hospital teams that may include starting, stopping or changing a medication. This plan should be acted on by the GP, for example a repeat prescription started. There should also be some form of acknowledgement that this has been done, and this should be easily seen within the notes for other doctors and staff to view.

Due to issues with traditional paper discharge summaries, the Royal Sussex County Hospital has introduced a secure digital summary that is emailed to local GP practices.

For the purposes of the audit, a sample of 40 consecutive discharge summaries from a certain date were included from the author's training practice. There were no exclusion criteria, in order to represent the diverse cohort of patients discharged from hospital.

In 95.5% of patients, the correct change in medication was made, but this was only referred to in the 'Journal' section of the notes in 57% of patients.

Overall, GPs were accurate in reading and acting on hospital treatment plans. Significant changes in treatment were often not specifically mentioned in the patient's GP-entered notes, and there was no unified Read code used between partners. An agreed way of making an easily viewed coded entry would aid clear documentation and improve consistent and safe patient care.

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**026 - Audit**

**An audit of rubella immunity status amongst women of childbearing age from a deprived population in UK General Practice**

Lucy Allender, 1Hannah May, Pip Fisher, 1University of Leeds, Yorkshire, 2Whitehouse Centre, Huddersfield

**Introduction:** Rubella infection during pregnancy can lead to miscarriage and foetal abnormalities if contracted before 16 weeks gestation. Research suggests that migrant women are less likely than UK born women to be rubella immune and may be overrepresented in cases of Congenital Rubella Syndrome in this country. Sections of the UK born population may also be more at risk due to incomplete immunisation. We audited the rubella status of an at risk population with a view to influencing practice.

**Methods:** The audit was performed in a UK general practice caring for asylum seekers, refugees, and UK born patients who are homeless or have substance misuse problems. Data was collected on the rubella status of all 254 women aged 15-45 registered at the practice on 1/11/10 using SystmOne and paper notes.

**Results:** 76.4% (194/254) of the audited population were asylum seekers or refugees, reflecting the practice population. Rubella status was known for 71% (181/254) of the women.

All of the UK born women of known rubella status were rubella immune.

9% (13/146) of the non-UK born women whose rubella status was known were seronegative. A further 3% (5/146) had been vaccinated elsewhere in the UK.

**Discussion:** A clinically significant proportion of the asylum seeker and refugee women were found to be non-immune to rubella. In light of our results, we recommend that non-European immigrant women of childbearing age should be screened for rubella immunity on registering in UK general practice, rather than delaying until pregnancy.

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**027 - Audit**

**An audit on influenza and pneumococcal vaccination uptake in diabetic, asplenic and immunosuppressed patients attending the Lower Broughton Health Centre**

Oluwatosin Sotubo, 1Krishnakant Buch, 1Lower Broughton Health Centre, Manchester, 2The University Of Manchester, Manchester

An audit was undergone studying patients attending the Lower Broughton Health Centre in Manchester to establish vaccination uptake in those who were diagnosed with diabetes mellitus, asplenia and immunosuppression and the reasons for patients not receiving the influenza or pneumococcal vaccinations. The sample of the audit included 91 patients with diabetes mellitus, plus 4 patients over 65 years old recorded to have asplenia or immunosuppression. The sample was derived retrospectively from the patient's computer records. Of the 91 diabetic patients 33 (36.26%) patients received both the influenza and pneumococcal vaccination, 26 (28.57%) patients received only the influenza vaccination and 2 (2.20%) patients received only the pneumococcal vaccination. Most significantly 32.97% of patients received neither vaccination. A total of 36.60% of patients refused to start or complete the course for the influenza vaccine,
25.00% of the causes were unknown, and 18.75% of patients were new to the practice. In contrast, the commonest reason for not having the pneumococcal vaccination was unknown. A total of 12.50% of patients were new to the practice and only 1 (1.79%) patient had a previous allergy or adverse reaction. Out of the 4 patients with asplenia or immunosuppression, 75.00% of those patients were noted to have both vaccinations. However, 1 patient only received the pneumococcal vaccination and the reason for this was unknown. It is clear that the uptake of both influenza and pneumococcal vaccinations in diabetic patients at the Lower Broughton health centre is substantially suboptimal, specifically so in regards to receiving the pneumococcal vaccination.

**028 – Audit**

**Uptake of seasonal influenza vaccinations among patients in ‘at risk’ groups**

Sarah Mills1, University of Edinburgh, Edinburgh

**Introduction:** Department of Health (DoH) guidelines aim for a >70% uptake of influenza vaccinations among at-risk patients.

**Method:** An EMIS search of the database of all the patients registered in the practice during 1 calendar year. The search was done using inclusion criteria of the DoH’s ‘main at risk groups’: age >65, any chronic lung/heart disease, any serious liver/kidney disease, diabetes, immunosuppressed, or serious nervous system disease. It was impossible, using the practices records system, to include the DoH ‘minor at risk groups’: patients’ profession (e.g. healthcare or poultry workers) or other factors (e.g. carers).

**Results:**

<table>
<thead>
<tr>
<th>Indication for vaccination</th>
<th>No of patients with that condition</th>
<th>No of patients given seasonal flu vaccinations</th>
<th>% vaccinated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 65 or over</td>
<td>751</td>
<td>535</td>
<td>71%</td>
</tr>
<tr>
<td>Chronic lung disease</td>
<td>569</td>
<td>114</td>
<td>20%</td>
</tr>
<tr>
<td>Chronic heart disease</td>
<td>27</td>
<td>20</td>
<td>74%</td>
</tr>
<tr>
<td>Serious kidney disease</td>
<td>2</td>
<td>1</td>
<td>50%</td>
</tr>
<tr>
<td>Serious liver disease</td>
<td>11</td>
<td>1</td>
<td>9%</td>
</tr>
<tr>
<td>Diabetes + Insulin</td>
<td>8</td>
<td>4</td>
<td>50%</td>
</tr>
<tr>
<td>Immunosuppression: chemotherapy</td>
<td>21</td>
<td>8</td>
<td>38%</td>
</tr>
<tr>
<td>Immunosuppression: splenectomy</td>
<td>2</td>
<td>1</td>
<td>50%</td>
</tr>
<tr>
<td>Immunosuppression: HIV</td>
<td>5</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Multiple Sclerosis</td>
<td>11</td>
<td>3</td>
<td>27%</td>
</tr>
<tr>
<td>Age 65 or over</td>
<td>751</td>
<td>535</td>
<td>71%</td>
</tr>
<tr>
<td>Chronic Disease &lt;65</td>
<td>656</td>
<td>152</td>
<td>23%</td>
</tr>
</tbody>
</table>

**Conclusions:** The practice was exceeding DoH standards for seasonal flu vaccinations in >65 year olds; however, at-risk patients <64 were significantly less likely to receive seasonal flu vaccinations. Vaccination rates in these groups did not meet the DoH. Audit of the vaccination rates among other at-risk groups (e.g. healthcare workers, carers) these populations would be useful for public health means.

**029 – Audit**

**Treatment of adult vitamin D deficiency in primary care**

Johanna Curtis1, Mary O’Brien1, Nick Harvey1, Solent Healthcare, Southampton, Public Health, NHS Southampton, MRC Lifecourse Epidemiology Unit, University of Southampton

Vitamin D insufficiency is common, particularly in dark-skinned UK populations. Evidence is accruing that commonly used treatments (calcium with 800iu cholecalciferol daily) may be inadequate to ensure repletion. We therefore undertook an audit of vitamin D insufficiency and its treatment in a General Practice setting.

General Practice records from 245 patients who had a history of vitamin D insufficiency (25(OH)-vitamin D < 50nmol/l) were reviewed. Pre and post-treatment 25(OH)-vitamin D concentrations were recorded, together with details of treatment. Patients were of predominantly Asian origin and ranged in age from 20 to 87 years. The concentration of 25(OH)-vitamin D was < 50 nmol/l in all patients and <25nmol/l in 57% (insufficiency and deficiency respectively, using historical UK definitions). 73% of patients had 25(OH)-vitamin D concentrations measured before and after treatment. 13% of patients treated with 800iu cholecalciferol/day and 33% of patients given 300,000iu ergocalciferol (1 to 3 doses) achieved 25(OH)-vitamin D >50nmol/l by 6 months. 22% of patients with deficiency and 33% of patients with insufficiency had no significant increase in 25(OH)-vitamin D while taking 800iu/day cholecalciferol>6 months.

**Conclusions:** Treatment with daily 800iu cholecalciferol or intermittent 300,000iu ergocalciferol achieved repletion of vitamin D insufficiency in only a minority of this cohort of mainly Asian patients. This is consistent with previous data and suggests that simply adhering to the recommended daily intake of vitamin D (400iu), or using “standard” prescription calcium and vitamin D oral supplements (800iu/day) will be inadequate to ensure repletion in dark-skinned populations in the UK. Vitamin D insufficiency is common, particularly in dark-skinned UK populations. Evidence is accruing that...
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030 - Audit
Are we under-diagnosing vitamin D deficiency?
Deborah Patel1, Richard Darnton1,  1Kirkstall Lane Medical Centre, Leeds

Introduction: An estimated 50% of adults in the UK have vitamin D insufficiency. It is associated with significant morbidity and should be suspected when routine blood tests show hypocalcaemia. We thought that our practice may be under-investigating hypocalcaemic patients and thus under-diagnosing vitamin D deficiency. Therefore we decided to audit a cohort of hypocalcaemic patients to determine if they had been appropriately investigated and treated.

Method: 28 patients with corrected serum calcium less than 2.2mmol/L over the past 6 months were identified; their clinical records were reviewed and categorised.

Results: 14 (50%) of the patients with low calcium did not have their vitamin D levels checked; of these only 3 were treated. 13 (46%) of the patients with low calcium had their vitamin D levels checked; of these 11 were found to have vitamin D deficiency but only 7 were treated. 1 patient declined investigations.

Discussion: The results show that a large proportion of patients did not have the cause of their hypocalcaemia identified and the majority of these are likely to have vitamin D deficiency. A significant number of patients did not receive any treatment for their hypocalcaemia, despite many having a diagnosis of vitamin D deficiency. This suggests that in our practice we are under diagnosing and under treating vitamin D deficiency. This may reflect practice across the UK but multi-centre studies are required before these conclusions can be generalised.

References:

031 - Audit
Characterising emergency admissions of patients with sickle cell crisis in NHS Brent: engaging GPs to improve the care of their patients
Stuart Green1, Carole Arnobi2, Ogo Okoye2, Ricky Banarsee2, Karen Phekoo1,  1Imperial College, London, 2NHS Brent, London

Introduction: The London Borough of Brent has one of the highest populations of people with Sickle Cell Disease (SCD) and use the Emergency Department (ED) rather than seek advice and support from their GP, with an estimated cost of £8.7 million per annum.

Aim: Characterise the utilisation of the ED by patients with SCD resident in Brent with short lengths of stay and multiple admissions

Methods: Data was extracted by the PCT for emergency admission of patients with sickle cell disease between January 2008 and July 2010. The episode data was subsequently filtered and converted to spells and analysed

Results:
- Most patients admitted are between the ages of 21-25 years
- Thirty six percent of admissions result in a length of stay of less than 2 days (168/467)
- Two medical centers were identified to have the highest rates of emergency admissions for Sickle Cell crisis within the study group
- There is no correlation between age of patients and length of stay
- Sixty nine percent (324 spells) of admissions were part of a series of admissions for an individual patient i.e. multiple admissions
- Discussion/conclusions: Practices with higher levels of admissions related to multiples admissions or short length of stays were identified.
- Strategic engagement of GPs will ensure the delivery of the GP education package is targeted where needed.
- It is anticipated that the targeted delivery of the education package will lead to a contraction in the demand equation for ED services

032 - Audit
Patients' views on improving sickle cell disease management in primary care: a focus group discussion

Background: Sickle Cell Disease (SCD) is the most common and fastest growing genetic disorder in England. Little is known about the views of patients with SCD on the care they receive from primary care professionals. Before developing a primary care education intervention, the views of patients were obtained through the use of a focus group.

Aims: A focus group was conducted with the aim of identifying SCD patient perspectives on the service they receive from their general practitioner (GP).

Methods: Participants comprised 10 patients and carers. The focus group was facilitated by a clinical psychologist from a local sickle cell centre. The focus group discussion was video recorded. The recording was then examined by the project
Team, and recurring themes identified. A comparison was made with notes made by two scribes also present at the discussion. A final list of key themes and suggestions was made.

**Results:** Patients and carers often bypass GPs for acute problems but feel that GPs have an important role to play around repeat prescriptions and general healthcare. Patients believe sickle cell disease is often ignored and deemed unimportant by GPs.

**Conclusion:** Participants identified key themes and suggestions for the project team to use in developing a GP educational intervention that will be used to improve SCD management in primary care.

### 033 - Audit

**Tuberculosis diagnosis and treatment: where are the delays?**

**Methods:** A random sample of patients, GPs and asthma nurses was carried out and used alongside an extensive literature review to develop methods to improve compliance and treatment.

**Results:** 2006, analysis of patients' notes who had TB in the Portsmouth Hospital's catchment area showed delay in referral to TB specialists, particularly in those who had non-respiratory TB. TB education was given by the TB team to physicians, surgeons and General Practitioners. The aim was to try and improve referral of potential patients with TB and help reduce time to treatment.

**Discussion:** Education has led to a 31% reduction in mean time between onset of symptoms and starting treatment in the group with non-respiratory TB. There are no clear guidelines on time from onset of symptoms to treatment but we suggest that there should be no more than three weeks from onset of symptoms to seeing a healthcare professional was 81 days for all TB patients.

### 034 - Audit

**The dynamic use of the British Thoracic Society (BTS) guidelines for asthma**

The BTS guidelines have revolutionised and regulated the treatment of asthma. As with any stepwise regime it is easy to work your way up increasing treatment as and when required. My question was looking at this notion in reverse. I proposed the following: 30% of asthmatics should be stepped down from their treatment at their annual review.

I took all the asthmatics in the practice and reviewed their management plan at the annual review, initial results-25% of patients were appropriately stepped down however a further 25% patient should have been stepped down.

A number of interventions took place-speaking with the nursing and medical staff about the audit and the findings and the importance of stepping down. The above was then repeated 3 months later, unsurprisingly there was little change, 25% patient were stepped down however a staggering third of patients could have been stepped down.

The results did not alter due to the short time period in between the two data collections. I have put in place a number of changes since the second set of results these include-the QoF template being altered to include discussion about stepping down treatment. An education module for the clinical staff has been developed discussing using the BTS guidelines dynamically.

This audit will then be repeated in 12 months, it would also be important to review the clinical outcome how many of those patients who were stepped down had to revert back to initial manangement and the time period in between.

### 035 - Audit

**Compliance with asthma treatment in the under 20's; how can primary care do more?**

The number of young people in the UK diagnosed with asthma has doubled in the past 30 years. During this period the methods deployed to control asthma in young people have vastly improved, with the evidence basis for the effectiveness of corticosteroid and beta-agonist therapy being widely accepted. However, improving compliance amongst young people in primary care with these therapies has proved more difficult with various approaches having been undertaken in the past with varying levels of success.

This audit examined compliance with therapy regimes amongst under 20s in the Stockport area of Greater Manchester. The notes of all patients under 20 registered as asthmatic across a large sample of GP practices were audited. The treatment regime being provided by the practice was compared against the current NICE guidelines and the number of exacerbations of asthma and how often reviews were carried out was also considered. Further to this interviews with a random sample of patients, GPs and asthma nurses was carried out and used alongside an extensive literature review to develop methods to improve compliance and treatment.

The results showed that whilst patients felt supported by their practice, their compliance with treatment and reviews was not optimal. Regular reviews of patients regimes to the least intrusive system was shown to significantly improve
Not enough spit! - and why we need more: sputum culture in adult patients with non-CF bronchiectasis

Introduction: Non-CF bronchiectasis is under-diagnosed and under-recognised in primary care. Recently published national guidelines emphasise that sputum culture is an important component of both diagnosis and management of bronchiectasis. Observations made during normal working practice suggested that sputum culture is not routinely undertaken in patients with bronchiectasis. This study examined the rate of sputum sampling and culture prior to antibiotic prescribing in bronchiectatic patients.

Method: Antibiotic prescribing and sputum culture results were recorded for all adult patients with bronchiectasis presenting with a respiratory tract infection over a 3-month period.

Results: One sputum sample was sent for culture; 17 courses of antibiotics were prescribed to 7 patients; each patient received only one antibiotic.

Discussion: Sputum samples were not routinely sent in this group of patients despite publication of recent national guidelines; some patients may not be able to provide sputum; repeated courses of the same antibiotic may encourage resistance; sputum culture helps to guide appropriate antibiotic prescribing in exacerbations, as well as appropriate referral to secondary care.

Conclusion: Raising awareness of the importance of sputum sampling in the management of bronchiectasis may in turn increase the rate of sputum samples sent for culture; given that bronchiectasis is under-diagnosed, case finding may be facilitated through targeted searches of more susceptible patient groups; for example, those frequently prescribed antibiotics for respiratory infections.

An audit to identify if patients with chronic obstructive pulmonary disease are being screened for osteoporosis, depression and cardiovascular disease in general practice

Background: Chronic obstructive pulmonary disease (COPD) primarily affects the airways but is not limited to the lungs and tends to co-exist with several other conditions.

Objective: This audit aims to identify whether three of the co-morbidities of COPD, osteoporosis, depression and cardiovascular disease are being appropriately screened for at the Park View Group practice.

Method: A computerised system was used to identify which patients suffered from COPD. More tailored searches were then made using appropriate search codes and allowing us to establish what proportion of patients had been screened for osteoporosis, depression and cardiovascular disease.

Results: The sample included 123 patients. Of these, 100% of patients on long-term oral steroids were on appropriate osteoporosis prophylaxis but only 28% on repeated short courses were being monitored appropriately. Regarding screening for cardiovascular disease, 73% had a cholesterol check and 57% a blood pressure check in the last 15 months. Finally, 49% of patients had been screened for depression in the last 15 months.

Conclusions: Despite limitations in the method of the audit, results show that some aspects of patient care in chronic obstructive pulmonary disease could be improved on. It is important to raise awareness of this amongst the practice staff and take steps towards improvement such as putting in place a standardised and effective template for COPD reviews.

Secondary prevention of fractures: osteoporosis prevention for patients seen in fracture clinic

Background: Current guidelines suggest all patients over the age of 50 with a fracture should have an osteoporosis risk assessment to prevent future fractures. Having an inpatient stay represents a window of opportunity for these patients to have a falls assessment and osteoporosis risk addressed; however, many patients have their fractures treated as outpatients.

Aim: To see if patients over the age of 50 with a fracture are being identified as patients in need of an osteoporosis risk assessment in the secondary care setting.

Method: A 2 week period of Fracture Clinic appointments was analysed to identify patients over the age of 50 with a fracture. The bone fractured, any previous fractures, and number of visits to clinic were noted. All fracture clinic letters relating to that patient were analysed for the keyword osteoporosis.

Results: Out of 463 fracture clinic appointments: 103 patients were identified as being over 50 with a fracture. Only 2 of these patients had osteoporosis mentioned in the letter to GP.

Conclusion: Patients treated as outpatients represent a group likely to be missed for assessment with respect to osteoporosis prevention. This highlights a need for better communication between primary and secondary care to identify these cases. To aid this process with several other recommendations, this author proposes a leaflet is given by orthopaedic services to all patients over the age of 50 and for their clinic letter to automatically include a recommendation to the GP to review with respect to osteoporosis risk.
039 – Audit

**Weight outcomes as a function of initial BMI in 34,271 adults referred to a primary care/commercial weight management partnership scheme**

**Jamie Stubbbs**, David Brogelli, Jenny Allan, Carolyn Pallister, Stephen Whybrow, Amanda Avery, Jacquie Lavin, Slimming World, Alfreton, Derbys; University of Surrey, Guildford, Surrey

**Objective:** This project audited weight loss outcomes as a function of initial BMI in a primary care/commercial weight management organisation (CWMO) partnership scheme.

**Methods:** 34,271 adult patients, referred for 12 weekly group sessions were categorised by BMI groups <30kg/m², 30-34.9kg/m², 35-39.9kg/m² and ≥40kg/m². Weight outcomes were analysed using individual weekly weight records.

**Results:** Weight losses were -2.9, -3.6, -4.1, and -4.8kg for the BMI categories <30kg/m², 30-34.9kg/m², 35-39.9kg/m² and ≥40kg/m², respectively. Regression analysis showed that after adjusting for age and gender, relative to the <30kg/m² group, absolute weight losses were 0.8, 1.4 and 2.4kg more for the 30-34.9kg/m², 35-39.9kg/m² and ≥40kg/m² groups, respectively (all p<0.001). Percent weight change at 12 weeks was similar in each BMI category at -3.7%, -4.0%, -4.0% and -3.9%, respectively. These differences were small but significant (p<0.001). Regression analysis showed that after adjusting for age and gender, relative to the <30kg/m² group, absolute weight losses were 0.3%, 0.3% and 0.1% greater for the 30-34.9kg/m², 35-39.9kg/m² and ≥40kg/m² groups, respectively (all p<0.001). For each BMI category those achieving 5% weight loss at 12 weeks were 33%, 37%, 36% and 36%, respectively. The percentage of those losing 10% in their first 12 sessions, by BMI category was 6%, 6%, 6% and 5%, respectively. There was no significant difference in the number of weeks attended in different BMI categories (p=0.905).

**Conclusions:** Referral to a commercial organisation is as effective for people with high BMIs as for those who are moderately overweight.

040 – Audit

**Monitoring metabolic parameters in patients taking olanzapine: an audit**

**Una Clancy**, Maurice Clancy, University College Cork, Cork, Ireland; Beaumont Hospital, Dublin, Ireland

**Background:** The Maudsley Prescribing Guidelines recommend that patients receiving olanzapine should have their glucose, lipids, blood pressure and weight measured on a regular basis.

**Aims:** To determine whether patients receiving olanzapine are being monitored in general practice to detect the associated adverse metabolic effects: impaired glucose tolerance; hypercholesterolaemia; weight gain and hypertension.

**Methods:** This audit was carried out in a large general practice consisting of eight general practitioners. Patients receiving a prescription for olanzapine were identified on the practice electronic records. GP monitoring of the recommended parameters was recorded as present or absent for each patient.

**Results:** 64 patients were receiving olanzapine. Mean age was 49.61 years (SD=16.9). 71.9% (n=46) were male and 28.1% (n=18) were female. 11% (n=7) had documented diabetes. 42.2% (n=27) had had a fasting glucose measurement within the last year; 63% (n=4) more than one year ago and 51.6% (n=33) had no recorded glucose investigation. With regard to lipid measurements, 59.4% (n=38) had had a measurement in the last year; 10.9% (n=7) more than one year ago; and 29.7% (n=19) had no recorded investigation. 42.2% (n=27) had had their blood pressure recorded. Patients’ mean age was statistically significantly older in those who had received glucose and lipid measurements (p<0.05).

**Conclusions:** The significance of older age as a predictor for glucose and lipid measurements may suggest practitioners do not see olanzapine alone as an independent indication for monitoring. GPs should aim to improve monitoring rates so as to detect patient development of conditions such as diabetes.

041 – Audit

**Familial hypercholesterolaemia: can we identify the silent killer?**

**Jamie Green**, Springfield Surgery, Brackley, Northamptonshire

**Introduction:** Familial Hypercholesterolaemia affects 1 in 500 people in the UK. Typically only 16% of these are diagnosed. The aim was to identify those patients with familial hypercholesterolaemia and if their management adheres to the 2008 NICE guidelines. Then those patients who fit the ‘Simon Broome’ criteria for familial hypercholesterolaemia were identified.

**Methods:** Patients coded with familial hypercholesterolaemia on the computer system were identified. It was then established if they had been coded and managed correctly. Patients with a family history of familial hypercholesterolaemia were identified and their notes reviewed to identify if they could have the condition. Finally we reviewed patients with a total cholesterol of >7.5 mmol/l and a family history of premature ischemic heart disease to considered if they fit the ‘Simon Broome’ criteria.

**Results:** 10 patients coded with familial hypercholesterolaemia. 7 were miscoded, 3 had a correct diagnosis, 1 of these treated correctly.

8 patients with a family history of familial hypercholesterolaemia. 1 fulfilled the criteria for diagnosis.

42 patients had a total cholesterol of >7.5 mmol/l and a family history profile premature cardiac disease. 2 met the definite ‘Simon Broome’ criteria. 15 met the possible ‘Simon Broome’ criteria.

**Discussion:** Familial hypercholesterolaemia left untreated will result in a 50% chance of myocardial infarction by 50 years in men and 30% in women by 60. As a result of this audit, 14 further patients were referred to the lipid clinic and their children now stand the chance of early identification and treatment.
**042 - Audit**

Significant weight loss can be achieved on a short funded intervention; evaluation of the cost-effectiveness of the commercially available LighterLife weight-management programme provided for obese patients in an NHS setting

Claire Hallam¹, Gill Mullins¹, Jane Mawdsley², John Broom¹, Jackie Cox¹, Bar Hewlett¹, LighterLife UK Ltd, Harlow, Victoria Park Health Centre, Wirral

**Introduction:** NICE encourages the NHS to work in partnership with commercial weight-management organisations. This audit reports on weight loss achieved by obese patients whose participation in the LighterLife Total programme: a very-low-calorie diet (VLCD) combined with behavioural-change was subsidised by their NHS GP practice.

**Method:** 60 obese adults were invited by the practice. 36 responded; 35 were medically eligible and enrolled (26 females, 9 males; mean start BMI 45, range 36.8-64.7). They were fully funded by the practice at a subsidised cost by LighterLife, attending weekly LighterLife weight-management groups for 12 weeks maximum, followed by up to 6 weeks’ weight stabilisation (with the patient paying a nominal amount). The practice paid only for weeks patients attended. Data were collated for weight/BMI at baseline then weekly.

**Results:** 5 patients attended for baseline session only; 27 of the remaining 30 (90%) lost clinically significant amounts of weight (>5% of body weight); 20 (67%) lost >10%. Mean weight loss was 16.0kg (4.4-35.5kg), 12.8% of body weight. Total cost of the intervention to the practice was £13,622.14, equivalent to £283.8/kg (£129.6/lb) of weight lost. Without subsidy and including VAT (e.g. self-funding individuals) this equates to £41.58/kg (£18.90/lb) of weight lost.

**Conclusion:** While headline costs for VLCDs may appear greater than ‘healthy-eating’ approaches commonly available in the commercial sector, participants are not required to purchase food. Therefore the significant amounts of weight loss achievable may mean a VLCD programme like LighterLife Total represents a more cost-effective intervention for individuals and the NHS.

**043 - Audit**

Successful weight management may be associated with rapid, significant weight loss: an audit of outcomes 6-months post-weight loss of the commercially available LighterLife weight-management programme provided for obese patients in an NHS setting

Claire Hallam¹, Gill Mullins¹, Jane Mawdsley², John Broom¹, Jackie Cox¹, Bar Hewlett¹, LighterLife UK Ltd, Harlow, Victoria Park Health Centre, Wirral

**Introduction:** It is commonly believed that rapid weight loss leads to rapid weight regain, particularly following a very-low-calorie diet (VLCD). This audit reports on outcomes 6-months post-weight loss in obese patients who lost weight in an NHS setting via a commercially-provided weight-management programme.

**Method:** 16 females with initial BMI≥37 completed 12 weeks on the nutritionally-complete LighterLife Total VLCD, followed by 6-weeks weight-stabilisation (via structured reintroduction to food), at their GP practice. Throughout the intervention patients participated in weekly behavioural-modification groups for weight management, using transactional analysis/cognitive behavioural therapy techniques. Data were collated for weight/BMI at baseline, then weekly. Mean weight loss at 18 weeks was 20.0kg (range 9.4-35.5kg), a mean 17.5% loss from baseline. Patients were invited for follow-up at the practice 6-months post-weight loss, and weight/BMI recorded. During VLCD patients were funded by the practice, and paid a nominal fee during the weight-stabilisation phase. The practice paid only for weeks patients attended.

**Results:** 13 of the 16 patients attended 6-month follow-up. Mean 79% of initial weight loss was maintained; mean weight loss from baseline was 15.8kg (range -34.4kg to +4.7kg), 69% maintained >10% weight loss. The 4 subjects who maintained <10% weight loss experienced the lowest weight reductions during the weight-loss phase.

**Conclusion:** Weight loss achieved rapidly on VLCD can be maintained; furthermore, successful weight management may be associated with compliance during weight loss. Careful monitoring during weight loss may highlight non-compliant subjects who may be suitable for removal from a funded intervention to maintain its cost-effectiveness.

**044 - Audit**

An audit to identify the effectiveness of current nursing lifestyle advice delivered within general practice for obesity

Anneke Alves¹, University of Manchester, Manchester

**Background:** Obesity is an increasing health problem within United Kingdom and is one of the main challenges to our health service. It puts many burdens not only to the National Health Service but also on several body systems.

**Objective:** This audit examines whether identified obese patients registered at Maples Medical Center lost weight due to effective intervention from nursing staff.

**Method:** The practice’s computer database was used to identify patients that had a body mass index (BMI) beyond the normal range. The patients included in the sample had to be currently registered to the practice; they needed to have been coded as having 'Obesity' and also had an 'Initial obesity assessment'.

**Results:** The sample size of the audit was 96 patients. The mean BMI of the population sample was 38.5kg/m² with all patients having received nursing lifestyle advice. 62.5% of patients lost weight and the biggest reduction in BMI since the patients initial assessment was 5.4kg/m². The smallest reduction in BMI after the initial assessment was only 0.1kg/m².

**Conclusions:** The audit shows that current nursing dietary advice is effective in reducing BMI in obese patients, however...
Introduction: Many adults with intellectual disabilities are living longer and in the community. Their health needs are being recognised more since the release of health reports in the UK. The adverse effects of long-term weight gain is well known. Adults with ID are more likely to be overweight for many factors, social, behavioural, and medical. Many use antipsychotic medication to help them manage mental illness and behaviour. The drug regimens are often complex and include antipsychotics, antiepileptic drugs and others. The responsibility for reviewing drug regimens lies with the prescriber who, in community services, is the primary care general practitioner. This study reports on the weight parameters of adults with ID in a community service who use psychotropic medication that includes antipsychotic drugs. The height and weight measurements of fifty-two adults using medication were used to calculate their BMI ratios. Over 50% had a BMI ratio greater than 30. The most commonly used drugs included second generation antipsychotics. The group was compared with a cohort of adults with ID who did not use medication. The mean BMI ratio was 27 for this group. The results document BMI ratios of adults with ID. The results indicate the impact of psychotropic medication use on the weight of adults with ID.

Method: Patients who still have their IUS retained should be contacted and a re-audit will be performed in 5 years’ time. Furthermore, the rate for those who attended a 6 week check up was 55%.

Results: 20 patients were identified and 7 patients were excluded due to their early removal of IUS. Reasons for early removal are identified. The rate of IUS removal before it expired was 31%. In addition, IUS which was used for contraception and menorrhagia (5 years duration) had a removal rate of 10%, while IUS which was used for woman going through menopausal (7 years duration) had a 100% removal rate. Furthermore, the rate for those who attended a 6 week check up was 55%.

Conclusion: The rate of IUS removal after it expires is unsatisfactory. Recommendations are suggested in the GP practice. Patients who still have their IUS retained should be contacted and a re-audit will be performed in 5 years’ time to determine success.
048 – Audit

**The progesterone only implant: is the duration of use three years as recommended?**

Jessica Veitch1, 1The University of Manchester, Manchester

**Aims:** By auditing the implants inserted at Walkden Medical Centre we want to find out if relying on the patient’s memory and initiative alone is effective in ensuring the implant is removed on or before the recommended three year duration of use, to ensure effective contraception for all patients using the contraceptive implant at all times.

**Methodology:** EMIS was used to search for all patients at the practice who had an implant inserted between 15/04/04 - 15/04/08. Their notes were searched to find the date of implant insertion and removal.

**Results:** 35 implants were inserted in the 4 year period. 53% were removed early, mostly due to unwanted side effects, the most common of these being irregular or heavy bleeding.

Of the implants not removed early, 47% were removed before or at 36 months. 40% of implants were removed between 1 and 11 days after the recommended date of removal. 13% of implants were removed over a month after the recommended date of removal.

**Conclusions:** It is recommended to issue a reminder to patients that their implant is due for removal to ensure all patients at this practice are covered by an effective, licensed contraceptive at all times.

049 – Audit

**Pre-conception haemoglobinopathy testing for females in a high risk group: an audit at the Whitehouse Centre, Huddersfield.**

Jane Stratton1, Joanne Miller1, Pip Fisher1, 1University of Manchester, Manchester, 2Kirklees Primary Care Trust, Kirklees

**Introduction:** NICE guidance states that women at high risk of carrying a haemoglobinopathy should be offered testing before pregnancy to increase reproductive choice. The Whitehouse Centre is a General Practice with many patients who are asylum seekers or refugees. Most such patients are at risk of carrying a haemoglobinopathy, therefore we try to offer testing at registration. We audited our practice to see if we are following NICE guidelines.

**Methodology:** The sample was half of all women registered, aged 12-50 years, excluding patients who self identified as ‘white British’.

**Results:**

- All patients with a record of an offer of a test for haemoglobinopathy took up the offer.
- 46% of the sample had been tested for haemoglobinopathy before pregnancy
- 20% were pregnant at registration so pre-pregnancy testing would not have been possible
- Low ferritin caused difficulty in interpreting results (for thalassaemia screening) in eight of the 79 tested.
- Four of the eight patients with ambiguous results due to low ferritin were not adequately followed up
- Six carriers were identified, of whom three had partner testing and two received genetic counselling.

**Discussion:** The audit shows that haemoglobinopathy testing prior to pregnancy is feasible in general practice. Low ferritin can cause difficulty in interpreting results of screening for thalassaemia trait and is common in the risk population. Robust mechanisms are needed to ensure such women have iron supplementation followed by repeat testing. Testing is only worthwhile if identified carriers are followed up to enable informed reproductive choice.

050 – Audit

**Preconception care for women with diabetes mellitus summary of an audit at The Lighthouse Medical Practice, Eastbourne**

Jaiyeola Olaleye1, Greg Folwell1, Mark Evason1, 1The Lighthouse Medical Practice, Eastbourne, East Sussex

**Introduction:** Current research has shown that women with diabetes are seven times more likely to have a stillborn baby than other women. They also have more than double the risk for caesarean sections and congenital malformations.1 Preconception care is therefore crucial in ensuring a favourable outcome for diabetic clients as detailed in national guidelines. We undertook an audit evaluating our practice with service improvement on re-audit.

**Methods:** RCOG and NICE2 guidelines focused on two criteria were used: provision of preconception counselling and contraception. A list of female diabetic clients aged 16 - 44 years in our practice was obtained and analysed.

The results were presented at the practice audit meeting with recommendations made. A re-audit was carried out subsequently.

**Results:**

1st Audit cycle:

- 357 (2.47%) of the 14,476 registered patients were diabetic females.
- 26 (7.28%) of the 357 diabetic females were aged 16 - 44 years
- Of the 26, only 2 (7.69%) had received preconception counselling and 11 (42.3%) had contraception

2nd Audit Cycle:

- Of the 26 diabetic female patients, 7 (27%) had now received preconception care and 13 (50%) were on contraception.

This showed a marked improvement.
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Changes implemented / discussion: In our practice, preconception care has improved for these patients by instituting routine contraceptive counselling, inclusion of preconception care with check-lists on our annual diabetic reviews template and production of posters. Preconception care including counselling, contraception, lifestyle advice and antenatal care are essential components to be delivered in primary care settings for diabetic clients.

References available.

051 – Audit

Audit of antiretroviral drug interactions in HIV patients attending an infectious diseases outpatient clinic

Kamal Kaur, Matthias Schmid, Jay Foster, Wing Roberts, Newcastle University, Newcastle

Introduction: According to British HIV Association (BHIVA) guidelines, patients should not be on drug regimens that can result in serious drug interactions. However the risk of drug interactions is particularly exacerbated in HIV patients who usually take complex drug regimens. Due to changes in local outpatient prescription policy (effective 2009), whereby GPs have taken over responsibility for patients non-HAART medication prescriptions an audit of current practice was carried out with the following aims: 1. To compare prevalence and severity of drug-drug interactions (DDIs) in 2011 versus 2009. 2. Explore the effect of any DDIs on drugs involved. 3. Identify key contributory factors and recommend further ways to manage these.

Method: Inclusion criterion was HIV positive adults (aged >18) on HAART. Prospective medication lists were collected over a 3-week period and 45 patients’ medication lists were confirmed with GP practices. A verified HIV drug interactions website was used to screen medication lists for any DDI.

Results: Overall both prevalence and severity of DDIs increased; 11% more patients had a potential DDI in 2011 (n=125). Inaccuracy between GP and hospital medication lists increased; risk of additional (i.e. non-hospital documented) GP-prescribed medications causing DDIs doubled in 2011.

Conclusion: Changes in prescribing policies may lead to an increased risk of potentially dangerous DDIs. It is important to have measures in place which can reduce discrepancies between hospital and community medication lists. As prescribing responsibilities in HIV patients shifts to primary care, improving GPs’ education and awareness of high risk of DDIs in these patients is paramount.

052 – Audit

Missed opportunities for HIV testing

Heather Kendall, 1Department of GU and HIV medicine, Whittall Street Clinic, Birmingham, 2University of Birmingham, Birmingham, 3University Hospitals Birmingham Foundation Trust, Birmingham

Late diagnosis of HIV infection remains a major challenge in the UK, including half of the newly diagnosed patients in 2010. Patients diagnosed late have poorer prognosis compared to other HIV infected patients. British guidelines for HIV testing provide the list of clinical indications for HIV testing. BHIVA national 2010 audit investigated the extent of late diagnosis within each HIV centre.

Accordingly, medical histories of all patients diagnosed between August and October 2010 were investigated for clinical presentations that could have been related to HIV infection two years before their diagnosis.

Amongst 19 patients diagnosed within that period, nine (47%) had a clinical diagnosis indicative of HIV before their diagnosis, and 6 of these (67%) had CD4 counts less than 350 cells/mm3 including 4 (44%) with CD4 count less than 200 cells/mm3. The most common clinical presentations were herpes zoster and unexplained thrombocytopenia. The majority of cases (86%) were missed in general practice settings, with the rest being in acute medical settings.

Late diagnosis of HIV infection therefore remained as a challenge in our HIV centre. Protocols to improve uptake of HIV testing in general medical settings are urgently needed, particularly in primary care settings.

053 – Audit

Retrospective audit of chronic kidney disease referrals to secondary care

Madhu Potluri, Emily Pollock, Swati Purohit, Murugan Sivalingam, 1Lister Hospital, Stevenage, Hertfordshire

Introduction: Since widespread usage of estimated glomerular filtration rate (eGFR ml/min), there has been an increase in chronic kidney disease (CKD) referrals from primary care. We aimed to follow up referrals deemed not appropriate for management in secondary care.

Methods: 143 referrals deemed not appropriate out of 488 were retrospectively studied between 01/01/2009 to 15/11/2010. Materials used: referral letters from GPs, response letters from consultants and biochemistry results.

Results: 67 patients were male and 76 patients were female. Mean age was 67.7 years (SEM 1.7). 134 patients had referral eGFR data with median referral eGFR 42.5 (SEM 2.5). 90 patients had referral proteinuria with a median referral albumin/creatinine ratio (ACR) 2.0 (SEM 5.1). 52 patients had diabetes, 65 patients had hypertension.

The 52 patients with diabetes had lower eGFRs (mean eGFR 43 +/- 24) at referral compared to the hypertensives (eGFR 59.7 +/- 30) (p value = 0.003).

119 patients had follow up data. The median referral eGFR in this group was 42.50 (SEM 2.5). The median eGFR at follow up was 49 (SEM 3.2). Improvement of eGFR was highly significant (p = <0.001).
Methods: A retrospective single centre analysis of 98 consecutive EP procedures & 62 device cases over a 5 month period.

Introduction: Clinical & non-clinical codes are used to assign each finished consultant episode (FCE) into a Health Resource Group (HRG). This is the basis of payment by results by which nationally agreed tariffs for the FCE are charged to the primary care trust. We therefore hypothesised that accurate clinical coding would generate the correct income for any given FCE for cardiac electrophysiology (EP) & device cases.

Results: There were large inaccuracies in clinical coding (Table 1 and 2). For EP procedures, this did not ultimately influence the overall tariff principally because 60% of atrial fibrillation ablations were coded as atrial flutter. The latter generates more income. For devices there was a significant discrepancy between total tariff generated with original & new clinical codes (net increase of £19,710) driven by complex devices miscoded as simple procedures.
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057 - Audit
Cervical cancer screening in an ethnically diverse population - an audit conducted at a GP surgery in East London
Ann-Marie Streeten1, 1Merchant Street General Practice, London

Conclusions: Inaccurate coding can have serious implications, and is important for health resource planning. A simple "tick-box" checklist has been developed to be completed by the operating physicians at end of the procedure to support the coders. A re-audit is underway.

INTRODUCTION

Background: Since the introduction of the cervical screening program there has been a large body of evidence collected to ascertain why certain socioeconomic, ethnic or age groups do not attend for screening. There is a paucity of evidence looking at uptake rates in GP practices in East London, with little evidence to indicate how screening uptake can be improved.

METHODS

We conducted an audit of all women in the 25-64 year old age group who attend a General Practice in Bow, East London who in December 2009 had been recorded to have not attended for smear test within the last 5 years.

We analysed the records of 141 patients who had not attended for cervical smear which represented 74% of the eligible population. A larger than expected proportion of this group were oriental, 13% compared to 3% in the general population with no difference seen in the Asian or white communities. 20% of patients suffered with a mental illness. We found that only 32% of patients who had not attended for a smear test ever had it mentioned to them during a consultation with a doctor or a nurse.

We feel that for GPs based in difficult to reach communities, perhaps with a larger than usual ethnic minority community and with a diverse set of language and socioeconomic barriers, cervical screening should be discussed opportunistically with patients within the setting of a consultation with a doctor/nurse.

RESULTS

We found that only 32% of patients who had not attended for a smear test ever had it mentioned to them during a consultation with a doctor or a nurse.

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Conclusion: We feel that for GPs based in difficult to reach communities, perhaps with a larger than usual ethnic minority community and a diverse set of language and socioeconomic barriers, cervical screening should be discussed opportunistically with patients within the setting of a consultation with a doctor/nurse.

058 - Audit
Don't forget the neutrophils! An audit of the impact of education about neutropenic sepsis
Mary Bunn1, Karen Groves1, 1Queenscourt Hospice, Southport

Background: Neutropenic sepsis is an oncological emergency, which may present in primary care with minimal symptomatology, requiring prompt recognition and treatment.

Aim: To see if an educational intervention has sufficient impact to ensure GPs consider neutropenic sepsis and act promptly.

Method: An educational DVD (Sussex Cancer Network) presents a case scenario where minimal symptoms present shortly before a fatal outcome.

45 GPs attending 3 day palliative care courses, watched it and were shocked by the speed of deterioration. A free text questionnaire investigating knowledge and understanding was completed before and after the DVD, and the impact was assessed.

Results: Only 12 (27%) of the 45 participants had had any formal training in recognition or management of neutropenic sepsis previously. Although prior to the DVD, 32(71%) recognized the need for IV antibiotics only 2 (4%) stated that this should be undertaken urgently. 31(69%) stated that clinical signs might include raised temperature and 30(67%) mentioned decreased neutrophil or white cell count. After the DVD 43(96%) stated the need for IV antibiotics within an hour of presentation. 18(40%) mentioned recent history of chemotherapy in considering a diagnosis of neutropenic sepsis. 40 (89%) felt the DVD had been an effective training tool.

Conclusion: Following an educational intervention, there was increased awareness of the important risk factors, and the urgency and mode of management required. As more patients on chemotherapy are being managed at home, it is imperative that doctors are equipped to support them effectively in the community.

059 - Audit
Review of presenting symptoms and time to diagnosis of children with primary brain tumours
Jill Choudhury1, Vanessa Thomas1, Martin Hussey1, 1Poole Hospital NHS Foundation Trust, Dorset

Introduction: Brain tumours are the commonest cause of death from cancer in children and of those who survive, 62% are left with a significant disability. Presenting symptoms are often non-specific, creating a diagnostic challenge. Time from onset of symptoms to diagnosis is considerably longer for brain tumours than other childhood cancers.

Guidelines assessed: The Diagnosis of Brain Tumours in Children: A Guideline for Healthcare Professionals (developed by The Children's Brain Tumour Research Centre, University of Nottingham)

Methods: Retrospective case note analysis of children diagnosed with a brain tumour between 1995 and 2010 at Poole Hospital NHS Foundation Trust. Data was collected on presenting symptoms, time between onset of symptoms and referral to Paediatrics, time between referral and being seen by a Paediatrician and time between being seen by a Paediatrician and CNS imaging.

Results: The most common presenting symptoms and signs were headaches, nausea and vomiting, vision abnormalities and motor abnormalities. Time from onset of symptoms to diagnosis ranged to above 2 years. Time taken from being referred to being seen by a Paediatrician ranged from the same day to several months; most children were seen on the same day that they were referred. The time between being seen by a Paediatrician and having CNS imaging ranged from the same day to one year; most children had CNS imaging on the same day or the next day.

Implications for practice: The guidelines developed by The Children's Brain Tumour Research Centre need to be disseminated widely amongst both Paediatricians and GPs.
### 060 - Audit

**Audit of under-five mortality rates in a rural hospital in South Africa before and after implementation of monthly mortality meetings and a standardised paediatric admissions proforma**

Joanna Thorne¹, Afsana Bhuiya¹, ¹Mseleni Hospital, Umkanyakude district, KZN, South Africa, ²St Marys VTS, London

The Millennium Development Goals set by the UN in 1990 include reducing child mortality rates in children under five years of age by two thirds by 2015. Interestingly, despite efforts, statistics in South Africa have deteriorated (60 per 1,000 births in 1990 to 69 in 2006 - Millennium Development Goals website.)

During our OOPE placement, we audited all deaths of children under five years of age at Mseleni Hospital, a small rural hospital in Kwa-Zulu Natal, South Africa over the period of January to December 2010.

In 2010 41 children died on the paediatric ward, the majority (38) in the under five age bracket.

Each death was reviewed and contributing modifiable factors from home circumstances to specific ward related problems recorded. We aimed to reduce those deaths with factors relating to the ward itself.

A standardised paediatric admissions proforma was rolled out at the hospital with structured boxes to prompt physicians on prescribing doses, important aspects of the history (e.g HIV status) and a clear set of instructions for nursing staff.

A monthly mortality meeting held on the paediatric ward was also started in December 2010 to facilitate re-education and improvement in practice by discussing each specific case and any issues arising.

We aim to collect the data for the first six months of 2011 and compare it to the first six months of 2010 to ascertain whether these two interventions have effected any reduction in the number of deaths with modifiable factors attributable to the paediatric ward.

### 061 - Audit

**Safeguarding children; a re-audit on the safeguarding policies in place in the general practice**

Sarah Arthur¹, ¹The University of Manchester, Manchester

**Introduction:** In 2000, eight year-old Victoria Climbié died from severe maltreatment at the hands of her carers. Her mistreatment and failure of the ‘system’ to protect her, changed the governmental frameworks and policies that safeguard children. As a result of this, the Royal College of General Practitioners developed a toolkit that allows Practices to effectively assess their policies in place. Adswood Medical Practice first used the toolkit in 2010 and this re-audit evaluated their progress since.

**Method:** The qualitative toolkit was used in conjunction with a questionnaire that was delivered to all members of staff at the Practice. Categories that were assessed included, practice policies and procedures, staff recruitment and training, patient record systems, and information for patients. In addition, last year’s recommendations were assessed.

**Results:** A RAG (Red, Amber, Green) rating system was used to analyze the toolkit and questionnaire. The Practice had acted upon each assessment point. Furthermore, practice policies and procedures achieved 75% completed overall. Staff recruitment achieved 50%. Patient record systems achieved 75%. Information for patients achieved 100% and last year’s recommendation achieved 60% completed.

**Conclusion:** Over the past year Adswood Medical Practice have developed their electronic coding for children and families in need or at risk. Furthermore all staff have been trained on safeguarding. This Re-audit has recommendations that will tighten the gaps within the Practice, including developing a more detailed Practice policy on safeguarding, initiating Independent Safeguarding Authority checks for all staff and informing each member of staff of the Read codes.

### 062 - Audit

**Audit of GP referrals to Macclesfield accident and emergency department**

James Wall¹, Mark Nicol¹, ¹Accident+Emergency Dept. Macclesfield District General Hospital, East Cheshire NHS trust, Macclesfield, Cheshire

**Introduction:** GP referral letters of high quality are an essential part of good quality care with multiple functions. The role of the GP as gate keeper has been highlighted recently, facilitating smooth patient interaction with secondary care, minimising potential for medication errors thereby ensuring patient safety and assuring appropriate resource utilisation.

SIGN guidance number 31 promotes a recommended referral letter covering three main areas:

(i) demographic details  
(ii) referring and registered GP  
(iii) Clinical Information

**Methods:** We reviewed 23 GP referral letters to the emergency department of a DGH against the SIGN recommended referral document between May to July 2010

**Results:**

(i) Demographic details  
- Name of patient present in 90% of letters  
- Address in 90%  
- DoB in 86%
(ii) Referring GP present 74% of cases; Registered GP in 70%
(iii) Clinical Information
- Reason for referral present in 77%
- History of presenting complaint/exam findings present in 87%
- Past history in 73%
- Additional relevant information e.g. social history in 27%
- Allergies/clinical warnings in 42%
- Medications noted in 73%

Conclusions: The need for improved documentation has been highlighted specifically in two areas.
Firstly enhanced documentation of the reason for referral will aid in efficient resource allocation, potentially minimising costly and unnecessary investigations. Secondly the presence or absence of drug allergies and patient medications warrants more consistent recording to reduce the possibility of medication errors with associated morbidity and mortality consequences.

063 – Audit

Study of referral patterns from primary to secondary care in a single general practice (April – October 2010)
Suresh Sanders¹, Dedridge Medical, Livingston

General Practice is constantly under pressure to examine its use of services. There are implications that there are “efficiency savings” to be made and that implementing referral management schemes may facilitate this.

Aim: The aim of this study was to examine the referral patterns of one practice over a 6 month period from April 2010 to October 2010. Data from 1998 was also available.

Design/Method of Study: All referrals on SCI gateway were examined. In 1998 data was recorded manually and extracted from the Annual report. Setting: A practice in Livingston with a patient population of 11,000 and eight partners, on variable sessions. The practice runs an individual list system for routine appointments.

Results/Conclusion: The result of this survey indicate that there may be “low” and “high” referring GP’s. Of the GP’s in post over 12 years, those who had high and low referral rates in 2010, were much the same, in 1998. It is hard to interpret why this may be, as there are so many variables, such as demographics, incomplete computer use/GP’s with special interests/absence/use of locums/missed referrals/risk taking behaviour. We would thus challenge the use concept that a “good GP” is a low referring GP.

In our study of the GP’s present in 1998 and 2010, 3 out of 4 demonstrated an overall decrease in referral rates, from 12%-31%. This is in contrast to other studies which demonstrate rising referral rates in general practice.

064 – Audit

Identification of poor performance in UK NHS organisations
Rachel Locke¹, Samantha Scallan², Camilla Leach¹, Kerry Ball¹, Mark Rickenbach¹, Joyce Goodman¹, Dedridge Medical, Livingston

Introduction: The Revalidation Support Team (RST) research programme was set up in August 2010 to identify and explore any gaps in knowledge not included in other RST work. It aims to provide assurance that systems and processes developed within the RST work streams are fit for purpose, as well as relevant to and grounded in doctors’ experiences and challenges. The second project in this programme, awarded to the University of Winchester, seeks to understand how NHS organisations currently identify poor performance amongst doctors.

Method: The aim of this research project was to scope the existing knowledge base concerning the identification of poor performance amongst doctors working in NHS organisations, and to collate the processes, methods, tools and resources currently used to identify practice performance issues. This was achieved through a literature review, a survey of a purposive sample of UK NHS trusts using ‘Freedom of Information’ requests and interviews with key informants.

Results: The outcome of the work will be a snapshot of the resources in use along with an evaluation of their effectiveness and potential areas for development.

Discussion: The presentation will report the tools and approaches currently in use to identify doctors about whom concerns have been raised, and the areas for future development/research.

065 – Audit

Audit on minor surgery in a GP practice
Katarina Bray¹, Manchester, Manchester

Background: With an increasing number of General Practitioners (GPs) developing a specialist interest in the area of dermatology, a range of operative procedures can now be offered to patients with low-risk dermatological lesions at the primary care level. This audit looks at minor surgery in a GP practice and explores key aspects including the types of
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surgical procedures conducted and post-operative infection rates. Regular review and audit of minor surgery within a G.P practice is of great importance to its eligibility in providing this service.

Methodology: Specific readcodes relating to particular types of minor surgical procedures were used to search the Microtest and Evolution databases at a chosen general practice. A subsequent list of all the patients (within a specified time frame) who had undergone a dermatological surgical procedure alongside specific information about the procedure were acquired. Analysis of this was then conducted and results obtained.

Results: 118 patients were found to have undergone a minor surgical procedure within the specified dates chosen. Excision of lesions were found to be the most commonly performed procedure, (26.7%), with benign naevi as the most commonly operated on lesion (18.6%). Only one post-operative infection was suspected.

Conclusion: In general the types of surgical procedure chosen for specific lesions were found to be in keeping with current guidelines. Overall this audit highlights the vast number of surgical treatment options available for dermatological lesions within a primary care setting, thus emphasising the growing nature of G.Ps developing an interest within this specialist area.

066 – Audit
Post-splenectomy prevention of infection in general practice
Colin Goudie1, 1Queen Margaret Hospital, Dunfermline, Fife

Background: Splenectomy increases a patient’s risk of life threatening infection. British Committee for Standards in Haematology (BCSH) guidelines are designed to reduce this risk. We have audited compliance with BCSH guidelines in post-splenectomy patients in one general practice with 7100 registered patients.

Methods: The ‘Vision’ patient database was searched for patients with a Read-code for splenectomy and their infection prophylaxis was audited against four BCSH criteria:
1. Pneumococcal polysaccharide vaccine (PPV) boosters every 5 years
2. Hib/Men C one-off vaccine
3. Influenza vaccine, annually
4. Life-long prophylactic antibiotics

Results: Cycle-1: Five patients were identified. All five (100%) met criteria 1, 2, and 3. Two patients (40%) achieved criterion 4, but three were prescribed the wrong dose of penicillin V.
Outcome-1: Patients not on the appropriate antibiotic dose were recalled and prescribed the correct dose.
Cycle-2: Eight patients were identified. All five of the previously audited patients met the 100% standard in all criteria. Three new patients were identified, none of whom met any of the criteria. These patients were identified as the practice updated its database of patient notes on Vision.
Outcome-2: A practice protocol was developed, aiming to improve the identification of post-splenectomy patients and ensure they are offered the appropriate prophylaxis.

Conclusion and implications: In one practice, we found that standards of prophylaxis in post-splenectomy patients were not being met. Annual audit resulted in the introduction of a protocol, based on the BCSH guidelines, and has improved the management of post-splenectomy patients.
**067 - Education**  The General Practice Nurse Foundation Pilot Programme: establishing an educational framework for nurses in general practice

Sandy Tinson1, Anne Moger1, Wessex Deanery, Otterbourne, Hampshire, Oxford Deanery, Oxford, Oxfordshire

The General Practice Nurse (GPN) Foundation Pilot Programme was developed to address the areas of recruitment and competency in the GPN workforce. It aimed to provide nurses who had never worked in general practice, with a base line competence in the GPN role, through a theoretical framework and work based learning. The pilot programme provided an innovative approach; giving nurses a structured and quality assured career pathway from secondary to primary care nursing.

Three cohorts of nurses (34 in total) were placed in established training practices across the Oxford and Wessex Deaneries. They were employed by the practice for one year on a Band 5 salary and a percentage of this salary was reimbursed by South Central SHA. Practices were also awarded a training allowance equivalent to that for GP training. The programme was accredited at graduate level and provided by Plymouth University (2008/9) and Bucks New University (2010).

In the absence of any mandatory training for GPNs the programme:

- provided nurses with the skills to function as competent and confident GPNs
- enabled nurses to find employment
- demonstrated real benefits in preparing experienced GPNs with a mentorship qualification, enabling them to sign off nurse competency.
- demonstrated the optimum length and content for a Foundation Programme.

As a result of this pilot programme, South Central SHA is now committed to supporting a standardised, accessible and structured educational framework for the non medical workforce in General Practice. This includes pre registration nurses, HCAs, as well as Foundation to Specialist and Advanced Practice.

**Conclusion:**

The amber light is useful in ensuring Learners engage with the ePortfolio early on. The time spent talking about TIDs is however, this marking schedule didn't give sufficient weight to the effect of insight which affected the 'Educational Prescription.' MGPSTP; therefore, decided to shade the RDM-p result using either a + delineating evidence of insight or - for evidence of a lack of insight. However this still didn't take account of trainee engagement in the process resulting in further modification to create the traffic light system.

**068 - Education**  How to get the most out of your trainees - The GP scholar scheme

George Gavriel1, Claire Stewart1, Akin Osakuade1, Sarah Egan1, Greg Simons1, Milton Keynes VTS, Oxford Deanery

**Aim:** To improve the standard of training for Milton Keynes GP trainees by helping trainees engage with their learning.

**Method:** We reviewed the interaction of the trainees and the Programme Director (PD) team. This revealed no formal process was available for trainees to feedback to the PD's to encourage adult learner led learning. The outcome was a decision to implement a scholar system, we designed a person specification for the role that would be filled by an ST3 trainee. We advertised the post to existing ST2 trainees towards the end of their ST2 year. The post is not formally remunerated although we offered training in medical education and funding to attend the UKCEA and RCGP conferences.

**Results:** A year into this process we have noted a significant improvement in the interaction of the trainees and the PD teams through a very active trainee committee implemented and chaired by our scholar. The trainees are now responsible for the curriculum of the weekly day release teaching with 30% of the teaching being trainee led and taught. There has been an increase in the performance of our trainees through improved AKT and CSA results. The role has offered the scholar an addition to their CV demonstrating leadership experience in a competitive job market. We now have fierce competition for next year's scholar within our ST2 trainees.

**Conclusions:** The scholar scheme has made a significant impact to the GP training scheme and has been very rewarding to the scholar themselves.

**069 - Education**  The Milton Keynes vocational training scheme 'Traffic Light System' for early identification and management of trainees in difficulty

Greg Simons2, Claire Stewart1, Sarah Egan1, Akin Osakuade1, Milton Keynes VTS, Oxford Deanery

**Aim:** A tool to promote the early identification of Trainees in Difficulty (TID).

**Design:** A review of the current literature showed very little that would address MGPSTP need to easily identify TID's. The RDM-p model offered a powerful and comprehensive model but needed to be adapted; from this, a simple list of descriptors to help grade the learner was devised to enable the trainers to score trainees.

However, this marking schedule didn't give sufficient weight to the effect of insight which affected the 'Educational Prescription.' MGPSTP; therefore, decided to shade the RDM-p result using either a + delineating evidence of insight or - for evidence of a lack of insight. However this still didn't take account of trainee engagement in the process resulting in further modification to create the traffic light system.

**Outcome:** A rudimentary form of the Traffic Light Tool was introduced in April of 2010. Initial feedback showed the model to be intuitive though some needed practice to allocate the RDM-p grading. Calibration was provided by the MGPSTP trainers group.

The amber light is useful in ensuring Learners engage with the ePortfolio early on. The time spent talking about TIDs is now focused to enable targeted advice to the trainee and trainer. The PDs have found it useful to keep track of trainees and plot the trajectory of learners.

**Conclusion:** The Milton Keynes Traffic Light Tool is a straightforward, intuitive diagnostic tool that provides a structured approach to tackling the issues raised with TID throughout their GP training.
**070- Education**

**Adopting a ‘team learning’ approach: GP trainee experiences at Moss Valley Medical Practice**

Rachel Handscombe, Moss Valley Medical Practice, Sheffield

**Introduction:** The pressure on training places is increasing in General Practice. More trainees are spending part of their training in general practice and GP workload is increasing. Moss Valley Medical Practice adapted its training programme in response to these factors.

**The learning environment at Moss Valley:** Moss Valley currently takes three specialist trainees and a foundation doctor. In addition to delivering patient care, opportunities to learn include individual tutorials, joint tutorials, individual and joint debriefs, participation at the weekly multiple disciplinary team meeting and fortnightly clinical team educational meetings.

**Method of evaluation of trainee experience:** Although there has been positive feedback, there is concern that reduced individual one-to-one tuition is detrimental to the training. A brief questionnaire was therefore emailed to all the trainees in the practice since August 2010 (n = 10). The questionnaire asked for grading of responses on a Likert scale and allowed space for free text. It covered areas such as learning experience, ability to negotiate learning needs, ability to achieve specific goals, whether pastoral needs were addressed, benefits of interprofessional education and development of lifelong learning.

**Reflections of F2s and specialist trainees:** The reflections of the trainees will be displayed as part of the poster.

**Future developments:** This preliminary study will highlight areas of strength and weaknesses in this learning environment. It will form a stimulus for discussion on how GP training might be developed over future years at Moss Valley and beyond.

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**071- Education**

"GPST Study Days in their future ST3 practice - is it worthwhile? - a questionnaire evaluation"

Steve Holmes, Andrew Moss, Christian Stanley, Severn GP School, Somerset

**Background:** In Somerset, the Vocational Training Scheme includes In Practice Days. These are protected study days whereby ST1’s and ST2’s attend their future ST3 practice. The aim is for trainees to familiarise themselves with the surgery, staff and gain support from ST3’s. They occur once every two months.

We wanted to assess the views on these days in practice and the extent to which they were valued. The aim was to review opinions and provide feedback to the organisers, thus enabling appropriate development of the programme.

**Method:** We produced an anonymised feedback questionnaire which was given to Somerset GP STs. There were a mixture of open and closed questions with free text areas to enable the individual to express their own ideas. These were distributed at GP VTS teaching sessions in December 2010 and were evaluated by two GPSTs. The collated results from the questionnaire were presented to a sample of local GP trainers for comment.

**Results:** We obtained a 100% response rate from STs. 86% found the days useful, 9% not useful with 5% being uncertain as to the benefits. Key themes that arose from the questionnaires were that they provided:

1. relationship development with their Educational Supervisor
2. invaluable contact with ST3’s
3. an opportunity to review development

**Conclusions:** GP STs found that In Practice Days were useful for networking within their future practice and provided valuable training opportunities.

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**072- Education**

The opinions of GP tutors teaching medical students on criteria associated with the learning environment in a primary care setting

Inderpreet Kaur, Beverley Lucas, University of Leeds, Leeds

**Introduction:** The importance of community based medical education for undergraduate and postgraduate provision is now embedded within curricular design. Practices supporting a range of learners from different stages and teaching programmes might face different sets of quality criteria. To address this issue, Cotton et al (2009) carried out a study in which a set of core quality criteria for practice-based teaching were devised.

The aim of this study was to explore GP tutor views of these criteria from a practice perspective within the locality.

**Methods:** The opinions of GP tutors were sought via an online scaled response questionnaire with opportunity for qualitative free text comments. All GP’s who teach Medical Students within the locality were eligible for inclusion. Approval for the educational evaluation was obtained and an information letter addressing ethical issues accompanied the data collection approach. Data was analysed using a statistical package (SPSS), multiple regression analysis modelling and thematic qualitative analysis.

**Results:** Quantitative and qualitative data will be presented that outline themes associated with the quality criteria including; physical environment, learning environment, tutor characteristics, patient involvement and university department responsibilities.

**Discussion:** The domains of characteristics generated as a set of quality criteria have not yet been explored within a local practice context. A key strength of this study is the exploration of GP practitioner perspectives of the appropriateness and practicality of criteria generated for practice based education.
073- Education

Case load and learning experience of a foundation year 2 doctor in primary care

Kristian Mears, Rhys Davies1, Jamie Martin1, Richard Deferrars1, 1Hartley Corner Surgery, Camberley, 2Frimley Green Medical Centre, Frimley

Introduction: During the FY2 year, trainees have the opportunity to spend four months in General Practice. This period seeks to develop key themes from the Foundation Curriculum, particularly good clinical care, communication skills, maintaining good medical practice, maintaining trust and life-long learning. Our local programme has developed guidelines in order to promote coherence to the learning objectives. An audit was undertaken to assess compliance to guidelines.

Methods: Over 4 months from 2nd December 2009 to 6th April 2010 every appointment was prospectively recorded following a predesigned protocol. This included the age, sex, theme, and origin of the consultation.

Results: There were 472 clinical contacts, 47.2% male and 52.8% female. 31.8% of patients were under 18 years, 61.9% were aged between 18 - 69, and 14.6% aged over 69. 42.2% were taken up with routine administrative work. 77.5% were new consultations, 13.6% were personal follow-up, and 8.9% were other doctor follow-up. The most common presenting complaints were respiratory medicine, ENT & dermatology.

Discussion: These results support the stated objectives of an FY2 placement in General Practice. The working week was constructed to provide a core of clinical sessions, supported by dedicated teaching and the opportunity to pursue areas of specific interest. Weekly teaching had a planned timetable which adequately covered the principle consultation themes and supported the learning experience. Chronic disease exposure was focused on diabetes and obesity, in which a prospective screening study was performed. The PMETB survey of FY2 doctors in our scheme gave a higher than average overall satisfaction.

074- Education

An idiots guide to being a GP Registrar

Alexandra Watts1, Aarti Jivanji1, Nitesh Singh1, Karin Kadlecikova1, Sumit Gokani1, 1UHL, Leicestershire

During the first few months of training there is a lot of confusion as to what is expected of trainees. As trainees in the LNR deanery the majority of information we could get was from senior colleagues. We thought it would be useful if we could put all information together in a booklet that could be distributed to ST1’s. We designed a booklet and presented it to our small group at teaching. Feedback gained was positive and it was felt that having something like this would have been useful at the start of training. The booklet includes; how to get onto the Performer’s List, Consultations, Tutorials, Video consultations, Home visits, Travel expenses, Parking, Half-day teaching, Out of Hours, working time regulations, holiday, e-portfolio, workplace based assessments, travel expenses, subscriptions to professional defence organisation, referrals, fitness for work, useful websites, single point of access, the exams that are needed during training and 2 lists for medical bag contents.

It is hoped that this information will be disseminated to all new LNR trainees in August – both electronically and hard copy and in the future this could be used throughout the regions to help GP trainees find their feet.

075- Education

Debriefing of GP trainees following Out of Programme Experience (OOPE) in a low/middle income country

Clare Hollister1, Faye Harrison1, Rachel Pagnamenta1, 1School of Primary Care, Severn Deanery, Somerset

Debriefing after working in a low/middle income country is recognised as an important process in helping individuals integrate their experiences into their life and work in the UK. It is recommended as best practice 1 and most humanitarian organisations arrange debriefing for their staff. Debriefing is helpful in valuing an individual’s efforts, reducing feelings of isolation and stress, resolving challenging clinical, ethical and governance issues, identifying learning points and helping people to move forward. It is a form of reflective learning. Since the publication of Lord Nigel Crisp’s report in 2007 2 and the Gold Guide 3, an increasing number of Deaneries have made it possible for GP trainees to take OOPE in low/middle income countries. Personal debriefing may not always be offered to them on return to the UK. In the Severn Deanery, we are exploring ways in which structured and appropriate debriefing can be incorporated into the GP specialty training programme in order to improve the trainee experience after OOPE. Our poster discusses the implementation of this programme and makes recommendations that will be of interest to other Deaneries.

2 Global Health Partnerships: The UK contribution to health in developing countries; Lord Nigel Crisp, Department of Health 2007

076- Education

The Italian Job

Lucy Loveday1, University of Bristol, Bristol

Supported by WONCA Europe and the European Academy of Teachers in General Practice (EURACT), the Hippokrates Exchange programme is designed to enable young and future Doctors specialising in General Practice/Family Medicine to participate in an exchange with others across Europe. This initiative promotes best practice through the exchange of ideas and collaborative working. It also serves to enhance European co-operation, through the creation of new friendships and inspiring the acquisition of skills.
As I was fortunate to participate in a Hippokrates Exchange to Trento, Italy in July 2011, this account of Italian General Practice is based upon my personal experience and hopes to offer valuable insight into the similarities and differences between General Practice work and training in Italy and the UK.

**077 - Education**

**Evaluation of the NHS South Central-Cambodia health link**

**Chris Smith**, 1Imperial College, London

**Introduction:** In 2008, NHS South Central launched a new initiative entitled ‘Improving Global Health’ (IGH), aiming to both provide leadership development for NHS staff and contribute towards sustainable improvement in health developing countries. Partnerships have been formed in Cambodia, Tanzania and Kenya. Over 30 UK health professionals, including a number of GPs, have had placements with link organisations.

There has been a recent expansion in the number of links between UK health institutions and developing countries. At the same time there have been calls for stronger evidence on which types of interventions are effective.

**Aim:** The aim of this study is to evaluate IGHs development aim, drawing examples from the family planning workstream in Cambodia; a new service initiated by the link between NHS South-Central and the Maddox Jolie-Pitt (MJP) foundation.

**Methods:** The evaluation focussed on process and outcomes, using qualitative methods. Semi-structured interviews were conducted with Cambodian health workers, the Ministry of Health, and the local community served by the health link. The framework method was used for analysis. The evaluation also included a review of monitoring data relevant to the family planning workstream.

**Results:** Although achievements were modest, the findings suggest that changes in health services and practices of Cambodian health workers can reasonably be ascribed to the IGH scheme. Issues of ownership, alignment and harmonisation were raised.

**Discussion:** This study contributes to the literature on the effectiveness, impact and evaluation of health links. A number of areas for future study exist.

**078 - Education**

**Overview of Leonardo Hippokrates Exchange Programme in the UK**

**Soleman Begg**, 1Sandeeper Geeranavar, Madeleine Ginns, Luisa Pettigrew, Vikesh Sharma, 1RCGP Junior International Committee, London

This poster will give an overview of the organisation and benefits of the Leonardo Grants promoting the Hippokrates Exchange Programme. The RCGP Junior International Committee Exchange Group applied for funding from Leonardo da Vinci Programme in February 2010. The Leonardo Mobility Grant is part of the European Commission’s Lifelong Learning Programme. This enabled 30 funded two-week-long observational placements to occur in a GP surgery within one of 10 different European countries, within the Hippokrates Programme. The exchanges take place between January 2011 - April 2012.

Hippokrates is an exchange programme for medical doctors specialising in Family Medicine/General Practice and junior Family Doctors/General Practitioners (within 5 years of completing specialty training). The programme is supported by WONCA Europe and by the European Academy of Teachers in General Practice (EURACT).

The Hippokrates exchange offers a unique first-hand opportunity to learn about another primary healthcare system, and can be a stepping stone to further international experiences. It aims to encourage exchange and mobility among GP trainees and GPs within five years of CCT. Thereby it offers a broader perspective to the concepts of General Practice/Family Medicine at both professional and personal levels.

‘Leonardo Mobility Programme’ initiatives enable people to train in another country, co-operate on projects to transfer or develop innovative practices, and form networks focusing on topical themes in their sector.

The aim is to make vocational education more attractive to young people and, by helping people gain new skills, knowledge and qualifications.

**079 - Education**

**GP Out of Programme Years (OOPE) and the issue of sustainability:** introduction of a nursing award in rural Uganda

**Rachel Pagnamenta**, 1Severn Deanery, Bath, 2St. Mary’s Surgery, Timsbury, Bath

Increasing opportunities exist for GP trainees to undertake out of programme experience in low/middle income countries. Working in such settings can help trainees develop skills like dealing with diagnostic uncertainty and independent decision making. Crisp states that healthcare schools should work to ensure placements in developing countries are beneficial to the receiving country.

(1) So what can a trainee leave behind on returning to UK? In order to understand more about factors affecting morale and staff retention in a rural hospital in Uganda questionnaires were carried out amongst paediatric staff. Studies show Ugandan health workers are dissatisfied with their jobs, especially their working conditions.

(2) and that sustainability of health programmes is dependent on staff morale.

(3) Results of questionnaires suggested factors contributing most towards morale included financial incentives and continuing medical education. 86% of respondents stated that a monthly nursing award would contribute significantly to overall job satisfaction. An appropriate financial value and scoring system for the award were decided and the
This poster will outline the process of organising a course with an accredited Motivational Interviewing trainer and
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082- Education
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080- Education
Out of programme experiences (OOPE) in developing countries is swiftly being recognised as an important
devotional opportunity for GPs as part of their training. This benefits the host institution as well. Clinically, these
placements provide a valuable opportunity to learn first hand and increase awareness of the challenges of working in
developing countries. Working in a foreign country promotes respect for cultural differences, improves flexibility whilst
sharing knowledge with a multitude of professionals from diverse healthcare backgrounds. Shared experiences can lead to
protocol development with local stakeholder involvement, are evidence based, and in turn leads to improved patient care
within resource constrained environments. OOPEs also contribute to enhancing personal development for the individual
and improves leadership skills, confidence building and team working leading to an extremely rewarding experience
overall. Tropical diseases are not uncommon in the UK and its prevalence is gradually increasing given present day travel,
immigration and to some extent resurgence of infectious diseases secondary to immune deficiency disorders. Despite lack
of adequate training, GPs are expected to draw on limited experience to accurately diagnose and treat these conditions.
The UK Junior International Committee has always endorsed the benefits of OOPEs, recognising the benefits it brings to
all involved and GP Speciality Schemes are encouraged to allow trainees to participate in OOPEs. UK general practice
gains overall from having individuals with these additional skills and experiences. The authors here look at positives of
OOPEs from the personal experiences of those who have taken part in various programmes.

Hurdles to consultation skills for new GP trainees
Lindsay Moran1, Brian Nicholson1, Wan Ley Yeung1, "Yorkshire and Humber Deanery, West Yorkshire
In 1957 Balint made his medical literary mark with “The Doctor, His Patient and the Illness.” Since then there have been
scores of eminent Practitioners, including Byrne & Long, Stott & Davis, Pendleton, Neighbour, Fraser and Kurtz & Silverman,
who have looked at various consultation models to better understand the doctor-patient relationship and develop good
communication to be a successful doctor.

Achieving good consultation skills takes time and understanding, both of your own ability and persona, the consultation
models, their functionalities as well as being able to effectively manage patient responses and reactions. You can spend
a lifetime perfecting this art.

Yet for new GP Trainee's this consultation model is a new way of interaction with the patient. From an early stage at
medical school you are taught history taking - starting with history of presenting complaint, past medical history, drug
history and so forth. GP consulting however steers away from this model, operating a new history taking form. The
patient's ideas, concerns and expectations form the frame for the time constrained consultation with the previous
consulting structure dissembled and positioned around the new one. Accepting and developing this new entity is
challenging. The trainee is also faced with reduced senior involvement with their patients than in hospitals and the need
to approach unknown community services to aid in management.

This poster looks at the various hurdles and ways in which the curriculum aims to overcome these.

Teaching motivational interviewing to general practice trainees
James Tanner1, Ann Boyle1, Tim Millward2, "Brandon Unit, Leicester, "Bradgate Unit, Leicester, "Evington Centre, Leicester
Motivational interviewing is a client centred therapy which incorporates elements of Carl Rogers' work, Festinger's
theories of Cognitive Dissonance and Cognitive Behavioural Theory. Motivational Interviewing and its off-shoots, the
Drinkers Check Up (DCU) and Motivational Enhancement Therapy (MET) have been successful in the field of addictions
and more recent research has shown its effect can be extended into general health promotion, including weight
loss, blood pressure control and cholesterol reduction. Therefore it is not necessarily a skill unique to psychiatrists and
psychologists. In comparison to other therapies, Motivational Interviewing is often effective in a shorter time, making
it an effective skill for the General Practitioner (GP) to learn. It can also facilitate the transition from the patient in the
general practice setting into more formal addiction services, making it a powerful tool in primary care.

This poster will outline the process of organising a course with an accredited Motivational Interviewing trainer and
delivering the training to a selection of GP trainees via a two day course. It will present their feedback on the course
in terms of acceptability and practicality of the course to their everyday clinical work and include trainee's views on the
training and its relevance to GP training. Trainees improve in terms of confidence when talking to clients with drug
and alcohol problems and find it a worthwhile experience learning this valuable skill. They value the course and find it
appropriate to their place of work.
### 083- Education

**Exploring non-verbal communication with trainees for general practice**  
Sandy Miles, Samantha Scallan, Johnny Lyon-Mars, GP Education Unit, SUHT, Southampton University Hospital Trust

**Background:** Communication skills development is one of the cornerstones of training for general practice. The subtleties of non-verbal communication can add much to a consultation (Mears and Sweeney (2000); Byrne and Heath (1980)), but is an area trainees may struggle with or lack awareness of the significance (Endres and Laidlaw (2009)). Anecdotal evidence suggests that with an increasing emphasis on the assessment of performance of trainees through simulated surgeries, there can be a mismatch between the spoken interaction and non-verbal communication and this is emerging as a failure in failing to pass such assessments.

**Summary of Work:** The aim of this project was to design a teaching package on nonverbal communication which would raise the awareness of trainees to their own non-verbal behaviour in the consultation and to help them to tune into patient behaviour. The teaching resource was developed over several months, drawing on observations of early pilot sessions, expert input and discussion amongst educators about incorporating resources that could maximise learning.

**Summary of Results:** The poster will report the development of and evaluate the final teaching package within the context of the wider literature.

**Conclusions / Take home messages:** The research will consider how to harness the potential of such sessions for GP trainees, and how it can be embedded in the process of training.

### 084- Education

**Neuro-linguistic programming for successful general practice**  
Lindsay Moran, Wan Ley Yeung, Joanna Reynolds, Yorkshire and Humber Deanery, West Yorkshire

Neuro-linguistic programming, first started as a speciality in the 1970s when it was recognised that there are subtle conversational structures and superficial mannerisms for how people communicate. The way in which people talk, act and display their gesticulations gives a blueprint to how their brain operates. Tapping into this lets us know how we as individuals operate but also allows us to read other people, letting us know essentially what makes them tick. Knowing how an individual processes information can allow us to adapt our communication, personalising our traits and responses to invoke more of a motivational response in another person aiding the therapeutic suggestions. People are generally categorised into audio-digital, auditory, kinesthetic and visual.

Knowing how the mind operates also lets you focus to overcome mental barriers and achieve success. When NLP was invented the characteristics and personalities of successful people were analysed, one thing they all had in common was that they believed and knew they would be successful in what they did. This self-belief and confidence allowed them to succeed. Manipulating this can be the key to your own success as an individual and in clinical practice.

### 085- Education

**A combined linguistic and medical approach to improve written and verbal communication skills for international medical graduates**  
Ann Smalldridge, Duncan Cross, REACHE North West, Salford Royal Foundation Trust, RLC Surgery, Radcliffe, Bury

Our organisation provides education, training and support for internationally trained Refugee and Asylum seeking Health Professionals (RHPs). International Medical graduates (IMGs) may have many difficulties adapting to the NHS and several studies have identified effective communication as a challenge facing IMGs. This includes straightforward language barriers but also more complex issues relating to picking up non-verbal cues and concerns about different cultural protocols.

Communication difficulty can take many forms - language (e.g. grammar, use of idioms, tenses and pronunciation), clinical e.g. the content and structure of information required by a clinician and cultural e.g. how to address a consultant when you wake them in the middle of the night. Many of the learning needs are hidden.

A team of language teachers and clinicians ran a course for IMGs to improve written and verbal communication skills in a clinical context. It included history taking, summarising and presentation skills. The training involved a series of linguistic exercises placed in a medical context which were then applied to a clinical context using simulated patients and ‘mock’ records.

The combination of language and clinical tutors meant that analysis of communication difficulties could be made from different perspectives and detailed, specific feedback could be given to each student in these areas. Sometimes small adjustments to syntax, pronunciation and context improved the effectiveness of communication.

This strategy can be applied to other communication problems.

### 086- Education

**First 5 Launch - a look at Yorkshire and East Anglia**  
Lindsay Moran, Hussain Gandhi, Gary Howsam, Yorkshire and Humber Deanery, West Yorkshire, East Anglia Deanery, Cambridgeshire

Following the official launch of First 5 at the RCGP Conference in October 2010, the 31 faculties have each been promoting this concept, feeding into a national network detailing their work.

This poster looks at the achievements in Yorkshire and East Anglia to promote First 5, working within the frame of the five pillars - connecting with the college, promoting networks, career mentorship, encouraging CPD and support to revalidation.
### 087 - Education

**The value of actors to teambuilding and development of the primary healthcare team**

**Samantha Scallan¹, Johnny Lyon-Mans³, Carrie Hamilton¹, Sarah Wilding¹, ¹GP Education Unit, Southampton University Hospital Trust**

**Background:** Actors have been used for many years in the training and formative development of doctors. This project builds on earlier work (Lyon-Maris and Burrows (2009), Scallan et al (2011)), using actors to help build and develop the wider primary care team. The aim of the training is to give the front of house primary care team experience in dealing with challenging patient encounters, and to test out their responses to emergency situations in a high-impact training session.

**Summary of Work:** An evaluation was undertaken to i. look at the method and process of the sessions and ii. to gather feedback from participants. Observational data was collected at a sample of training sessions, along with written feedback from participants. The data were analysed to provide an evaluation of the usefulness of the approach and method, and to identify how this type of training may be developed further.

**Summary of Results:** This project is on-going. The poster will share the findings of an evaluation of this method of using actors in the development of the wider primary care team and give an overview of the novel process.

**Conclusions / Take home messages:** The project considers how to harness the potential of simulation for the wider primary care team, and how it may be integrated into the working day of a practice.

### 088 - Education

**Improving the spread of GP appraisals throughout the year - a pilot of two strategies**

**Alethea Peters¹, Susi Caesar¹, Samantha Scallan¹, ¹Wessex School of General Practice, Winchester, Hampshire**

**Background:** What is already known in this area: End of year ‘bulking’ or ‘bunching’ of appraisals in the last quarter of the appraisal year (January - March) is a commonly recognised problem across the UK’s Primary Care Appraisal and Revalidation Services. The aim of this innovation was to reduce the number of appraisals occurring in the last quarter of the year.

**Summary of Work:** What this research adds: Two different methods of bringing appraisal dates forward in the year were piloted. The ‘Term’ method and ‘Bring Forward’ month method. Overall both methods led to a reduction in the number of appraisals in the last three months of the appraisal year, reducing the pressure on the appraisal system. However, although the outcomes were similar, there are some major differences between the two methods which have implications for those managing Appraisal Services.

**Conclusions:** The ‘Term’ method was found to be a successful strategy to move appraisals for services which have a large degree of appraisal bunching. It was found to be a much more interventionist approach which, although more disrupting for the appraisees, and more complicated to implement for the appraisers and administrative team, led to the greatest reduction in bunching at the end of the year. The ‘Bring Forward’ method was found to be better suited to smaller ‘tweaks’ of the system.

### 089 - Education

**Meeting the educational needs of GP retainers: time for change?**

**Tabitha Smith¹, Mark Taylor¹, Ian Wyer¹, Chris Elfes¹, Samantha Scallan¹, ¹Dorset GP Centre, Bournemouth University, Bournemouth, Dorset, ¹Wessex School of General Practice, Winchester, Hampshire**

**Background:** What is known in this area: The GP retainer scheme has long been recognised as providing a way to maintain the participation of GPs in the workforce at a time when raising a young family impacts on availability for substantial practice, particularly for female doctors. The scheme is intended to allow flexibility in clinical service, without the need to participate in the additional business/administrative side of running a practice. Difficulties with the structure of the scheme and issues over employment terms are well recognised, and calls for them to be addressed have seen the scheme evolve over time.

**Summary of Work:** What this research adds: In Dorset there has not been any formal educational activity specifically aimed at the needs of retained GPs. With funding from the Wessex Deanery, a programme of meetings was set up to facilitate addressing the educational needs of these doctors. The programme was made up of themed sessions and small group discussion. Outside speakers were used for two sessions, and the facilitators resourced and ran the other meetings. Feedback from participants was gathered by questionnaire.
Conclusions: The sessions on complaints and revalidation were rated as the most useful. All the participants found the discussion sessions very useful or useful. Participants were asked what the most useful outcome of the sessions were for them, responses referred to ‘support,’ ‘stimulating discussion’ and ‘sharing.’ Since the end of the formal programme of sessions, the retainers have continued to meet on a monthly basis and the group is now self-facilitating.

Background: The registrar year of GP training is daunting. Registrars can struggle to identify sources of help for:
- Their own education and professional development
- Accessing patient services
- Sourcing information and education for patients regarding their own health.

Summary of work: GP trainees’ views were sought regarding the need and/or usefulness of a scheme to collate information into a guide for GP trainees, and the format of the resulting “handbook.”

Summary of results: There was varying opinion amongst GP trainees on the amount of information available to them. Unmet needs were identified, including ‘difficulty finding information to give to patients or to aid their own learning.’ The majority of trainees felt they would benefit from a “handbook” containing this information.

Conclusions: The handbook has been produced under the title (Dorset GP Infonet), as it is an online resource. It is divided into sections addressing local services, patient resources, and professional resources. We present sample pages from the handbook, available to trainees starting their registrar year in August 2011. To encourage regular use, it will be available as part of the Dorset GP School website with a home page and with direct links to key sites.

Take-home message: We identified areas in which GP trainees and their patients would benefit from information and collated this in an easy-reference guide.

This website gives working clinicians easy and effective access to resources that meet their day to day educational requirements. We are not aware of any similar educational site.

Clinicians are flooded with information on a huge number of national and regional courses and presentations, but do they get the practical tools and solutions they need?

Orthopaedics has been highlighted as a local issue. Shoulderdoc.co.uk collected 115 different shoulder examination tests. In two recent appraisals, doctors were unsure which ones they should use before considering whether to refer. The website narrated Power Point Presentation targeted their specific needs.

Knowledge has never been more readily available and, without the appropriate skills, more difficult to keep abreast of. The website provides links to selected internet learning sites: those clinicians who are not members of the BMA have free access to BMJ learning (via Univardis); clinicians are introduced to the TRIP database or GPnotebook.

Guidelines and templates can be retrieved instantly: Worcestershire Antibiotic Guidelines, the stroke and TIA presentation supports a new referral guideline, the Oxford Hip Score with the hip examination presentation.

Local courses and events are coordinated, high priority agendas are highlighted, discussion forums may be useful for isolated clinicians.

We have high quality search facility, video, audio and the paradigm of cloud technology – and in Worcestershire the evidence is that clinicians are using it, and managers want it too!


Introduction: The challenge of linking educational theory and applications for practice suggests a more focused need for enhancing reflective skills. This paper outlines an educational innovation that sought to foster the enhanced development of primary care educators reflective practice skills.

Methods: During an educational theory module within a postgraduate certificate in primary care education participants were encouraged to write their personal reflections within an electronic format as a means of promoting enhanced reflective practice skills. Preparation included directed learning and the use of structured models of reflection from multiple health care professional perspectives. Following the first cohort of general practitioners, a qualitative (process) educational evaluation of the innovation was conducted.

Results: The course participants were prolific in writing about their education and practice scenarios. One of the strengths of the journal entries was the scope and variety of the dialogue including exploring creative connections between theory and practice.
A community of primary care ethics researchers in the UK need opportunities to meet face to face, to share ideas, and assessment of journals have featured within much of the subject specific literature along with the requisite time required to devote to this practice. We present some of the key learning points in terms of enhancing personal skill development and facilitating reflective practice in mentorship activities.

Discussion: The inclusion of a formative journal within the educational theory module was viewed as a useful way of promoting the development of reflective practice skills, both personally and in others. Issues of access, ethics and assessment of journals have featured within much of the subject specific literature along with the requisite time required to devote to this practice. We present some of the key learning points in terms of enhancing personal skill development and facilitating reflective practice in mentorship activities.

093- Education
Using the RCGP domains of core competence to structure general practice specialty training block release teaching - the East of Scotland model
David Shackles1, Elaine McNaughton1, Donald Gemmell1, David Bruce1, East of Scotland Deanery, NHS Education for Scotland, Dundee

In 2007 with the introduction of General Practice Specialty Training programmes the East of Scotland General Practice unit restructured its traditional block release teaching programme to align with the new RCGP curriculum. Over the course of the 3 or 4 year training programme we aim to facilitate coverage of the core knowledge, skills, attitudes and expertise needed to demonstrate competence as a GP. The curriculum is used as an approach to practice. Teaching is based on clinical scenarios with registrars exploring the competencies that they require for each case using the six domains of core competence and the three essential application features. The facilitated programme delivered in the first 2 years is designed to encourage trainees to develop a methodology for tackling clinical and other problems encountered in general practice. This methodology is used to enhance their learning in the more self directed practice based year. It also encourages consistency of purpose amongst facilitators and presenters involved in our block release programme.

094- Education
Developing expertise - using the stage theory of clinical reasoning as an educational tool in training for general practice
Alison Lea1, South Manchester GP Training Programme North Western Deanery, Manchester

Introduction: Diagnostic and clinical reasoning is an essential skill. There is now an extensive literature base, from a variety of domains, which explore and explain how doctors make decisions and develop expertise. Striving to advance the teaching methods has lead to search the clinical reasoning domain thoroughly.

One model proposed by Schmidt and colleagues (1990) lends itself particularly well to small group teaching, the stage theory of clinical reasoning and has been developed for a session on back pain.

Educational encounter: Pattern recognition is an essential component of expertise and the aim was to develop this cognitive skill in a specific context. The objectives were to activate the prior experience of trainees and assimilate with illness scripts during an experiential teaching session.

Speciality trainees in General Practice were organised into small groups. The brief was to build a picture of a patient with one of the following, mechanical back pain, spinal stenosis or osteoporotic vertebral collapse.

By using an illness script as a guide, and by drawing on their own clinical experiences, a patient was created, in visual and verbal domains, was elaborated with detail and presented to their peers.

Evaluation: The initial feedback from the session was that it was enjoyable and fun. It appealed to them as their experience from clinical practice was essential. Due to the active nature of the session some were disengaged. Further longer term evaluation will be presented.

095- Education
Ethics of the ordinary - a meeting run by the Royal Society of Medicine with the Royal College of General Practitioners
Andrew Papanikitas1, Peter Toon1, Paquita De Zulueta1, John Spicer1, Rhona Knight1, David Misselbrook1, King's College London, London, Queen Mary University London, London, Imperial College, London, London Deanery, London, RCGP Ethics Committee, London, Royal Society of Medicine, London

Ethics has long been recognized as an important aspect of primary health care. Accordingly, there have been calls to examine the ethical content of primary healthcare. On February 15th 2011, the Royal Society of Medicine ran a conference in association with the Royal College of General Practitioners to address this.

The day aimed to examine ethics in primary healthcare, the everyday concerns of patients and practitioners which are often neglected in ‘bioethical’ circles, and to generate discourse between academia, education and practise.

Two keynote speakers opened the event: Iona Health, RCGP president, and Deborah Bowman, senior lecturer in medical ethics and law, discussed how professionals or patients in the primary care setting may not share the assumptions, values and priorities dominating bioethical literature. We generated our discourse in three workshops: on research in primary care ethics, on issues affecting training, and on issues in practice. There were also 15 poster presentations.

A community of primary care ethics researchers in the UK need opportunities to meet face to face, to share ideas, present work and talk about literature. They need a database of researchers and literature, and a need to signpost work connected to particular methods and topics. Collaboration needs to be encouraged as successful projects involve a skill mix and more than one academic discipline. We present these and other key themes arising from our keynote lectures, workshops and poster presentations.
Education Poster Presentations

096- Education  Ethical issues for students and trainees in general practice

We report insights from a workshop at a national conference looking at the ethics of ordinary, primary healthcare situations. The conference was run by the Royal Society of Medicine in association with the RCGP.

Training for uncertainty was a key issue discussed. Uncertainty of diagnosis and outcome was seen as a key feature of general practice and distinguished from concepts of probability and risk. Uncertainty can be ‘traded’ between doctor and patient. Tolerance of uncertainty has the potential to make clinicians seem vulnerable or complacent. However, chasing a diagnosis at all costs may also be harmful. Dealing with uncertainty is a key generalist skill, along with dealing with complexity and caring for patients over extended periods of time.

Learning to think was a skill the group considered important with regard to ethics. The duty of care was discussed and illustrates this: How is the duty to the patient in the consultation balanced against the duty to all the others who are waiting, on a GP’s personal list, registered with a practice or within the primary care trust boundary?

The workshop felt that learning is a right and a duty in primary healthcare. The group discussed the idea that is a right not to be prevented from learning, but learning does not necessarily entail teaching. The workshop felt that patient contact is best way of learning about everyday ethics. We hope that this presentation will generate further discussion at a time when the role and ethical boundaries of General Practice are being renegotiated.

097- Education  The Migrant Health Guide – an online resource for primary care practitioners
Karen Wagner1, Jane Jones1, 1Travel and Migrant Health Section, Health Protection Agency, London

The last Census in 2001 showed that 8% of people living in the UK had been born abroad. Whilst the majority of these migrants are young, healthy adults, some will have health issues relating to their country of origin, their reasons for/ experience of migration, and/or their living conditions in the UK. Primary care practitioners in the UK may consequently be caring for patients who have health issues with which they are unfamiliar.

The migrant health guide was developed as an online tool, to provide a one-stop-shop for information relevant to migrant patients, bringing together guidance and resources in an easily accessible format. It was launched by the Health Protection Agency in January 2011 www.hpa.org.uk/migranthealthguide.

The countries A-Z section allows practitioners to look up the country of origin of a patient during a consultation and see key messages relevant to their care such as which infectious disease tests are recommended, and which nutritional deficiencies, or cultural practices such as female genital mutilation are prevalent in their country of origin. Translated patient information leaflets, and links to relevant support charities and help-lines are included on topic-specific pages. In addition further information about language and interpretation, cultural awareness and NHS entitlements is available within the guide, as well as a suggested supplementary new-patient checklist for patients from abroad.

The guide is continually evolving as new topics and resources are added. We hope that it will aid GPs and practice nurses who are caring for patients from diverse ethnic and cultural backgrounds.

098- Education  Mental health education for GPs in the UK
Lisa Hill1, Ian Walton1, 1Staffordshire University, Stafford

Education of GPs in mental health has so far been delivered mainly by psychiatrists. GPs want to learn about somatisation, psychosocial problems, difficult patients, stress management and how to prevent burnout, however psychiatrists emphasise diagnostic criteria and medication for disorders such as schizophrenia, bipolar disorder and depression. (Hodges et al. American Journal of Psychiatry 2001)

Solution: A Module and a Diploma providing key skills and tools that can be effectively used in a 10 minute consultation together with a fully integrated university and RCGP accredited Masters Program that develops the GP leaders to teach and develop training and mental health services in Primary Care. Learning that is Values and Case Based and taught by local experts including patients. An educational style based on reflective learning and focused on helping GPs meet their revalidation requirements and anticipated needs (Andragogy)

Outcomes: Practices who had a GP attend the diploma training demonstrated a reduction in referrals to secondary care compared to practices who had not (PCT data). Our education resulted in over 500 patients being discharged from psychiatry back into primary care through a local LES that was failing prior to the education package (Midlands PCT) Defines the roles of GP and those of the psychiatrist. Promotes clinical leadership role for Primary Care. Engages attendees and increases their understanding, empathy, confidence and self reported increase in skills. (Attendees feedback) Reduces stigma and contributes to excellent Clinical Governance

099- Education  Training and action for patient safety: patient safety skills for GP registrars
John Bibby1, Beverley Slater2, Victoria Robins1, Serwaa McClean1, Jo Buchanan1, Sarah Allum1, 1PEAKSpartnership Ltd, West Yorkshire, 2Yorkshire & Humber Health Innovation and Education Cluster, West Yorkshire, 3Bradford Institute for Health Research, West Yorkshire

Education of GPs in mental health has so far been delivered mainly by psychiatrists. GPs want to learn about somatisation, psychosocial problems, difficult patients, stress management and how to prevent burnout, however psychiatrists emphasise diagnostic criteria and medication for disorders such as schizophrenia, bipolar disorder and depression. (Hodges et al. American Journal of Psychiatry 2001)

Solution: A Module and a Diploma providing key skills and tools that can be effectively used in a 10 minute consultation together with a fully integrated university and RCGP accredited Masters Program that develops the GP leaders to teach and develop training and mental health services in Primary Care. Learning that is Values and Case Based and taught by local experts including patients. An educational style based on reflective learning and focused on helping GPs meet their revalidation requirements and anticipated needs (Andragogy)

Outcomes: Practices who had a GP attend the diploma training demonstrated a reduction in referrals to secondary care compared to practices who had not (PCT data). Our education resulted in over 500 patients being discharged from psychiatry back into primary care through a local LES that was failing prior to the education package (Midlands PCT) Defines the roles of GP and those of the psychiatrist. Promotes clinical leadership role for Primary Care. Engages attendees and increases their understanding, empathy, confidence and self reported increase in skills. (Attendees feedback) Reduces stigma and contributes to excellent Clinical Governance
**Background:** Patient safety is a major issue costing lives as well as millions of pounds. Positive and sustainable changes in safety culture are needed and require behavior change of individuals and organisations. Training and Action for Patient Safety (TAPS) is an exciting and innovative programme developed by Yorkshire and Humber Health Innovation Education Cluster (HIEC) designed for general practices working alongside hospitals and mental health services to improve patient safety through action learning.

**Method:** The programme was paced over 20 weeks requiring 2.5 days out of the workplace. Each participating practice identified a multi-professional team of 3-5 including GP Registrar, GP Trainer and others such as receptionists, nurses, practice managers, or pharmacists. Individual on-line learning was followed by team-based action learning in multi-professional workshops. Teams worked on a safety topic important to their practice, formulating and instigating an action plan. Teams from across a healthcare economy participated together, and provided supportive peer review. Run charts derived from data collected weekly were used to analyse and measure changes. Follow-up interviews and multiple-choice-questionnaires assessed change in participants' knowledge, skills, and attitudes.

**Results:** In the pilot 8 out of 11 teams demonstrated improvement in patient safety practices. Communication skills and multi-disciplinary teamwork were reported to have improved. Both junior and senior members of staff referred to TAPS providing a toolkit of transferable skills for making and measuring changes to patient safety that can be used in different environments and for different problems. TAPS can provide valuable additional learning for GP Registrars.

**100- Education**

**The evolution of patient involvement in primary health care, and how this relates to UK health reforms, general practice and GP education**

Jill Wilson¹, Charlotte Wilson², ¹School of Primary Health Care, Severn Deanery; Severn, ²Richard Huish Sixth Form College, Taunton, Somerset

Since the beginning of the NHS there has been much discussion of patients rights and responsibilities, and patient involvement remains integral to the current significant political reforms, with communities expected to be involved in the planning, delivery and monitoring of Primary Care services in the future.

The historical perspective is here reviewed, with a 'timeline' for the the rise of ‘patient power’ in NHS care, showing how this is linked to past and current health care reforms and to developments in primary care in general and to education for established and would-be GPs in particular.

Past interactions between political policies, public opinion and professional bodies representing the education of GPs are explored and evaluated.

If patient involvement is to be effective in the continuing development of primary health care and its practitioners then it is important that the lessons of history are learned.

**101- Education**

**Warts and all - the delivery of minor surgery in primary care.**

David Matthews¹, ¹University of Manchester, Manchester

**Background:** From curettage to sclerotherapy, minor surgery affords the general practitioner an opportunity to deliver cost effective surgical procedures in primary care whilst achieving high patient satisfaction rates. This report studied the minor surgical procedures available in primary care, the incentives for their provision and the trends developing in their availability.

**Methods:** A literature review was carried out, including current NHS policy and guidelines. Particular focus was given to the revised G.P. contract of 1990 and the Directed Enhanced Services Scheme introduced in 2004.

**Results:** Minor surgical procedures can be classified as additional services and directed enhanced services (DES). Additional services include cryotherapy, curettage and cauterisation. DES are subclassified as steroid injections, invasive procedures and injections of varicose veins and piles. There is no direct remuneration for the provision of additional services. DES receive direct payments from Primary Care Trusts.

**Conclusion:** The provision of minor surgical procedures in primary care is being guided by the costs involved in their delivery, skills and facilities available at individual practices and remuneration received. Larger practices are more likely to make the capital investment necessary to provide a more comprehensive range of procedures. Large centres of excellence in primary care are set to dominate the delivery of minor surgery in the future. This will allow for economy of scale, fewer referrals to secondary care, increased patient satisfaction and a more effective and efficient provision of community surgery.
### Practice/Project Poster Presentations

**102- Practice**

**Migrant health screening in general practice**

**Alison Callaway**, \*The Meridian, Coventry*

At our specialised practice for asylum seekers and refugees, all newly registered patients have a comprehensive nurse assessment which seeks information on family and social circumstances, language, current and past health, and immunisation status. Screening questions are asked concerning TB, mental and sexual health, including, for women, past history of female genital mutilation. Blood tests are offered for hepatitis B and C, syphilis and HIV, with accompanying information and counselling. Mantoux testing is carried out.

Effective arrangements for follow-up of screening results are essential. This entails good communication with and referral pathways to sexual and public health services.

Non-immunised children and adults are given *catch-up* immunisations as per the WHO protocol. BCG vaccinations are administered where indicated.

Pregnant women with FGM are referred for shared care early in pregnancy so a reversal procedure can be arranged if necessary. In addition, female children of women who have undergone FGM are regarded as potentially at risk of having this procedure, and parents are counselled on the illegality of FGM.

Refugees have often experienced traumatic events, including in some cases torture in their countries of origin, and may be very affected psychologically. We have developed links with other services and agencies that can support such patients, including the Coventry Refugee and Migrant Centre, which offers specialised therapeutic services.

It is important that when they first arrive in the UK, the specific health needs of refugees are recognised. A screening protocol, such as the one outlined above, represents a systematic approach to identifying and addressing these.

**103- Practice**

**Eye care and sight loss services commissioning guidance for GP consortia**


**Introduction:** The need was identified for effective comprehensive guidance for GP Consortia to support commissioning of eye care services in line with the QIPP agenda. The guidance was developed by a high-level group, in line with the aims of the UK Vision Strategy, a consensus-based, sector-wide framework of identified priority outcomes for excellence in eye health and sight loss, promoting the patient journey and experience.

**Approach/methods:** A cross-sector group with broad representation, including patients, was established to develop guidance for commissioning of innovative, patient-centred, evidence-based eye care services. Department of Health representatives attended group meetings.

A review was initiated of current guidance. From this, it was decided:

- dedicated guidance was needed to inform GP Consortia
- the guidance must be clear, relevant and have validity
- use of an electronic format to allow for ease of use and later modification if necessary
- examples of best practice should be included

Draft guidance was constructed for iterative review and amendment by the group. Final guidance and a communications strategy was agreed. Evaluation of the effectiveness of the guidance is part of the initiative and informs future development.

**Results:** Clear and concise guidance was produced and will be launched on 16th June 2011. Dissemination activity will be on-going with evaluation initiated in the late autumn 2011.

**Discussion:** The multi-disciplinary, cross-sector approach has enabled the development of useful guidance that supports the current NHS approach to commissioning. The effectiveness of the guidance will be continually evaluated.

**104- Practice**

**A case for screening for hypertension in places of religious worship in Yorkshire?**

**Mandeep Singh Baveja**, \*Shaftsbury Medical Centre, Leeds*

**Aims:** This poster will discuss whether screening for hypertension in areas of religious worship could potentially be a valid use of resources for health promotion in at risk ethnic groups who frequently are thought to present less to primary care.

This poster will discuss findings of blood pressures measurements taken of members of the Sikh community at a Gurdwara (Sikh Temple) in Leeds. Analysis of the results will present an answer to the question as to whether screening for hypertension at places of religious worship in at risk communities could potentially be a justified use of resources in the primary prevention of cardiovascular disease.

As of yet little work has been done in this area in the UK and this poster aims to discover whether or not this is justified.
**Practice/Project Poster Presentations**

**105 - Practice**

**Radiolucent staghorn delayed diagnosis and the role of different radiological modalities**

Aws Alfahad1, Paul Malcolm1, Norwich Radiology Academy, Norwich, Norwich University Hospital, Norwich

**Key learning objectives:** The visualisation of radiolucent stones, such as uric acid stone, is difficult and often missed. The aim is to demonstrate that radiolucent stone can be elusive thus a diligent search that might include CT KUB is required to reach the correct diagnosis.

**Description:** Imaging of renal calculi plays an essential role in the diagnosis, management, and follow up of patients with stone disease. A variety of image modalities are available including plain x-ray, ultrasound, intravenous urogram, computer tomogram. Patient characteristic, waiting time, and radiation dose play a part in decision making.

In our case a polycythemic patient with longstanding renal colic and microscopic hematuria symptoms had significant delayed diagnosis of radiolucent staghorn, that was not perceived on repeated KUB x-rays over ten years. Although a second US scan raised suspicions; it provided rather limited information. Traditionally, IVU was considered the gold standard for diagnosing renal calculi, but this modality has largely been replaced by unenhanced CT scan. Abdominal ultrasound remains the investigation of choice for pregnant women and children with renal colic.

In our case Computed Tomography (CT) Images reformatted in axial and coronal planes were used to demonstrate radiolucent right kidney staghorn calculus obstructing the upper pole calices. This had made a major impact on patient management who consequently had nephrostomy and ureterostomy.

**Conclusion:** Early consideration of CT scan in patients at high risk of developing radiolucent stone or with persistent symptoms.

**106 - Practice**

**Transferring care**

Yusrah Shweikh1, Emma Donaldson1, Peter Paine1, Jeremy Tankel1, Salford Royal NHS Foundation Trust, Manchester

**Background:** Good communication between health professionals is central to patient care. GPs rely on discharge summaries for information regarding hospital admissions. The contribution of inadequate discharge summaries to patient harm has been the subject of previous study1. The literature also suggests that improved communication during patient transitions may reduce readmission rates2.

**Method:** We conducted a two-year quality improvement project resulting in the creation of a new discharge proforma named the Transfer of Care (TOC) document. Key changes include a word limit for free-text entry and additional subject fields for details of medications stopped, started and those with altered doses. We audited discharge summaries on an acute medical ward before and after the implementation of the TOC document. Their quality was assessed based on prescription accuracy and the adequacy of information on medication changes.

**Results:** Before the use of the TOC document, there were prescription errors for 50% of patients discharged. In 61% of cases, documentation about drug changes on discharge was insufficient and frequently absent altogether.

Using the TOC document, prescription errors fell to 17% and in 83% of cases the patient’s GP was adequately informed about medication changes.

**Discussion:** The quality of discharge summaries in our Trust has been reliably improved using the new TOC document. We recommend all such proformas have subject fields which mandate pertinent medication information to be entered in line with the Academy of Royal Colleges guidelines3.

**107 - Practice**

**Community ophthalmology: seeing change**

Yusrah Shweikh1, Marie Clayton1, Sheila McCorkindale3, Salford Royal Foundation Trust, Manchester, Salford PCT, Manchester

**Background:** No guidelines exist on ophthalmology referrals to secondary care. Standard practice involves GOS18 forms completed by opticians being verified by GPs before specialist referral to the hospital eye service (HES). Anecdotal evidence of prolonged waiting times and discharge from specialist care without intervention suggests room for substantial service improvement.

**Audit:** GOS18 forms were analysed to collect data on reasons for referral, outcomes from clinic appointments and re-attendance for follow up. 49% of referrals resulted in discharge without treatment or follow up. A further 11% were treated with simple interventions.

Based on these findings, the PBC Operational Board approved a bid from a GP cluster for a pilot primary care-led ophthalmology clinic. Patients were seen by an ophthalmologist and referrals were triaged, offering an alternative to direct hospital referral.

**Re-audit:** The pilot was rated as a high-quality service by clinicians and yielded excellent patient satisfaction survey results. Patient comments included:

“After having been a patient at Manchester Royal Eye Hospital, the convenience of Walkden eye clinic was most satisfying.” Waiting times were significantly reduced and there was a high rate of discharge. The new follow up ratio was low and HES referrals were reduced. Overall, the service proved cost-effective and financially sustainable.

**Outcome:** These results were presented at the regional Operational Board meeting where it was decided to roll the scheme out to the PCT. This allows referrals to be made to community clinics in addition to direct HES referral. We await the feedback with interest.


**Evaluation of a community-based diabetic retinopathy screening initiative**

**Methods**

A population-based diabetic retinopathy screening programme is not available for people with diabetes in Ireland. In 2008, the development of diabetic retinopathy screening was prioritised by the Expert Advisory Group (EAG) for Diabetes. In anticipation of a national programme, a community-based screening initiative was established in the south of Ireland which utilised existing optometry/ophthalmology services. The aim of this study was to evaluate the community-based model of diabetic retinopathy screening.

**Results**

Overall 30 practices took part in the screening initiative (94%). To date, 43% of patients (n=1559) have participated and screening is ongoing. Preliminary analysis suggests <1% of patients required urgent referral (within 2 weeks) and <6% of patients required 13 week referral (n=68).

**Discussion**

This initiative addresses the well-documented need for retinopathy screening for patients with diabetes, enhancing the utilisation of existing resources in the community. Results will inform the imminent National Retinopathy Screening Programme in Ireland.

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**Screening a high risk practice population for undiagnosed Type 2 Diabetes**

**Introduction**

The burden of Type 2 diabetes is increasing and is partially attributed to rising obesity. Type 2 diabetes can remain asymptomatic for many years before diagnosis. Screening should be an effective way to reduce the burden of disease. Trials have shown that screening an older socially representative cohort reveal prevalence of frank undiagnosed type 2 diabetes of 7%. We sought to uncover any hidden diabetes or impaired fasting glucose in our practice population by screening a high risk population.

**Methods**

From a practice list of 14,382 we found 174 patients who were aged over 40, had a BMI over 40 and were not known to be diabetic. From this cohort, 81 were found not to have a fasting glucose in the previous 12 months. These patients were invited for screening by sampling fasting venous glucose levels.

**Results**

81 patients were invited for screening and 42 patients responded. 5 patients (mean age - 56.4 yrs, mean BMI 43.2) had a fasting glucose between 6.0 and 6.9 mmol/L. One patient had a fasting glucose of 8.6 (Age - 83, BMI 51.5). 36 patients had normal fasting glucose levels (mean age - 52.4, mean BMI 42.5, mean glucose - 5.4 mmol/L).

**Discussion**

We identified 5 patients with impaired fasting glucose. These patients have been counselled and had opportunity to modify their other cardiovascular and metabolic risk factors. We detected one patient with frank diabetes. However, 53.4% of our targeted population were already under screening because they are another chronic disease register.

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**Pilot project: long term glycaemic control in Type 2 Diabetes: tier 2 vs. to hospital outpatient clinics**

**Purpose**

The complex needs of patients with long term conditions ideally require local networks to operate across the care setting and be multidisciplinary. This study uses the concept of glycaemic burden to assess long term glycaemic control in patients with Diabetes, in a community based clinic compared to a traditional outpatient department (OPD).

**Methods**

Data was collected retrospectively from a historical cohort of 27 patients over a period of 2 years, 20 people treated with oral therapies, 7 with insulin, 18 males, 9 females with an average age of 65.7 SD 7.2 years. During year 1, all patients attended the OPD at King’s Mill Hospital and were followed up for a further year in the community based tier 2 clinic. Diabetic control was assessed by serial HbA1c measurements. These were taken monthly in tertiary care and every 3 months in tier 2 clinic.

**Results**

Data analysis showed that in the year following discharge from tertiary care to the tier 2 clinic most patients experienced a reduction in HbA1c, a corresponding fall in glycaemic burden. On average, respectively, HbA1c and glycaemic burden rose from 8.5% SD 1.4 to 9.5% SD 1.8 (p=0.001) and 1.05 SD 1.4 to 2.07 SD 1.8 (p=0.001) during hospital based care but fell to 8.5% SD 1.2 (p=0.001) and 1.01 SD 1.2 (p=0.003) following a transfer to community based care reflecting an improvement in glycaemic control.

**Conclusions**

These data show that effective management of type 2 diabetes can be provided in an intermediate care setting.
The sexual health needs of older people will increase as the UK population ages. With the current public health focus on younger people, there is a risk that the sexual health needs of older people will remain unmet. This is a particularly important issue for General Practitioners, as older people are more likely to consult their General Practitioner with their sexual health needs.

Healthy People (DOH 2010) outlines how a new approach is needed, which gets to the root causes of people's circumstances and behaviour, integrating mental and physical health to enable and guide people's everyday decisions, particularly at the key transition points in their lives, such as when they start or leave school.

Occupational therapy (OT) is a research-based profession that uses strategies to improve a person's ability to engage in their everyday occupations. Occupation describes activities that are performed in everyday life, including; working, learning, playing, and socially interacting. Young people often have substantial barriers that impede their ability to perform their occupations. One of the profession's core skills is to look at the person holistically, assessing physical and mental capacities as well as the individual's physical, social and cultural environments. An OT assessing all these different components that can affect their behaviour enables the young person to identify the barriers they face and equips them with the strategies to develop their resilience to overcome them.

Occupational therapy for young people with emotional and behavioural difficulties has been an area of specialisation within the profession for many years. The practice of OT draws on specific knowledge of a variety of conditions, expertise in typical growth and development, and an understanding of behaviour change determinants. Assessment and intervention is client centred and individually tailored empowering the young person to make the changes needed in order for them to engage in more positive and productive occupations.

Anonymised questionnaires completed with adolescents at paediatric clinics and sent out to young adult cohorts across 3 different hospitals in Manchester.

Results: With 50 patients in the paediatric cohort and 28 in the young adult cohort, results show that clinics are reaching national guidelines. However, the majority of teenagers are trying to hide their lack of control. To combat this, they feel that broader support is needed, for example texts between clinics, forms before clinics, mentors, social events, and group learning. Teenagers who have had diabetes for a shorter amount of time are statistically more likely to want these methods of increased support. Centres are not meeting the NICE guidelines for transition, and young adults feel that they are met too few times before transition by the adult team.

Conclusion: More support for teenagers may be useful in controlling glycaemic levels, and pilots of these different methods should be trialed. The age at transition is not always correct; there is room for implementing different methods of deciding age of transition. Stricter guidelines should exist to make the transition process more sequential.

The sexual health of the population is a major public health concern. Current policies focus on the sexual health of young adults, while the need of older people receives little attention. A review of the literature surrounding sexually-transmitted infections in older people was undertaken, looking specifically at the incidence of sexually-transmitted infections and sexual and treatment-seeking behaviours in this population group.

Over the last twenty years the number of sexually-transmitted infections diagnosed in older people has increased. Health Protection agency data shows an increase in the rate of diagnosis of all sexually-transmitted diseases in those aged 45 to 64 years between 1998 and 2007.

Advances in medicine and changing attitudes towards sex are responsible for an increase in sexual activity among older people. Older people may be at higher risk of sexually transmitted infections due to physiological changes in vaginal mucosa in menopausal women and decreased use of barrier methods of contraception.

Treatment seeking behaviour of older people has consistently shown delayed access to healthcare and a different pattern of access compared to younger people, with increased reliance on General Practitioners for sexual health problems.

The sexual health needs of older people will increase as the UK population ages. With the current public health focus on younger people, there is a risk that the sexual health needs of older people will remain unmet. This is a particularly important issue for General Practitioners, as older people are more likely to consult their General Practitioner with their sexual health needs.
114 - Practice

**Explaining rationing in primary care: prescribing for erectile dysfunction**

Gemma Armstrong1, Jennifer Black2, Pip Fisher3. 
1University of Manchester Undergraduate Medical Education, Manchester, 2Oswald Medical Practice, Chorlton-Cum-Hardy, Manchester, 3University of Manchester; Community Based Medical Education, Manchester

**Background:** According to current guidelines only patients with particular medical conditions qualify for drug treatment of erectile dysfunction on the NHS. Implementing these guidelines can lead to difficult discussions during the consultation. Failure to implement them may lead to exceeding the prescribing budget and potentially to investigation by the commissioning body.

Having a medical student attached to the Oswald Medical Practice in Manchester provided a good opportunity to review prescribing for erectile dysfunction.

**Methods:**
- A literature search was carried out to provide the practice with the evidence base needed for appropriate prescribing.
- Patients receiving prescriptions for erectile dysfunction were interviewed.
- GPs involved in prescribing were also asked for their views

**Results:**
- The understanding gained was used to produce a leaflet that can be given to patients to explain both how to use the medications prescribed and why these may be issued on a private basis.

**Discussion:**
- The leaflet should make consultations easier by improving patients' understanding of the rationale behind decision-making.

This project enabled our student to better understand not only the drugs prescribed but also:
- The cost arguments in rationing care
- The difficulties faced in the consultation when discussing the limitations to care on the NHS
- The patient perspective of a particularly sensitive issue

Students are often involved in audit but rarely in the step of implementing change. This project shows that all steps of the audit cycle can be educational and student involvement can benefit the practice.

115 - Practice

**Sex in the south of the city – Lewisham Lambeth Southwark**

Uzma Sarwar1, Ruth Hutt1. 
1Public Health, Lewisham

- The Local (Lewisham) RSH clinic reported slightly lower attendance in the last two quarter of 2010 and this report aims to investigate any possible reasons for this by looking at the following characteristics:
  - Review the demographic features of LSL in the 19 and under age group to establish whether a general decrease in population could contribute to the change in RSH attendance.
  - Report if there has been any local changes in sexual health services.
  - Attendance to other sexual health clinics, to establish if this is a local or region wide problem
  - Report on Chlamydia rates over the years to see if exhibiting of riskier behaviour as a result of lower attendance to Sexual health clinic.
  - Review the available Emergency hormonal contraceptive data- Lewisham data to ensure the rates of EHC use is not increasing conversely to attendance
  - Report if there have been any local changes in termination rates to ensure this is not a corresponding rise in terminations as related to attendance

TOP rates in LSL have historically been amongst the highest in the UK. The reasons for this have been linked to the large proportion of ethnic minorities and deprivation that affects this area. The TOP data is reviewed with ethnicity and age, showing which ethnic groups are most responsible for the local TOP numbers and showing different ethnic groups have peak TOP rates at different ages.

116 - Practice

**Prescribing Long-Acting Reversible Contraceptives (LARCs) in a community practice**

Jonathan Mills1, Mark Hage2, Marcus Bicknell2, Kirran Bilkhu2. 
1University of Nottingham, Medical School, Nottingham, 2Beechdale Practice, Nottingham

**Background:** Since 2008 the Department of Health has promoted the use of LARCs which are considered more cost-effective, even at one year compared to the costs associated with either unplanned pregnancy or the Oral Contraceptive Pill.

**Aim:** To assess the length of time patients remain on a LARC, reasons for discontinuation and identified side effects by reviewing all patients who have had a LARC fitted by a Nottingham practice.

**Methods:** Patients who had either Mirena (n=22), Implanon (n=32) or Nexplanon (n=6) fitted between 1/1/2008-25/7/2011 in a practice of approximately 4000 patients in Nottingham had their record examined.

Data on whether the patient had been screened for STIs, received LARC advice, side effects experienced, length of time and reasons for discontinuation were recorded. Data was analysed in SPSS 18.0

**Results:** 60 patients were identified. 44 (73%) had advice about contraception recorded and 14 (23%) were screened
Practice/Project Poster Presentations

for STIs, 1 had confirmed Chlamydia. Over 80% of patients continued with their LARC by one year follow-up. Common reasons for discontinuation related to bleeding (8%), patient dislike (7%) and wish to conceive (3%). Patients started on Implanon/ Nexplanon tended to be in their twenties compared to Mirena where patients were in their thirties. There was no difference in discontinuation rates between Implanon and Mirena.

**Conclusions:** Mirena, Implanon and Nexplanon are safe and effective contraceptives. Discontinuation rates were low and tended to be related to menstrual problems or patient dislike. Better recording of contraceptive advice and the opportunity to screen for STIs could be achieved.

117 - Practice

**Should GPs have a role in maternity care?**

Judy Shakespeare1, 1Summertown Group Practice, Oxford

Over the last 30 years GPs in the UK have almost disappeared from the delivery of normal maternity care. Their place has been taken by community midwives. This presentation would review the history and reasons for this change and the consequences, using the perspective of the Confidential Enquiry into maternal deaths. In addition it would focus on the joint work between the RCGP, RCOG and RCM to try to address this change. This would include reference to the Consensus Statement on the role of the GP in maternity care, developed between the three Colleges and the training and professional development consequences for practising GPs.

118 - Practice

**Pregnancy, epilepsy and drugs; a project to review what have we learnt from the UK and Ireland Epilepsy and Pregnancy Register**

Elizabeth Smithson1, Linda Parsons2, Henry Smithson1, 1Liverpool University, Liverpool, Merseyside, 2Luton and Dunstable Hospital Trust, Luton, Bedfordshire, 3Academic Unit of Primary Medical Care, Sheffield, South Yorkshire

The UK & Ireland Epilepsy Pregnancy Register (UKEPR) is the world’s largest prospective study (7,592 recruited women and 6,368 completed cases over a 15 year period from 1996). The primary outcome measure is the occurrence of major congenital malformations (MCM) defined as a structural defect found at or within 6 weeks of birth that requires medical or surgical intervention. Results show that the majority of women with epilepsy have a normal pregnancy with an uneventful outcome but many women still worry about the effects of epilepsy drugs (AED) on the foetus. The need to plan for pregnancy can be raised as part of the annual general practice epilepsy review but this opportunity is sometimes missed because of the uncertainty of what to tell the patient. The UKEPR provides evidence of the risks and benefits of various AED in pregnancy.

**Method:** An undergraduate project to review both evidence from the register and modes of action of commonly used AED to propose key recommendations for general practice.

**Findings:** There are various modes of action of AED, the actions are complex and many overlap.
AED with similar metabolites do not necessarily pose equivalent risk of MCM.
The risk of MCM with most AED is small at about 3%.
The rate with valproate is about 6.5% and rates increase in doses of >1000mg daily.
The monotherapy risk is less than with polytherapy.
Folic acid supplementation seems to have little effect on MCM.
Slow release preparations have no beneficial effect.

119 - Practice

**Ovarian cancer: is there any delay in referral at our practice?**

Simon Gowda1, 1Ashfields Primary Care Centre, Sandbach, Cheshire

Ovarian cancer carries the worst prognosis of gynaecological cancers and may initially present with non specific symptoms. An article in the BMJ in 2009 suggested that symptoms of ovarian cancer may be present in 90% of women who consult in primary care up to 15 months before diagnosis (1). I performed a retrospective study of the last 10 years of our practice patients (approximately 20,000) to find those diagnosed with ovarian cancer and to see whether there were delays in referral from the first presentation of symptoms but also to look at other markers such as how were they referred, presenting symptoms, stage at diagnosis and mortality. 22 patients were included in our study, 20 of which presented with local symptoms. The average age was 62. Abdominal/pelvic pain and urinary symptoms were the more common complaints. The average time from first presentation to referral was 1.6 months (range immediate-11 months). The majority presented as advanced cancers - stage 2 or worse. Average survival after diagnosis was 31.4 months. Overall there was no undue delay in time to referral of our patients.

1 Risk of Ovarian Cancer in women with symptoms in primary care Hamilton W BMJ 2009;339:b2998
120 - Practice

**Rare case of childhood malignant melanoma**

Melody Tsai¹, Amani Evans¹, Iskander Chaudhry², 'University of Manchester, Manchester, England;'Manchester Royal Infirmary, Manchester, England

**Background:** Malignant melanoma in childhood is exceptionally rare. Diagnosis of these lesions can be a challenge to clinicians as well as pathologists, leading to a delay in diagnosis and subsequent treatment. Such delay was reported to result in an increased mortality in up to 66% of cases. Here, we present a rare case of childhood malignant melanoma arising de novo in an otherwise healthy seven-year-old girl.

**Case:** A seven-year-old girl presented to her general practitioner with a 7 mm diameter scaly skin lesion on the right lower back, which was catching on her clothes and had bled. The lesion was initially diagnosed by several clinicians as molluscum contagiosum and subsequently, atypical dermatofibroma. After excision of the lesion and on review at a multidisciplinary team meeting, a diagnosis of severely atypical dermal melanocytic tumour, best regarded as malignant melanoma of childhood was made by a specialist dermatopathologist. The tumour had a Breslow thickness of 3.5mm and Clark's Level of IV. Further re-excision was advised and the patient was referred to a paediatric plastic surgeon.

**Conclusion:** This case illustrated that although rare, malignant melanomas can occur in children and are often diagnosed at more advanced stages as compared to adult cases. Clinicians should be aware of the potential diagnosis when faced with a changing mole. More importantly, a multi-disciplinary team approach to compensate for our current lack of experience in such cases could avoid delay in diagnosis and further maximize the benefits of treating this disease at an earlier stage.

121 - Practice

**Supporting young carers and their families: a strategy for GP practices**

Christine Slatcher¹, 'The Children's Society, London

Young carers are children and young people under 18 who provide regular and ongoing care and emotional support to a family member who is physically or mentally ill, disabled or misuses substances. A young carer becomes vulnerable when the level of care-giving impacts on his or her emotional or physical well-being or educational achievement and life chances.

The GMC (2007) stipulates that "doctors should be aware of the needs and welfare of children and young people when they see patients who are parents or carers, or who are cared for by children or young people." However, young carers can be hard to identify as many children grow into their caring role and families may be wary of involvement of support services.

This poster describes how GP practices in one county were enabled to work towards including young carers when achieving the QOF Management 9 indicator by:

- Encouraging a culture of openness enabling families to come forward for help
- Using a whole-family approach to improve GPs identification of hidden young carers
- Using the intranet for resources for information and signposting
- Identifying links with other agencies to improve multi-agency working to support young carers and their families
- Participating surgeries discovered that improving multi-agency contacts had added benefits, promoting best practice in other areas of work, especially safeguarding children.

Included in the poster presentation are resources which complement the RCGP Supporting carers in General Practice workshops and the e-learning module Supporting young carers.

122 - Practice

**Young people living in Britain in 2011: what lies ahead and what role can primary healthcare professionals play?**

Jane Roberts¹, Rachel Pryke¹, Emma Rigby¹, Lionel Jacobson¹, 'University, Sunderland, 'Winyates Health Centre, Worcester, 'University, Cardiff, 'AYPH, London

**Introduction:** Adolescence defines a period of development characterized by physical and psycho-social change. Most young people cope well with the transition to adulthood supported by families and, where available, appropriate health, social and educational services, access to employment and training. When funding for these structures is compromised health is put at risk. Youth employment is currently at its highest and 1 in 3 under 18 year olds live in poverty. The economic recession is having a disproportionate affect on young people with current policies potentially exacerbating the situation. Cuts to sexual health services, sports and leisure facilities and educational allowances for low income households will directly impact on young people's health invoking the inverse care law.

What do young people say about life in Britain today?

What is the role of healthcare professionals?

RCGP Adolescent Health Group:

- Raises awareness of and advocates for young people's health needs; is involved in multi-level education and training;
- Aims to influence national policy.

Association of Young People's Health: Is a multi-disciplinary membership organisation, aiming to raise the profile of youth health needs and to improve access to information, resources, and innovation.

**Conclusion:** Young people represent the future and have much to teach us; but they also face challenging times. Healthcare professionals, working collaboratively and mindful of the context of adolescent health can provide leadership and advocacy for policy reform which promotes health and inspires excellence of care in primary care settings.
123 - Practice

**Practice improving patient safety, the assessment of the sick child**
Sarah Allum, Jo Buchanan, Anne Baird, Janice Ellis, Porter Brook Medical Centre, Sheffield

**Introduction:** The Training and Action for Patient Safety (TAPS) project seeks to improve patient safety in the NHS in Yorkshire by involving trainees in the development of a patient safety project within their workplace. The Kennedy report in 2010 identified that some GPs have little or no experience of paediatrics as part of their professional training and it is known that inexperienced clinicians and inadequate documentation combined can create the potential for indefensible clinical errors. We analysed the assessment of the acutely unwell child in a general practice, as this was an area of concern for nurses and trainees, and identified strategies for ensuring clinicians were adhering to NICE guidance.

**Method:** The TAPS project suggests a useful model for implementing change and measuring its effect. This requires the identification of measurable parameters in this case the vital sign measurement recommended by NICE for the assessment of the sick child. Various interventions were used to ensure clinician compliance and the parameters were monitored on a weekly basis. The analysis of the parameters is repeated weekly over a 20 week period.

**Results:** Interim analysis shows a clear improvement. Initially 14% were conforming to NICE guidance, currently 80% conform.

**Discussion:** Participation in the TAPS project provided a useful opportunity for the practice to reflect on and improve the assessment of the sick child. In addition a GP Speciality trainee has been able to introduce an initiative which improved patient safety and illustrated some of the key principles of change management.

124 - Practice

**Alder Hey general paediatric clinics in community settings: experience from developing the AH@ service for Knowsley PCT**
James Burn, Margaret O’Connor, Sue Thom, Nicola Lyons, Alison Van Dessel, Mark Keegan, Rosemary Hawley, Chris Mimnagh, Alder Hey Children’s NHS Foundation Trust, Liverpool, Knowsley Primary Care Trust, Merseyside, Wingate Medical Centre, Merseyside

**Background:** Quality care closer to home is a common commissioning strategy. We describe the first 2 years of AH@ (Alder Hey at...) clinics, delivered in purpose built Primary Care Resource Centres (PCRCs).

**Methods:** In 2008 Knowsley PCT met with Alder Hey Hospital (AH) to commission delivery of general paediatric OPD care within PCRCs, and to reduce inappropriate use of tertiary specialist clinics. The provider created a virtual hospital with administrative, laboratory, radiology and clinic letter access provided in a range of sites. Paediatric equipment and documentation was reviewed, and additional resources provided. Five AH@ consultant clinics started in 2009 at 4 sites, following marketing to practices.

**Results:** In 2009 there were 246 new patients seen. Clinic numbers were reviewed and provision matched to demand; in two sites clinic frequency was reduced. In 2010 there were 50% more new patients seen, though clinic utilisation was still below hospital averages. The new/follow up ratio moved from 75% to 100% as the service matured. Satisfaction surveys have shown almost unanimous patient approval with strong preference over traditional hospital clinics.

**Discussion:** The time for these clinics to be established and become financially viable for the secondary provider was longer than expected. Benefits included easier patient access, high patient satisfaction, and stronger relationships between GPs, specialists, community nursing and related professions. The majority of new patients are seen once in an AH@ clinic for an opinion, and returned to primary care with a defined care plan, evidenced by low patient follow up ratios.

125 - Practice

**A service evaluation of the Abertawe Bro Morgannwg University Trust (ABMU) Musculoskeletal Clinical Assessment Service (MCAS)**
Emma Redshaw, Mark Ridgwell, Cardiff University, Cardiff

**Objectives:** To evaluate the effectiveness of ABMU MCAS in its first year (1st September 2009-2010).

**Study design:** Retrospective analysis of triage and clinic data. Interview and subjective observation of the extent to which ABMU MCAS meets NHS guidelines for musculoskeletal interface services.

**Setting/Participants:** Clinic data analysed for all members of ABMU MCAS team operating from two GP practices.

**Results:** 71% of GP referrals were triaged to MCAS rather than T&O. Non-attendance rates (10%) were better than the national average (12%). MRI request rates were 12%. 86% of cases were managed independently by MCAS without referring to T&O. These rates of referral are better than the 70-80% independent management recorded by other Trusts (Sefton 80%, Colchester 75%, Oxford 70%). 90% of MCAS, T&O referrals were offered surgery. 7% of patients offered surgery declined giving an overall conversion to surgery rate of 83%.

**Conclusions:** ABMU MCAS is fulfilling its objective of providing effective Primary Care management of MSK conditions, alleviating pressure on Secondary services. MCAS conversion to surgery rate (83%) meets the NHS guidelines of >80% listing of T&O referrals from specialist Primary Care MSK clinics. The low percentage of T&O referrals discharged at first out-patient appointment (<10%) suggests MCAS is decreasing the number of inappropriate Orthopaedic referrals from Primary Care. Analysis of the extent to which MCAS meets NHS criteria for MSK interface services highlighted the commencement of regular MDT meetings and case discussions, as key areas for development.
Introduction/Methods:

I. Introduction:
Many psycho-social and disease-related factors have been suggested to be associated with recurrent and long sick leaves. Therefore, clinicians reliant solely on disease related factors when issuing sick notes can potentially underestimate sick leave durations. We aimed to evaluate the association between sick leave durations following acute musculoskeletal injuries in otherwise fit workers in relation to the site of injury and other non injury related factors, especially sector of employment and work related factors.

II. Method:
Comprehensive medico legal reports (of settled cases) of workers from different employment sectors were reviewed. These reports included GP notes, hospital notes, medical investigations and results. The inclusion criteria were very strict so that only patients with pure musculoskeletal injuries were included. Information relating to workers demographics, the type of injury, site of injury, place of injury, treatment, sick leave period and hobbies were collected.

Results:
2288 reports of workers from different employment sectors were included. 88.7% of worker had simple minor injuries and almost 30% had sick leaves less than a week. Sustaining an injury in the lower limb was associated with longer sick leaves only by patients doing heavy manual jobs. Ordinary workers took longer time off work compared to their senior colleagues. Age and gender were not associated with long sick leaves.

Conclusion:
There are many non-injury related factors that are associated with longer sick leaves and these must be considered when predicting sick leaves durations. This might explains the discrepancy in sick leaves durations even for the same medical condition.

126 - Research

Sick leaves durations following acute musculoskeletal injuries; Do the sites of injury and non-injury related factors matter?
Mohammed Alsamaq1, Zeiad Alshameeri1, Mohammed Mustafa1, Dilip Malkan1, *Kings Mill Hospital, Nottinghamshire, 2Cape Hill Medical Centre, Birmingham

Introduction:
Many psycho-social and disease-related factors have been suggested to be associated with recurrent and long sick leaves. Therefore, clinicians reliant solely on disease related factors when issuing sick notes can potentially underestimate sick leave durations. We aimed to evaluate the association between sick leave durations following acute musculoskeletal injuries in otherwise fit workers in relation to the site of injury and other non injury related factors, especially sector of employment and work related factors.

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There are many non-injury related factors that are associated with longer sick leaves and these must be considered when predicting sick leaves durations. This might explains the discrepancy in sick leaves durations even for the same medical condition.

127 - Research

What patient factors influence a GP’s use of the NICE guideline in the care of non-specific low back pain?
Mahbuba Choudhury1, Tamar Koch1, *University College London, London

Introduction:
Non-specific Low Back Pain (NSLBP) is prevalent in the United Kingdom. However, its management is highly variable within primary care. Many have postulated that patient factors have an overriding influence on clinical practice. This study aimed to identify patient factors influencing GPs’ use of the NSLBP NICE guideline.

I. Method:
33-item questionnaires were sent to patients with NSLBP at three London General Practices. Medical records of respondents were compared to key recommendations in the NSLBP NICE guideline, to determine the level of guideline concordance.

II. Results:
122 respondents participated in the study (14.8% response rate); 45.1% were male with a mean age of 44.22 (SD=12.279) years. LBP advice was provided to 62% of patients, with 6.9% receiving information on recommended non-pharmacological therapies (RNT). 52.4% were inappropriately managed for RNT. Higher levels of perceived disability positively correlated with inappropriate provision of an MRI (p = 0.025), a physical and psychological combined intervention (PPI) (p = 0.003) and RNT (p = 0.004). Consulting the same doctor positively correlated with appropriate PPI provision (p = 0.000) and a referral in the first consultation (p = 0.011). Patients who felt comfortable with their doctor received their preferred treatment (p = 0.004); a referral in the first consultation (p = 0.011) and RNT advice (p = 0.05). Ethnic minorities (p = 0.044) and female patients (p = 0.035) were less likely to receive NPT. Patients with depression were negatively associated with appropriate PPI (p = 0.000) and preferred treatment (p = 0.013) provision.

III. Conclusion:
Patient factors have an influence in the management of NSLBP and need to be addressed in future guidelines, to increase compliance.

128 - Research

Efficacy and safety of prolonged release oxycodone/naloxone used in a primary care setting for patients with moderate to severe osteoarthritis or back pain
Mick Serpell1, Paul Schofield1, Anna Taylor1, Meena Jain1, *Napp Pharmaceuticals Limited, Cambridge, 2Gartnavel General Hospital, Glasgow

Introduction/Methods:
Codeine is increasingly considered too constipating for long-term use but few other opioids have undergone trials against codeine in primary care to inform prescribing. This primary care-led multi-centre, randomised, double-blind 12-week study was designed to examine analgesia and constipation, in patients given either codeine/paracetamol or prolonged release oxycodone/naloxone tablets (OXN; naloxone acts locally in the gastrointestinal tract to counteract opioid-induced constipation, without reversing the central analgesia of oxycodone). Pain scores (BS-11 pain scale), bowel function index (BFI) scores (0-100 scale) and health status regarding constipation (0-100 VAS scale) were determined at baseline and 12 weeks.

Results:
OXN was comparable to codeine/paracetamol for analgesic efficacy (mean daily pain scores at week 12 were 4.20 for OXN and 4.64 for codeine/paracetamol, n=135 patients). Treatment discontinuations and adverse event profile were similar between groups. In patients constipated at study entry (OXN: n=56, codeine/paracetamol: n=41), mean BFI scores showed a clinically significant improvement in the OXN group (reduction of 22.8 points) not observed in the codeine/paracetamol group (9.4 point reduction; >12 point change is clinically significant). Patients taking OXN reported a mean overall improvement in health state of 8.9 points compared to 3.3 points in the codeine/paracetamol group.

Conclusion:
For patients with OA or back pain and constipation, OXN provides effective and comparable analgesia to codeine, a clinically significant improvement in constipation and an associated improvement in health status scores, which may lead to improved outcomes for primary care patients with long-term pain conditions.
**Research Poster Presentations**

**129 - Research**

**Multiple drug therapy in patients with chronic diseases comorbidities - a systematic review**

Eyitope Roberts1, Umesh Kadam1, Corp Nadia1, 1Keele University, Staffordshire

**Introduction:** There are clinical guidelines on optimal drug treatment for individual chronic diseases but not when people experience multiple diseases at the same time (comorbidity). The prevalence of chronic disease comorbidity is on the rise in general practice. The appropriate management of comorbid conditions is a major challenge for practitioners because of the associated side effects of polypharmacy (multiple drug therapy) and multiple drug interactions. The aim of the review was to identify previous evidence on chronic disease comorbidity and associated drug treatments.

**Methods:** Six chronic diseases were selected for the review: diabetes mellitus, cardiovascular disease, cerebrovascular disease, chronic obstructive pulmonary disease, osteoarthritis, and depression. Studies that examined or reported on medication therapy in adults aged 18 years and over with varying combinations of the chronic diseases were included. The process involved: (i) a systematic search of online healthcare databases, (ii) screening of paper titles, (iii) assessment of abstracts, and (iv) critical appraisal and quality assessment of the selected articles.

**Results:** Overall, 1017 relevant articles were identified and through the selection process this was reduced to 59 relevant articles. After critical appraisal and quality assessment a total of 11 articles was eventually included.

**Conclusions:** Overall, few studies on the subject. Majority of studies focused on chronic disease and comorbid depression, and associated sub-optimal drug treatment. General Practitioners and their teams will need to identify and develop ways to best manage patients with chronic diseases comorbidity, especially in relation to multiple drug treatments in order to provide optimal care.

**130 - Research**

**The role of investigations in reassurance? A systematic review**

Alexandra Rolfe1, Christopher Burton1, 1University of Edinburgh, Edinburgh

**Introduction:** Clinicians often undertake investigations which have a high-probability of being negative. It is expected that this will reassure doctor and patient that there is no serious underlying illness. However, many patients still worry about their symptoms. We analysed the effect of investigations in providing reassurance and assessed aspects of the investigation process that can enhance the reassurance value.

**Methods:** Using Cochrane collaboration criteria we undertook a systematic review. We analysed randomised controlled trials which looked at reassurance, anxiety, symptoms or healthcare use after an investigation to investigate symptoms with a low probability of serious disease. 6826 abstracts were analysed and 53 full papers examined. Searches of references, cited and related papers revealed an extra 16 papers. 20 papers from 19 trials met the full inclusion criteria and study quality was assessed.

**Results:** Trials comparing investigations alone versus control/usual care did not show significant differences in reassurance, anxiety or symptoms; either short or long term. Subsequent healthcare use is marginally decreased after investigations compared to control. Trials that included an adjunct to the investigation, such as a brief explanation or leaflet, did more to reassure.

**Conclusion:** Investigations, per se, do little to reassure patients. Certain aspects of the investigation process, such as providing information about what a negative test means may reduce health anxiety. The timing of this information appears to be important. Therefore, good communication with the patient about what the test involves and the meaning of a negative test appears to be essential for maximising the reassurance value of an investigation.

**131 - Research**

**Ought general practitioners share confidential patient data on an implied consent model with respect to the Summary Care Record?**

Karan Trivedi1, 1University of Birmingham, Birmingham

**Background:** The National Health Service in England is implementing a large-scale initiative called the Summary Care Record (SCR). This electronic patient record will make health information from the General Practitioner (GP) record available nationally. The current consent model for the initial upload is ‘informed implied consent’ and has been met with controversy. Ethical issues including, lack of public awareness following the information campaign, have been raised by patients. Little qualitative research has been undertaken looking at GPs’ views.

**Methods:** Empirical bioethical research was undertaken interviewing twelve GPs in the Birmingham and Black Country area between January and March 2011. Their personal views and professional experiences of consent and the SCR were explored and analysed using ethical theory to establish to what extent GPs reflected the ethical arguments outlined.

**Results:** Participants felt that whilst implied consent felt more palatable, the consent model for the SCR was that of presumed consent. Concerns with the validity of the informed presumed consent model were raised; it was also challenged in terms of paternalism and whether GPs ought to be making the decision for the SCR upload. Participants often resorted to a risk/benefit equation when assessing whether they should upload for the SCR.

**Conclusions:** The upload of confidential patient data with respect to the SCR is not ethically justifiable on the basis of consent, reflected both in arguments presented in the literature and from empirical research conducted. Justification may be sought on the basis of other factors, however further research is required to evaluate them.
132 - Research

**GMHAT/PC- its use in signposting patients appropriately**

Bennett Quinn, Vimal Sharma, Pat Mottram, Sally Sanderson, John Copeland, 1 Blackheath Medical Centre, Wirral, 2 Cheshire & Wirral Partnership Wirral & Cheshire

Following field studies carried out to establish the validity and feasibility of the Global Mental Health Assessment Tool (Primary Care version) (GMHAT/PC) in primary and general health settings we received a Northwest innovation award to use GMHAT/PC in primary care mental health services in the Wirral.

Four practitioners from the primary care mental health team used the GMHAT/PC interview as a part of their assessment of all consecutive patients referred to the team for a period of three months starting in December 2010.

Over 170 patients have been seen so far. The practitioners as well as service users found GMHAT/PC acceptable and useful. The output report of symptoms and diagnosis was particularly helpful in preparing a treatment plan. The care pathways included in the program were helpful to the practitioners. The time pressures in the assessment clinics due to other data entry requirements proved to be a barrier to realising the full benefits of care pathways in planning the treatment of the patients. The practitioners found GMHAT/PC helpful in enhancing their clinical assessment skills.

Further data on diagnostic breakdown will be presented.

We will also share our experiences of using GMHAT/PC in a surgery, where we found it useful not only in diagnosing and treating common mental disorders, but the patients found it therapeutic as well as the GP covered most areas of mental health and tried to understand the patient’s problem.

133 - Research

**Scottish Population Health Research Register (SHARE)**

Aileen Grant, Frank Sullivan, Brian Mckinstry, Aziz Sheikh, Janet Hanley, Shaun Treweek, 1 University of Dundee, Dundee, 2 University of Edinburgh, Edinburgh, 3 NHS Lothian, Edinburgh

The UK’s technical ability to identify people eligible for medical research is not yet matched by practical capability to approach them directly to ask them to consider participation in those studies. The consequence is that recruitment to research is much more difficult than it might be and consequently some projects fail. This makes Britain less attractive to undertake clinical research than it should be. In order to overcome this increasingly important obstacle, we plan to create a Scottish Population Health Research Register (SHARE) of Scottish residents who wish to be considered for participation in a range of studies.

Deterministic record linkage using the Community Health Index number allows linkage to a wide variety of data sources including the Scottish Morbidity Register (SMR) data suite and primary care clinical computing systems. This capability already enables the use of clinical records for epidemiological studies (using anonymised data) or follow-up of study subjects who have participated in clinical trials. However, the current legal and research governance framework prevents researchers from making direct contact with potentially eligible subjects; rather, initial contact must come through clinicians who have direct responsibility for their care. If sufficient numbers of people in Scotland with other health conditions would consider registering to participate in research, this resource could be extended to the wide range of researchers who might wish to approach people on the basis of their health status. Facilitating this more active approach to increase the efficiency of clinical research in Scotland is the purpose of this project.

134 - Research

**Providing healthcare to A8 migrant patients: perspectives from primary and secondary healthcare providers**

Jennifer Cleland, Leighton Walker, Alan Denison, 1 Division of Medical and Dental Education, University of Aberdeen, Aberdeen

**Background:** Global migration means that healthcare providers often treat patients with poor English, different illness-related beliefs and different healthcare expectations. These can cause communication problems and act as barriers to care. Following the expansion of the European Union, patterns of migration in the UK have changed. The new group of “A8” migrants have limited English proficiency (LEP) but may differ from traditional migrant populations in terms of healthcare attitudes and behaviours.

**Aims:** To identify perceived barriers to providing quality healthcare to A8 migrants in North-East Scotland, and use this to inform undergraduate and postgraduate medical education.

**Methods:** A qualitative study using individual semi-structured interviews with hospital doctors and general practitioners.

**Results:** The following themes were identified as issues within A8 consultations: long consultations; language barriers and using translators (e.g., confidentiality issues with using family members); cultural barriers to communication (e.g., patients’ describe their symptoms differently); different expectations of healthcare (e.g., little understanding of the system of GP as gatekeeper); differences in the use of health services (e.g., a less preventative approach to healthcare); and effects on the doctor (e.g., less satisfaction with the consultation). Comparisons across primary and secondary care indicate the same issues but different approaches to managing these issues.

**Conclusions:** The data identified several themes of relevance to medical education, such as the need for training in use of telephone translation services. However, it was clear that systems level changes, such as protected consultation time, are also necessary to support effective cross-cultural communication.
**135 - Research**

**YASH: Young Asian Sexual Health - What can South Asian young people tell us about their sexual health and education needs?**

*John Reynolds-Wright¹, Alice Nunn², Michelle Marshall³, Hina Kanabar¹, University of Sheffield, Sheffield, South Yorkshire*

**Introduction:** Young people’s sexual health in the UK has been a concern for public health policy and, despite falling teenage pregnancy rates, sexually transmitted infections (STIs) among young people have shown an increase. The numbers of Asian teenagers engaging in sexual intercourse is reportedly lower than their Black counterparts, however, there is some evidence that Asian young people are more likely to report ‘regretful intercourse,’ ‘unequal willingness’ and higher rates of anal intercourse, and so are still at risk of STIs through their behaviour.

**Methods:** 16-19 year old South Asian people are being recruited from NHS, schools, universities and community organisations to participate in focus group (FG) or individual interviews. The Topic guide was developed following a literature review, steering group discussions and pilot FG. Following each FG or interview, emergent themes were explored in subsequent groups.

**Results:** NVivo 8 software was used to code, organise and support thematic analysis, but at time of submission, this is incomplete. Three focus groups and 6 interviews have been completed so far although data collection is still underway. Preliminary analysis indicates emerging themes, including observation and reporting by other members of the community, responsibility to the family, and lack of parental communication regarding sex.

**Conclusion:** South Asian young people have distinct health education needs that are underpinned and informed by their ethnic, religious and cultural background. In order to deliver the best level of care to this group, awareness of these needs is essential.

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**136 - Research**

**Encouraging community health workers (CHWs) in Southern Sudan to use government treatment guidelines**

*Simon Clausen¹, Elizabeth Clausen¹, General Practitioners, Bristol*

**Background:** Southern Sudan has spent much of its recent history in civil war. This has led to a void in the training of health professionals. Preventable diseases account for the majority of morbidity and mortality in under 5s.

**Aim:** To encourage CHWs to adhere to guidelines when treating preventable diseases in under 5s.

**Design:** Data was collected at quarterly intervals after regular teaching and training. Further data was collected following the introduction of the GOSS treatment guidelines at each of the seven health facilities. Acute watery diarrhoea 41% vs 61%; Malaria 60% vs 74%; Acute respiratory infection 23% vs 81%; Malnutrition 32% vs 74%.

**Conclusion:** This study found that providing teaching and training to CHWs on the GOSS Treatment Guidelines lead to a higher proportion of patients being treated correctly for the main causes of morbidity and mortality in under 5s.

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**137 - Research**

**Ethnic differences in ECG parameters amongst disease free subjects**

*Sonal Nicum¹, Gregory Lip¹, Paramjit Gill¹, University of Birmingham, Birmingham*

**Introduction:** The ECG is commonly used in clinical practice for assessing cardiovascular disease and directing further investigations. The prevalence of ECG abnormalities has mainly been studied in White populations or ethnic populations with cardiovascular disease. However, there is limited data on ECG abnormalities in ethnic asymptomatic populations. This review aimed to document ethnic differences in ECG parameters between South Asian and Black African Caribbean groups compared to standardised ECG parameters derived from the White group.

**Methods:** Standard procedures were used to systematically search the databases: CAB, Embase, Medline, Psychinfo, CINAHL and Cochrane library. Inclusion criteria were resting ECG undertaken amongst disease free individuals, in a community setting, South Asian and Black African Caribbean subjects. 1483 papers were identified and 26 included for analysis.

**Results:** 18 papers looked at Black African Caribbean, 6 papers looked at South Asians and 2 papers looked at both Black African Caribbean and South Asian electrocardiographic data. Asians have a higher prevalence of Q wave and ST changes suggestive of ischaemic ECG changes. The Black African Caribbean population have a higher prevalence of electrocardiographic LVH, increased ST height and T wave abnormalities. However, AF and Q waves were more prevalent in White populations.

**Conclusions:** This review highlights ECG differences between asymptomatic ethnic groups and the importance of recognising these variations when interpreting the ECG in a clinical setting to prevent over investigation. The majority of papers identified differences between Black African Caribbean and White populations. Fewer papers examined electrocardiographic differences in South Asian populations.
**138 - Research**

**The relationship between social capital and cardiovascular disease: a cross-sectional study using the Health Survey for England**

Varun Anand1, Maya Patel1, Suhanya Nagendran1, Priyanka Palimar1, Peymane Adab1, 1University of Birmingham, Birmingham

**Introduction:** Cardiovascular disease (CVD) is the number one cause of death worldwide. Biological risk factors for CVD have been well described but less is known about the effects of social factors. Social capital encompasses networks, relationships and customs that shape the quality and quantity of a society’s interactions. Social capital is an area of increasing interest, but with little research conducted in relation to CVD, especially in England.

**Methods:** Data from the Health Survey for England 2006 were used. 10,196 adults responded to questions about their cardiovascular health and social factors in a computer-assisted interview. A social capital score was devised comprising of: people’s participation in group activities (Groups), trusting of others (Trust), relationship with neighbours (Community Relations) and level of anti-social behaviour (Safety and Belonging). This was compared with the prevalence of CVD, defined as angina, myocardial infarction or stroke.

**Results:** Participants with a low Groups, Trust, and Safety and Belonging score had a significantly increased risk of CVD when adjusted for age and sex. Once fully adjusted, the risk was over four times greater in participants with the lowest Safety and Belonging score compared with those with the highest score. A low overall social capital score also correlated with an increased risk of CVD in the age and sex adjusted analysis.

**Discussion:** Certain aspects of social capital may be important contributors to the burden of CVD in the UK. Strategies to improve social stability and neighbourhood safety may have a positive impact on cardiovascular health.

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**139 - Research**

**Identifying reasons for delay between symptom onset and initial health professional assessment following TIA and stroke**

Dawn Coleby1, Andrew Wilson1, Kate Windridge1, Nick Taub1, Claire Weston1, Thompson Robinson1, 1University of Leicester, Leicester

Prompt specialist assessment is important following TIA and minor stroke, where the immediate risk of recurrent stroke is high. NICE guidelines advise that patients with high-risk TIA’s are seen by a specialist within 24 hours of symptom onset, meaning that all need to be assessed within this interval. This study examined the timings from symptom onset to first health care professional. Patients newly diagnosed with stroke or TIA were recruited from an outpatient TIA clinic and inpatient stroke ward and invited to an interview.

Of the 435 participants, 240 (55%) contacted their GP either in or out of hours, 109 (25%) called an ambulance or attended ED, and 86 (20%) used other services including NHS Direct. For those using ambulance or ED services, median time between symptom onset and seeking help was 0.2 hours (IQR 0.1, 0.8) and from symptom onset to consultation was 0.5 hours (IQR 0.3, 1.2). For those using GP and other services, these timings were 6.5 hours (IQR 0.8, 36.0) and 11.5 hours (IQR 1.8, 49.7). Delay in seeking help was associated with transient and visual symptoms. Patients with motor symptoms and those who recognised symptoms as due to stroke sought help more quickly.

A high proportion of patients seeking help from their GP were not assessed in time to meet the NICE target, due to delay in contacting the practice, and/or attending non-urgent appointments. Further work is required to raise public awareness and to encourage patients to seek an urgent GP consultation or contact emergency services.

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**140 - Research**

**Caregiver burden in first-episode psychosis: a cross-sectional study**

Maya Patel1, Rachel Upthegrove1, 1The University of Birmingham, Birmingham

**Purpose:** This study aimed to investigate whether a patient’s duration of untreated psychosis (DUP), level of insight and severity of co-morbid anxiety or depression are associated with a higher level of caregiver burden, at first-episode psychosis (FEP). This was calculated after allowing for the influence of the severity of positive and negative symptoms, which have been associated with high caregiver burden in previous studies.

**Methods:** Twenty-three patients in recovery after FEP, and their caregivers were recruited. Patients were administered the Calgary Depression Scale for Schizophrenia (CDSS), Insight Scale (IS), and the Beck Anxiety Inventory (BAI). Caregivers were administered the Caregiver Burden Inventory (CBI). DUP and ratings on the Positive and Negative Symptom Scale (PANSS) were obtained from the patients’ clinical notes. Correlation analysis and stepwise multiple regression were performed to identify the predictors of CBI score.

**Results:** Patients’ CDSS and BAI scores were positively correlated with their carers’ CBI scores. \( r = 0.479, p = 0.021 \) and \( r = 0.438, p = 0.037 \) respectively. There was a negative correlation between DUP and CBI scores \( r = -0.478, p = 0.025 \). There was no correlation between patient scores on the IS, PANSS positive or PANSS negative and CBI scores. Stepwise regression revealed that the only significant predictor of caregiver burden was BAI score, accounting for around 24% of the variation in CBI scores \( R^2 = 0.24, p = 0.027 \).

**Conclusions:** The severity of anxiety symptoms after FEP is a significant predictor of the level of burden experienced by their main caregiver. This knowledge can be used to tailor strategies designed to aid caregivers.
**Methods:** Severity of depression and anxiety symptoms were measured in primary care patients referred to mental health workers using the PHQ-9 and HADS (n=1063). Each scale was assessed for Differential Item Functioning (DIF) and Differential Test Function (DTF) by gender, educational background and age. DIF was assessed with Mantel's 2, Liu-Agresti cumulative common odds ratio (LA LOR) and the standardised LA LOR (LA LOR-Z). DTF was assessed in relation to 2.

**Results:** PHQ-9, HADS Depression Sub-scale (HADS-D) and HADS Anxiety Sub-scale (HADS-A) did not exhibit bias in terms of gender and educational background (2 <0.07). However, both PHQ-9 and HADS-D did show bias with regard to age: PHQ-9 2=0.103 (medium effect); HADS-D 2=0.214 (large effect). PHQ-9 items exhibiting DIF by age covered: anhedonia, energy and low mood. HADS-D items exhibiting DIF by age covered psychomotor retardation and interest and interest in appearance.

**Conclusions:** PHQ-9, HADS-D and HADS-A do not generally exhibit bias for gender and educational background. Bias was observed in PHQ-9 and HADS-D for age. Caution should be exercised interpreting scores both in clinical practice and research.

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**142 - Research**

A qualitative research project to assess the value of using patient experience within the planning and development of an e-learning educational course about autism

**Susanna Almond1, Sara Ryan1, Richard Lehman1, Helen Salisbury1, 1University of Oxford, Oxford**

**Background:** E-learning is now well established across many disciplines for use in education. A number of studies have looked at the use of e-learning in medical education. However, little is known about the impact of using patient experience material within e-learning.

**Aims:** The aims of this project are to explore whether using patient experience material enhances the content of e-learning modules and to determine whether using video clips of patient experience have added educational value for e-learning.

**Methods:** The RCGP and The Health Experiences Research Group (University of Oxford) have used themes identified from qualitative research on patient experience to design an e-learning course on autism as part of the continuing professional development programme for general practitioners (GPs). In addition to informing the design, these educational sessions that make up the course integrate text-based learning with video clips of patients, or their carers, discussing aspects of autism that they have identified as important. These clips have been selected from the autism site within Healthtalkonline (www.healthtalkonline.org), a patient-centred resource developed using rigorous qualitative research methods to collect and analyse patient's first-hand experiences. The impact of using patient experience within the e-learning course will be evaluated using online questionnaires and focus group discussions with participating GPs.

**Results:** Results of how using patient experience informs and broadens course design will be presented in addition to questionnaire and focus group analyses. Video clips to illustrate examples of patient experience enhancing the learning experience will also be presented.

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**143 - Research**

The provision of mental health care for people with learning disabilities in primary care

**Nadiya Hassan1, Elizabeth England1, 1University of Birmingham, Birmingham**

**Background:** While people with learning disabilities (LD) have greater mental health needs than the general population, they receive inequitable mental health care from primary care services. This qualitative study aimed to explore the views and experiences of GPs and practice nurses in providing mental health care for individuals with LD. Their perceptions may help inform the delivery of equitable mental health care for individuals with LD.

**Methods:** Nineteen semi-structured interviews were conducted with consenting primary care professionals from different general practices in one PCT. Interviews were conducted until data saturation was achieved, as evidenced by data collection and concurrent analysis using a framework approach.

**Results:** Practitioners regarded the provision of mental health care for people with LD to be challenging, owing to a number of perceived hurdles, which included slow help-seeking behaviour amongst individuals with LD, barriers to providing accessible primary health care, and difficulty diagnosing mental illness in the LD population. Although variable levels of joint working practice between practitioners and the community learning disability team (CLDT) were described, many practitioners reported that they liaise with the community team, and highlighted the benefits of adopting a collaborative approach to care. Over half of the participating cohort felt the need to receive training in LD and mental health.

**Discussion:** Developing effective teamwork through interprofessional education may have the potential to strengthen the collaborative relationships between general practices and CLDTs, as well as further improve training in those areas of mental health care for people with LD that may challenge practitioners.
**144 - Research**

**Anaemia, cardiovascular disease and chronic kidney disease (CKD): a cross sectional study of the QICKD (Quality Improvement in CKD) trial data**

Simon de Lusignan\(^1\), Olga Dmitrieva\(^1\), Hugh Gallagher\(^1\), Kevin Harris\(^1\), Charles Tomson\(^1\), David Goldsmith\(^1\), \(^1\)University of Surrey, Guildford; \(^2\)South West Thames Renal Unit; \(^3\)St Helier; \(^4\)University Hospitals of Leicester, Leicester; \(^5\)Southmead Hospital, Bristol; \(^6\)Guy’s and St Thomas, London

**Background:** Anaemia (Hb level ≤ 11 g/dl) is a common and associated with poor outcomes in cardiovascular (CVD) and renal disease.

**Objective:** To report the prevalence of anaemia in CKD and associated CVD.

**Method:** Anonymised routine primary care data from the Quality Improvement in CKD (QICKD - ISRCTN5631023731) trial; data from 127 practices (N = 1,099,292). We identified people with stage 3 to 5 CKD, haemoglobin, ferritin, and CVD data.

**Results:** The prevalence of CKD is 5.33% (n=54,801) and of these 8.6% (4690) are anaemic. The proportion of patients with CKD and Hbs≤10g/dl is 3.0% and Hbs≤9g/dl is 1%. The commonest form or anaemia is normocytic (80.5%, n =3744).

The prevalence of hypertension is higher for patients with both CKD and anaemia when compared to patients with CKD alone 67.2% (3154) vs. 54% (27049). Heart failure (HF), peripheral vascular disease (PVD), ischaemic heart disease (IHD) and stroke is almost doubled in CKD patients with anaemia: 14.5% (682) vs. 6.1% (3049) in HF; 7% (326) vs.3.6 % (1803) in PVD; 27.2% (1276) vs.17.1% (8580) in IHD; and (18.1%, 847) vs (10.4%, 5216) in stroke.

86.7% CKD patients with anaemia have a low ferritin. 61% (n=2,862) of people with CKD and Hbs≤11g/dl are taking aspirin and 73% (n=3,422) are taking non-steroidal anti-inflammatory drugs (NSAID) and 14% are taking warfarin and 12% clopidogrel. Over half the people with anaemia and CKD are prescribed oral iron; it appears ineffective.

**Conclusions:** There is scope to improve anaemia management in CKD in primary care.

**145 - Research**

**Trends in admissions for diabetes and diabetes-related lower extremity amputations in the Republic of Ireland over a five year study period**

Diarmuid Quinlan\(^1\), Claire Buckley\(^1\), Anne O’Farrell\(^1\), Tony Lynch\(^2\), Davida De La Harpe\(^3\), Nurdiana Basharuddin\(^1\), Howard Johnson\(^4\), Ronan Cavanagh\(^4\), Ivan Perry\(^1\), Colin Bradley\(^1\), \(^1\)University College Cork, Ireland, \(^2\)Health Intelligence Unit, \(^3\)Sheffield Hallam University, Sheffield, \(^4\)St Vincent’s Hospital, Dublin, Ireland

**Background:** Diabetes has many complications including Lower Extremity Amputation. This significant complication is classified as major or minor based on anatomical location. Site of amputation affects quality of life and functional capacity. This study looks at trends in hospital admissions for diabetes and for diabetes-related Lower Extremity Amputations over time. In-patient care is the only way in Ireland that we can detect diabetic patients whom underwent amputation.

**Methods:** Retrospective review of HIPE (Hospital In-Patient Enquiry) data

**Results:** Over the 5 years, there was an increase in the rate of admissions for diabetic patients (p =0.02) and for diabetes-related Lower Extremity Amputation (p =0.03). The increase in amputations was mostly due to an increase in minor amputation rates.

**Conclusion:** This study found that as the prevalence of diabetes in Ireland has increased over time, the number and rate of hospital admissions for diabetic patients and diabetes-related Lower Extremity Amputations has also increased. Fortunately, the rise in amputation rates is in line with the increase in diabetes prevalence and not in excess of it. Furthermore, while amputation rates have increased overall, major amputation rates have remained static and only minor amputation rates have increased. Minor amputations are not as clearly indicative of poor quality of care as major amputations. Thus, intervention strategies to improve foot-care may underlie the trends observed in this study. Improving diabetes care needs to continue to be prioritised in Ireland to reduce complication rates. Primary care has a major role to play in diabetic foot-care and ultimately, amputation prevention.

**146 - Research**

**How useful is a patient decision aid for patients with T2DM when making a decision about starting insulin. Patient opinions from the PANDAs (Patients And Decision Aids) study – a quantitative analysis**

Brigitte Colwell\(^1\), Nigel Mathers\(^1\), Alastair Bradley\(^1\), Chirk-Jenn Ng\(^2\), Ian Brown\(^3\), \(^1\)University of Sheffield, Sheffield, \(^2\)University of Malaya, Kuala Lumpur, Malaysia, \(^3\)Sheffield Hallam University, Sheffield

**Introduction:** Patient decision aids are evidence-based, patient-centred tools designed to inform decisions on patients' health care therefore could be a useful tool to help patients make decisions about their treatment choices. Using data from the PANDAs study we can explore patient opinions on the usefulness of the PANDAs decision aid.

**Methods:** PANDAs was a cluster randomised controlled trial carried out across South Yorkshire, to establish whether the use of a decision aid improves the decision quality and health outcomes of patients with T2DM who are considering insulin therapy. Patients recruited into the intervention arm of the study completed the decision aid prior to their consultation with their doctor or nurse, as well as a questionnaire that asked for their opinion of the decision aid.

**Results:** 175 patients were recruited into the study, 95 into the intervention arm. The mean age was 67 years, mean length of diagnosis 9 years. When asked about the information in the decision aid: 83% felt it helped them to recognise that a decision needs to be made; 86% felt it helped them know that the decision depends on what matter most to them; 86% felt it helped them think about how involved they wanted to be in the decision about treatment and 88% felt it helped them to prepare them to talk to their nurse or doctor about what matters most to them.

**Conclusions:** Information provided in DAs, such as PANDAs, can help patients to participate in the decision-making process about their future treatment.
Results from screening for pre-diabetes & diabetes among patients with hypertension from a primary-care outpatient clinic in Singapore.

**Methods:** Screening for DM among hypertensive patients instead of general population maybe appropriate due to frequent coexistence of hypertension & DM. The incidence of DM among hypertensive patients is not well documented. In Singaporean public primary-care policies (polyclinics), hypertensive patients are routinely screened for risk factors and conditions like DM / pre-DM. This study aims to assess the incidence of DM / pre-DM from the routine screening of hypertensive patients and their characteristics.

**Results:** Total of 4,943 hypertensive patients had panel tests between Dec 2004 and Dec 2005, 517 were excluded (258 were previously diagnosed DM / pre-DM and 259 were not on antihypertensive medications), leaving 4,426 patients. Total of 4,062 (91.8%) had normal venous glucose (< 6.0 mmol/L), 187 (4.2%) were newly-diagnosed DM and 177 (4.0%) were IFG / IGT. After multivariable analysis, newly-diagnosed DM patients had higher BMI (p<0.05), systolic BP (p < 0.05), triglycerides (p < 0.01) and lower HDL (p < 0.05) compared to the normal group. For pre-DM patients, they were more likely to have higher LDL (p<0.05) and BMI (p < 0.05) compared to the normal group.

**Conclusions:** Screening among hypertensive patients in an Asian primary-care setting showed an incidence of ~10% with abnormal glucose metabolism. A higher BMI and systolic BP were associated with developing DM / pre-DM. Screening for & optimal management of BP and weight-control for overweight/obese patients may reduce the incidence of DM in this group.

Young women with diabetes on teratogenic drugs have suboptimal contraception: results from a UK multi-ethnic cohort

**Background:** The obesity epidemic is driving an increase in the number of young women who are developing type 2 diabetes mellitus (T2DM). There is mounting concern about the use of teratogenic drugs in these women of child bearing age. We aimed to describe the use of teratogenic drugs and reported contraception use in women with diabetes of child bearing age.

**Methods:** This was a cross-sectional analysis of 22 GP databases in Warwickshire January-June 2009. Women aged 14-49 years with pre-existing diabetes were identified. Demographic, anthropometric, medical history, medication and contraception data were extracted. Independent sample t-tests were used for normally distributed continuous variables, Mann-Whitney test for non-parametric variables and chi-squared tests for categorical variables.

**Results:** 470 women, median age 41 (35-46) years were identified. 67% had T2DM. Women with T2DM were more likely to be obese or hypertensive than women with T1DM (p<0.05). 41% women were on statin therapy (49% T2DM, 30% T1DM, p<0.001). 37% of women were on antihypertensive therapy (43% T2DM, 24% T1DM, p<0.001). 54% of women were prescribed teratogenic drugs (64% T2DM, 36% T1DM, p<0.001) but over half of these women do not have a documented form of concomitant contraception (57% T2DM, 60% T1DM).

**Conclusion:** Teratogenic drug use in women with diabetes mellitus of child bearing age is common, particularly in those with T2DM. These women are infrequently reported using concomitant contraception. There is urgent need to identify and overcome the barriers to effective contraception use to allow the optimal management of cardiovascular risk in these women.

Which women are having a hysterectomy and why? A national observational cohort study

**Background:** Hysterectomy is the most commonly major operation on UK women, with a lifetime incidence of 20%. In England who underwent hysterectomy, over a five-year period (2004-2009). The study described which women are having a hysterectomy, the indications for surgery and established crude mortality rates.

**Methods:** This observational study used Hospital Episode Statistics data (HES) to describe characteristics of all women in England who underwent hysterectomy, over a five-year period (2004-2009). The study described which women are having a hysterectomy, the indications for surgery and established crude mortality rates.

**Results:** Total of 4,943 hypertensive patients had panel tests between Dec 2004 and Dec 2005, 517 were excluded (258 were previously diagnosed DM / pre-DM and 259 were not on antihypertensive medications), leaving 4,426 patients. Total of 4,062 (91.8%) had normal venous glucose (< 6.0 mmol/L), 187 (4.2%) were newly-diagnosed DM and 177 (4.0%) were IFG / IGT. After multivariable analysis, newly-diagnosed DM patients had higher BMI (p<0.05), systolic BP (p < 0.05), triglycerides (p < 0.01) and lower HDL (p < 0.05) compared to the normal group. For pre-DM patients, they were more likely to have higher LDL (p<0.05) and BMI (p < 0.05) compared to the normal group.

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**Conclusions:** Screening among hypertensive patients in an Asian primary-care setting showed an incidence of ~10% with abnormal glucose metabolism. A higher BMI and systolic BP were associated with developing DM / pre-DM. Screening for & optimal management of BP and weight-control for overweight/obese patients may reduce the incidence of DM in this group.
Conclusions: Use of sub-total hysterectomy is increasing despite an absence of evidence of benefit. RCOG Guidelines quote a mortality of 1-in-4,000, this study suggests that the true rate is more than double this frequently quoted figure. For cancers, mortality is more than 1-in-150.

It is recommended a comprehensive prospective national audit of mortality subsequent to hysterectomy is undertaken to ensure that reliable data on the risks of surgery are given to patients electing to have this procedure.

150 - Research
A preliminary report on knowledge on breast cancer and screening practices for breast and cervical cancers, among female patients attending Family Practice clinics in Sri Lanka
R.E Ediriweera de Silva1, E.D.P.S Fernando2, L.D.S Liyanage3, E.W Premaratne4, W.D.D de Silva5, K Maddumabandara6, 7
1University of Colombo, Colombo, Sri Lanka, 2University of Kelaniya, Ragama, Sri Lanka, 3District General Hospital, Nalawadapity, Sri Lanka, 4Lady Ridgeway Hospital, Colombo, Sri Lanka, 5Colombo South Teaching Hospital, Kalubowila, Sri Lanka

Cancer of the breast and cervix are the commonest cancers among Sri Lankan females. However, knowledge regarding these diseases and screening practices have traditionally been thought to be deficient among Sri Lankan women in comparison to those in western societies.

Objectives: To assess breast cancer knowledge, and screening practices for breast and cervical cancers among female patients attending selected Family Practice clinics.

Methodology: A descriptive cross sectional study is being carried out among women aged 40-65 years attending three selected Family Practice clinics from three communities, representing three districts of Sri Lanka. A pre-tested interviewer administered questionnaire was used to assess knowledge and screening practices towards common female cancers. The knowledge score was graded as very poor (<20), poor (20-40), average (40-60), good (60-80) and very good (>80), based on correct responses. The preliminary results of 59 participants were analyzed.

Results: The mean age was 52 (SD-8.8) years. 83% (n=49) were married. Ten percent, 83% & 6.8% respectively had received primary, secondary and tertiary education. A majority of the participants (79.6%, n=47) achieved a good score on breast cancer-related knowledge, while 6.8% had an average score and 13.5% had a poor score. Knowledge on risk factors was better (52.7% correct responses) than knowledge on symptoms of breast cancer (47.2% correct responses). Self breast examination was known by 44% (n=26) and practiced by 40.6% (n=24). 13.5% (n=8) had undergone a mammogram. 27.1% (n=16) had undergone a pap smear.

Conclusion: Screening practices for breast and cervical cancer remains poor despite good knowledge.

151 - Research
GP input following cancer diagnosis: lessons learned from the development of a structured cancer care review
Una Macleod1, Pat Quinn2, David Linden1, Susan Browne3, Elizabeth Mitchell4, 1Hull York Medical School, Hull, 2University of Glasgow, Glasgow, 3The Scottish Government, Edinburgh, 4University of Dundee, Dundee

Introduction: Cancer care reviews (CCRs) are embedded within general practice as part of the Quality and Outcomes Framework. Little is known about these reviews and if and how they contribute to the overall management of new cancer patients. The purpose of this study was to develop and test a structured format for these reviews.

Method: We developed a structured CCR template by [1] identifying existing evidence by undertaking a systematic literature review to ascertain patient needs post cancer diagnosis which could be addressed within primary care;[2] conducting a survey of existing practice by sending a questionnaire to general practices; [3] conducting interviews with general practitioners and district nurses and [4] investigating the views of people affected by cancer by conducting focus groups with lay representatives of people affected by cancer.

Results: A template was developed consisting of four sections: assessment of physical need, medication review, assessment of psychological need, signposting of relevant services. Lessons learned included: GPs viewed the CCR as useful, patients appreciated contact from GPs soon after diagnosis; both patients and professionals identified the application of the generalist GP skills such as the assessment and management of psychological distress as key to the care of cancer patients.

Conclusions: A template has been produced for use within general practice as the CCR which appears to be useful and acceptable. Broader lessons about the role of GPs in cancer care have been learned.

152 - Research
Logical decision-making? Health care professionals’ perceptions of the use of unscheduled care by people with long term conditions: a qualitative study
Jessica Drinkwater1, Susanne Langer2, Cheryl Hunter3, Peter Salmon1, Else Guthrie1, Carolyn Chew-Graham1, 1University of Manchester, Manchester; 2University of Liverpool, Liverpool; 3Manchester Mental Health and Social Care Trust, Manchester

Introduction: Unscheduled care (UC) is the use of emergency or out of hours services. Patients with long term conditions (LTCs) have been shown to be high users of UC. Reducing UC is a Department of Health priority and one of the new ‘Improving Quality and Productivity in the NHS QOF’ indicators.

CHOICE (Choosing Health Options in Chronic Care Emergencies) is an NIHR-funded project to design an intervention to improve the use of UC by patients with LTCs. This qualitative study aims to explore health care professionals’ (HCPs) views on patient decision-making to seek UC.
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Logical decision-making? Health care professionals’ perceptions of the use of unscheduled care by people with long term conditions: a qualitative study

Jessica Drinkwater1, Susanne Langer2, Cheryl Hunter3, Peter Salmon3, Else Guthrie1, Carolyn Chew-Graham1, Jessica Drinkwater1, Susanne Langer2, Cheryl Hunter3, Peter Salmon3, Else Guthrie1, Carolyn Chew-Graham1, 1University of Manchester, Manchester, 2University of Liverpool, Liverpool, 3Manchester Mental Health and Social Care Trust, Manchester

**Introduction:** Advance care planning (ACP) allows patients to make known their preferences about healthcare in anticipation of future mental incapacity. Intended to enhance choice and autonomy while aiding clinical decision making, it is now described in the Mental Capacity Act 2005.

This presentation reports on a qualitative study investigating knowledge and experience of ACP amongst general practitioners (GPs).

**Methods:** Following a narrative literature review,1 qualitative semi-structured interviews were carried out with twenty GPs. A small number of focus groups were held with lay people, before questionnaires were used to gain the views of approximately 200 primary care professionals.

**Results:** Important themes included GPs’ limited practical experience of ACP and lack of familiarity with both legal status and professional guidance. GPs showed a strong awareness of potential ethical problems, as well as practical and psychological barriers to the use of ACP. There was general support for its aims, and agreement on likely benefits. However, GPs felt strongly the need for more support and training in ACP.

**Discussion:** ACP is increasingly promoted in UK healthcare policy and the subject of recent professional guidance. Focus on patient choice in the Health and Social Care Bill 2011 is likely to enhance its relevance. However, despite evidence for its benefits, it is infrequently used: further investigation of ACP in UK primary care is crucial. Initial results of this study highlight the need for guidance and training for GPs in ACP; while demonstrating their support for the concept and commitment to more extensive use with patients.

154 - Research

A lone mother’s decision-making when her child is unwell during the out-of-hours period

Lizzy Bernthal1, Army, Southampton

This research explores how and what way aspects of Army life influence the decision-making of mothers, and what support Army mothers expect when their child is unwell during the out-of-hours period.

The study was conducted within an Army garrison in England during which time mothers were temporary lone parents for months while their husbands deployed. NHS Out-of-hours provision was over thirty miles away.

An exploratory stage, using focus groups with 24 parents, identified how Army life affected parents and what their expectations were for health care provision in the out-of-hours period. Phase One interviewed seven parents to explore the themes identified in the previous stage in greater depth. Phase Two interviewed a further seven mothers to investigate the decision-making process that led to consultation with a health professional.

This PhD study provides a rich and detailed description of how disruption, mobility and enforced separation affect parents living with young children within a garrison in England. It is distinctive as it theorises that emotional vulnerability caused by anxiety and fear of military enforced separation challenges a mother’s fundamental need for safety and belonging. An algorithm developed from the findings demonstrates that a partner's presence influences whether the mother calls health care services as a first or last resort. Thus, it makes an important contribution to the development of both civilian and military knowledge regarding a mother’s decision-making behaviour and her expectations for care when her child is unwell, particularly as a lone parent.

155 - Research

The hospital as a place of safety - the use of unscheduled care in patients with long-term conditions: a qualitative study

Carolyn Chew-Graham1, Cheryl Hunter1, Susanne Langer1, Jessica Drinkwater1, Else Guthrie1, Peter Salmon2, 1University of Manchester, Manchester, 2University of Liverpool, Liverpool, 3Manchester Mental Health and Social Care Trust, Manchester

**Introduction:** Unscheduled care (UC) is defined as non-routine face-to-face care, such as accident and emergency, out-of-hours or walk-in-centres. Health care policy emphasises the potential role for routine primary care in reducing UC use.

**Aims:** This study is part of the NIHR-funded research programme which aims to develop and evaluate an intervention...
Visible impact and experiences of health professional consultation: a qualitative study of people with psoriasis

Pauline A Nelson¹, Lis Cordingley¹, Christopher EM Griffiths², Carolyn A Chew-Graham³, ¹University of Manchester, Health Sciences Research Group, Manchester; ²University of Manchester, Manchester Academic Health Science Centre (MAHSC), Manchester; ³University of Manchester, Primary Care Research Group and National School of Primary Care Research (NSPCR), Manchester

Introduction: Psoriasis is a long-term inflammatory skin condition affecting around 2% of the UK population. It can impact on a person's quality of life, psychological and social functioning. Little is known about patients' perspectives about the impact of psoriasis on their lives and how they experience consultations with health professionals in both primary and secondary care.

Methods: A qualitative study was carried out with people recruited from community sources across the North West of England who had responded to an advertisement. Data were collected with consent, from a purposive sample of 20 people through in-depth semi-structured interviews about coping with psoriasis. Verbatim transcripts of interviews were analysed using the constant comparison method.

Results: Respondents identified the visual impact of psoriasis as the worst aspect of the condition, describing its effects on relationships and strategies to cope. People also reported difficulties in interactions with health professionals, in particular their failure to acknowledge the degree of impact which psoriasis has on wellbeing. Participants perceived a lack of specialist knowledge among GPs, as well as few opportunities to discuss their condition with and inadequate information from practitioners in secondary care.

Discussion: Health professionals might better support people with psoriasis by acknowledging the significant emotional impact of the condition's visibility, engaging not only with physical management but with the emotional and social consequences they experience. Professionals need to be able to explore people's understanding of psoriasis, identifying issues of importance to each individual so that more tailored support can be provided.

Quality assuring the 6-8 week baby examination in primary care

Joanna Clark¹, Harry Smallwood¹, Graham Fergusson¹, Rebecca Mann¹, ¹Taunton Rd Medical Centre, Bridgwater, Somerset; ²Musgrove Park Hospital, Taunton, Somerset

Introduction: The 6-8 week baby examination has an important role in detecting abnormalities missed in hospital and conditions which develop after discharge (L2). GPs receive training to perform this examination during Paediatric SHO posts early in their career. Few receive formal training (3-4). Competency-based training may account for why Neonatal Nurse Practitioners are significantly less likely to miss abnormalities at the newborn examination than SHOs (5). The UK National Screening Committee recommends monitoring of competence by assessors, attendance at CPD/refresher courses, and a minimum number of examinations to be performed annually (6).

Aim: To determine what quality assurance measures are in place in Somerset, and the views of General Practitioners.

Method: Anonymised electronic questionnaire e-mailed to GPs on the Somerset Performers List.

Results: 69.6% of GPs have not had any form of update training. 34.7% were unsure if, or did not feel they had adequate training and refreshment of skills to be competent to perform the examinations. 74.3% agreed that practitioners should perform a minimum number of examinations per year to remain competent.

Discussion: After initial training, GPs perform 6-8 week baby examinations for the rest of their careers with little update training or review of competencies. Some perform less than 5 examinations annually, and a large number are unsure if they remain competent. No update courses are available for this skill in the Southwest region and we plan to address this. Attendance of Paediatricians at every practice to assess competencies would be difficult. The nomination of a lead GP in each practice is an alternative. Further investigation into whether performance is affected by frequency of examinations is required before minimum annual numbers are imposed.
158 - Research

Background: Little is known about the epidemiology of non-communicable diseases in African children. We studied the prevalence of and risk factors for asthma symptoms and high blood pressure (HBP).

Methods: Two urban and five rural schools were randomly selected from government schools in Wakiso district, Uganda. A questionnaire was administered and anthropometric measures taken. Children reporting wheeze in the last year underwent exercise spirometry. Blood pressure (BP) was measured three times in one sitting at five minute intervals. If the mean systolic or diastolic pressure was elevated beyond the 95th percentile for that child, the process was repeated at two further settings. Follow up of children with HBP is being continued for a year.

Results: Five hundred and fifty two students were included. Ninety-five (17.2%) described wheeze, of whom only 7 (7.4%) demonstrated exercise induced bronchoconstriction (EIB). No significant risk factors were identified for wheeze or EIB. Ninety-two (17.1%) had HBP. At the first follow up, BP was still elevated in 46 (54.7%) of these children. Age increased (OR 1.40 (1.17 to 1.69, p=0.0003)) and male gender decreased (OR 0.47 (0.24 to 0.93, p=0.03)) the risk of HBP.

Conclusion: The low prevalence of EIB among children describing wheeze emphasises the difficulty of defining childhood asthma at a population level where the concept of "wheeze" is poorly understood. By contrast, it is feasible to accurately measure blood pressure in school settings with little training. High rates of HBP are cause for concern, but the appropriateness of currently available normograms is uncertain.

159 - Research

Fluticasone propionate/formoterol fumarate combination therapy has comparable efficacy to fluticasone propionate/salmeterol xinafoate in paediatric patients with asthma: a randomised controlled trial

Dr Joe diCapite, Andrzej Emeryk1, Rabih Klink1, Birgit Schwab1, Tammy McIver4, 1Department of Paediatric Lung Diseases and Rheumatology, Medical University, Lublin, Poland, 2Cabinet de Pédiatrie et de Pneumo Allergologie Pédiatriques, Laon, France, 3Mundipharma Research GmbH & Co. KG, Limburg, Germany, 4Mundipharma Research Limited, Cambridge

Background: A new fluticasone propionate/formoterol fumarate single aerosol inhaler combination therapy (FLUT/FORM; flutiform®) has been shown to have comparable efficacy to fluticasone propionate/salmeterol xinafoate (FLUT/SAL) in adults. This study compared these combinations in a paediatric population.

Methods: Patients (4-12 years; N=211) with mild-moderate persistent asthma were randomised 1:1 to treatment with FLUT/FORM (100/10µg) or FLUT/SAL (100/50µg), twice-daily using a spacer, in a 12 week open-label, parallel-group, multicentre study. The primary endpoint was change in mean FEV1 from pre-dose on Day 0 to Day 84. Secondary endpoints included change in mean FEV1 from pre-dose on Day 0 to 120 minutes post dose on Day 84, and discontinuations due to lack of efficacy.

Results: FLUT/FORM was comparable to FLUT/SAL for the primary endpoint (LS mean: 0.182L for FLUT/FORM (n=102) and 0.212L for FLUT/SAL (n=99); per protocol set). The treatment difference was -0.031L (95% CI: -0.093, 0.031); non-inferiority was demonstrated as the lower limit of the 95% CI exceeded the acceptance limit of -0.1L. Non-inferiority of FLUT/FORM to FLUT/SAL was also demonstrated for change from pre-dose to post dose FEV1 values. No patients discontinued due to lack of efficacy. Incidence of adverse events (AEs) was similar in both groups [FLUT/FORM n=31 (29.2%); FLUT/SAL n=28 (26.7%)]. Two patients taking FLUT/FORM and one taking FLUT/SAL experienced serious AEs, considered not related to treatment; no patients withdrew due to AEs.

Conclusion: Fluticasone/formoterol was comparable to fluticasone/salmeterol regarding measures of lung function and discontinuations due to lack of efficacy. Fluticasone/formoterol and fluticasone/salmeterol had comparable tolerability profiles.

160 - Research

Long-term safety study of fluticasone propionate/formoterol fumarate combination therapy in the treatment of asthma

Dr Joe diCapite, Adel Mansur1, Kirsten Kaiser1, 1Severe and Brittle Asthma Unit, Birmingham Heartlands Hospital, Birmingham, 2SkyePharma AG, Muttenz, Switzerland

Background: The long-term safety of a new fluticasone propionate/formoterol fumarate (FLUT/FORM; flutiform®) single aerosol inhaler combination therapy was assessed in this open-label, multicentre study.

Methods: Patients (≥12 years; N=472) with mild to moderate-severe asthma were treated twice-daily with FLUT/FORM 100/10 µg or 250/10 µg, for either 6 (n=256) or 12 months (n=216). The primary and secondary objectives were the long-term safety and efficacy of FLUT/FORM, respectively.

Results: A total of 224 patients received FLUT/FORM 100/10µg, twice-daily and 248 and 248 received 250/10µg, twice-daily; 413 (87.5%) completed and 59 (12.5%) discontinued from the study. Overall, 36.9% of patients (174/472) reported adverse events (AEs): 67 (29.9%) in the 100/10µg and 107 (43.1%) in the 250/10µg group. The most common AEs (>2%) were nasopharyngitis (9.5%), dyspnoea (5.1%), pharyngitis (2.8%), headache (2.8%), lower (2.5%) or upper (2.5%) respiratory tract infection, asthma (2.5%) and cough (2.1%); most were mild
The effect upon smoking habits of weight reduction exercise classes

**Methods:** Thirty-five smokers (n=35) who attended exercise classes were consulted by telephone interview and by a written questionnaire. They were asked how many cigarettes they smoked per day (i) immediately prior to attending exercise classes and (ii) immediately after attending the last exercise class. Only minor statistical analysis was performed as the data did not fit a normal distribution curve.

**Results:** Forty percent (40%) of all smokers who attended exercise classes reduced their tobacco consumption. The average reduction in the number of cigarettes smoked amongst all the smokers who undertook weight reduction exercise classes was 3.28 cigarettes per day.

**Conclusions:** This study concludes that there is a potential benefit to smokers who take exercise classes in that they reduce the number of cigarettes smoked per day.

Sheesha, hookah, narghile, hubble-bubble: is this included in smoking cessation advice offered by primary care in the West Midlands?

**Introduction:** Hookah smoking is part of Middle Eastern culture, which over the last 10 years has become more prominent in UK cities. There is a wealth of literature stemming from the Middle East indicating its comparable effects to cigarette smoking on health, specifically relating to high carbon monoxide levels in the blood. The habit is becoming more common in the UK particularly as a social activity in young adults, meaning that smoking occurs for long periods of time equating to the equivalent of 2-10 cigarettes. Are GPs and nurses in the West Midlands targeting this issue in their smoking cessation programmes?

**Methods:** A paper questionnaire on the topic of sheesha in smoking cessation was handed out at the Heart of Birmingham Primary Care Protected Learning Time Seminar attended by over 500 GPs, trainees and nurses from the region. Responses were collected by hand and analysed via a spreadsheet.

**Results:** To date 300 questionnaires have been collected. Preliminary results show, 3% of participants did not know what sheesha was, 95% did not specifically mention sheesha when asking about the patient’s smoking status, 86% did not mention sheesha in their smoking cessation talk.

**Discussion:** Smoking is the largest single preventable cause of death and disability in the UK and it is important that Primary Care staff include all types of smoking in their cessation programmes. It is important to educate staff about new changes in society and to provide the relevant literature so that they can provide the correct advice.

A self-management programme of activity coping and education (SPACE) for COPD: a randomised controlled trial

**Background:** Supervised exercise classes are one method of helping patients lose excess weight. However, there are believed to be other health benefits from participating in exercise classes. This study investigates the effect on tobacco consumption of cigarette smokers who participated in supervised exercise classes, where the sole aim of the classes was weight loss.

**Methods:** Thirty smokers (n=30) who attended exercise classes were consulted by telephone interview and by a written questionnaire. They were asked how many cigarettes they smoked per day (i) immediately prior to attending exercise classes and (ii) immediately after attending the last exercise class. Only minor statistical analysis was performed as the data did not fit a normal distribution curve.

**Results:** Forty percent (40%) of all smokers who attended exercise classes reduced their tobacco consumption. The average reduction in the number of cigarettes smoked amongst all the smokers who undertook weight reduction exercise classes was 3.28 cigarettes per day.

**Conclusions:** This study concludes that there is a potential benefit to smokers who take exercise classes in that they reduce the number of cigarettes smoked per day.
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<th>Improving uptake of lifestyle behaviour change using a 9-item simple lifestyle referral assessment</th>
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<tr>
<td><strong>Introduction:</strong></td>
<td>Patients at high risk of cardiovascular events may require medical and lifestyle management. Advice giving, motivational interviewing and referral to lifestyle schemes are the main methods by which primary care support lifestyle change. Unsystematic decision making at the point of referral for support with lifestyle change leads to mismatching between patient needs and the type of support provided producing high drop-out rates. Using evidence about individual influences on lifestyle behaviour change we have developed a short lifestyle referral assessment that can filter patients to the most appropriate care pathway.</td>
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<td><strong>Methods:</strong></td>
<td>We reviewed the qualitative cardiovascular literature reporting patient influences on lifestyle behaviour change. Themes were identified and mapped to quantitative data to identify which themes predicted uptake of lifestyle change. Key themes were used to construct a healthy lifestyle referral assessment</td>
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<td><strong>Results:</strong></td>
<td>The assessment comprises nine items and offers four care pathway options. The items relate to mood, understanding, motivation, intention, commitments, cost, transport, family support and confidence. The four pathway options are referral to lifestyle scheme, supported self-management, self-management and defer for re-assessment.</td>
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<td><strong>Discussion:</strong></td>
<td>By identifying the main patient influences to lifestyle change we have developed a tool that may help primary care deliver the right type and levels of support according to patient need. A more tailored approach to lifestyle change may improve uptake, participation and success rates in lifestyle change. The assessment is currently being evaluated.</td>
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<th>165 - Research</th>
<th>Steps to a better Belfast - physical activity assessment and research recruitment in general practice</th>
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<td><strong>Aim:</strong></td>
<td>There is a need to determine effective ways of increasing people's participation in physical activity. Pedometer-based programmes have been suggested as a possible strategy to encourage physical activity but there is little evidence regarding the effectiveness of this approach. Healthcare professionals in primary care have been advised to assess their patients' levels of physical activity but there is limited information regarding the feasibility of doing this in practice.</td>
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<tr>
<td><strong>Methods:</strong></td>
<td>This study aims to determine the feasibility of:</td>
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<td></td>
<td>- integrating brief assessment of current physical activity level into a primary care consultation;</td>
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<td></td>
<td>- recruiting patients from general practice to a trial in which they would be randomised to receive different pedometer-based exercise programmes, designed to increase their physical activity.</td>
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<td><strong>Results:</strong></td>
<td>The study's purpose is to explore the feasibility of identifying, in general practice, people who are physically inactive and recruiting them to a trial of a pedometer-based physical intervention. Their willingness to participate, their retention within the study and their reported experiences of the process of recruitment and participation will inform the design of a definitive study to compare the effectiveness of pedometer-based interventions in promoting physical activity with long-term follow-up (&gt;1 year).</td>
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<th>Bulimic symptomatology and subjective stress in individuals who perceive adverse food reactions</th>
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<td><strong>Background:</strong></td>
<td>Population studies suggest that around one fifth of the UK population perceive adverse food reactions (PAFR). Despite General Practitioners frequently encountering difficulty treating patients with PAFRs, few studies have explored the psychological dimensions of this phenomenon.</td>
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<td><strong>Aim:</strong></td>
<td>This study aims to identify the prevalence of PAFRs in a healthy population, and to evaluate the relationship between PAFRs and disordered eating, subjective stress and modern health worries.</td>
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<td><strong>Methods:</strong></td>
<td>A self-report questionnaire was completed by 194 medical or physiotherapy students. The questionnaire identified individuals with a PAFR and used validated measures of bulimic symptomatology (Bulimic Inventory Test Edinburgh), subjective stress (Perceived Stress Scale) and modern health worries (Modern Health Worries Scale).</td>
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<td><strong>Results:</strong></td>
<td>The prevalence of PAFR was found to be 28.4%. Female students were found to be more likely to report PAFR than male students. Those participants who had a PAFR demonstrated higher levels of bulimic symptomatology (p &lt; 0.0001) and higher levels of subjective stress than controls (p &lt; 0.05). Levels of modern health worries did not differ significantly in participants with and without a PAFR. This study has also made progress in validating a questionnaire to measure the severity of adverse food reactions.</td>
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<td><strong>Conclusion:</strong></td>
<td>This study suggests that PAFR is related to bulimic patterns of disordered eating and perceived stress levels. In light of this finding, primary care physicians may find benefit in screening for bulimia nervosa in individuals presenting with a PAFR; particularly young, stressed females who may use adverse food reactions to justify maladaptive eating.</td>
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<th>A survey of alcohol-related injury at three UK universities</th>
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<td><strong>Introduction:</strong></td>
<td>In the general adult population alcohol-related injury (ARI) is a significant cause of preventable morbidity and financial burden on healthcare resources. Whilst increased alcohol consumption is recognised as an issue in university student populations there has been little research in the UK to indicate whether this group are more at risk of ARI and would therefore benefit from targeted interventions.</td>
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168 - Research
Pharmacokinetics of transdermal buprenorphine compared with sublingual buprenorphine in healthy volunteers
Kevin Smith1, Gill Mundin1, "Mundipharma Research Limited, Cambridge

Background: The primary aim of this open, randomised, crossover study in 14 healthy male volunteers was to determine the peak plasma concentrations of buprenorphine from transdermal and sublingual preparations during the first 24 hours.

Methods: During two study periods, separated by at least 7 days, each subject was given one transdermal buprenorphine patch (20 µg/h) applied for a period of seven days, and one sublingual buprenorphine tablet (400 µg) administered 8 hourly within a single 24-hour period (three doses in total). Volunteers also received one naltrexone tablet (50 mg) 14 hours before receiving the first dose of study medication, and 12-hourly throughout the study period to block the effects of buprenorphine. Regular blood samples were taken for 48 hours in subjects receiving sublingual buprenorphine tablets, and for 192 hours in subjects receiving the transdermal buprenorphine patch.

Results: A total of 13 subjects completed both study periods. The delivery of buprenorphine from the transdermal patch was controlled and resulted in a plasma profile that was markedly different from that of sublingual buprenorphine. The profiles associated with the sublingual preparation exhibited high peak plasma concentrations and marked fluctuation in the three dosing intervals over the 24 hour period. As expected, these peak plasma concentrations of buprenorphine increased following successive doses of the sublingual tablets. The peak plasma concentration of buprenorphine from the transdermal patch was less than that associated with the sublingual tablets.

Conclusions: The transdermal patch provided a controlled delivery of buprenorphine, which was in marked contrast to that associated with sublingual administration.

169 - Research
The encryption and decryption of General Practice ethics: findings from a qualitative study
Andrew Papankitakis1, "Kings College London, London

What issues might UK General Practitioners (GPs) identify as ethical, how are these identified and what kinds of problems are they? This project combines review of academic, educational and practice literature with preliminary data from eighteen qualitative interviews and a focus group. The interviews are conducted with participants identified with academia, education and everyday practice.

Key findings illustrate a confusion of externally applied bioethical approaches. Participants with advanced training in ethics are conscious of it being pervasive, whereas those who have received only that provided at medical school or with specialist training identify it with conflict or areas pre-defined as problematic. Participants without a bioethical education describe a need for clear principles and guidance, with specific concerns such as maintaining confidentiality and handing information in a family practice setting. A change in government has led to the possibility that collectively GPs will have more explicit responsibility for rationing decisions. 'Decryption' of ethical issues is associated by participants with reflection, including using simple tools such as the Four Ethical Principles, or with small group work linked to the Balint movement.

Participants distinguished ethical behaviour from ethical understanding and the ability to critique. Some feel a general account of medical ethics should suffice, others criticise the use of jargon by experts or suggest that gathering a community of scholars interested in primary care ethics has the potential to disempower patients and practitioners, increasing the disconnect between theory and practice. Participants who did not profess to have special ethical expertise relied on textbooks, general journals, and charismatic educators to 'sugar coat' theory.

170 - Research
What are general practitioners’ perceived costs and benefits of teaching undergraduate medical students?
Michael Scales1, Robbie Foy1, "Academic Unit of primary Care Leeds University School of medicine, Leeds West Yorkshire

The proportion of the undergraduate medical curriculum taught in primary care placements is increasing. Beyond the direct educational impacts on students, there is likely to be a range of wider, benefits as well as costs, such as improvements in patient care. The literature on this is relatively sparse. It would be useful to identify those impacts to help inform decisions by practices who participate in undergraduate education. In particular there is little information how these impacts are perceived by tutors and non-tutors within the same practice.
Research Poster Presentations

171 - Research

A qualitative study to explore how the educationally literate group of GPVTS trainees experience professional learning in the transition to general practice
Alice Shiner1, Amanda Howe1, 1University of East Anglia, Norwich, Norfolk

Many newly qualified GPs experience difficulties maintaining professional learning, particularly in today's uncertain working environment. They may also have difficulties demonstrating requirements for revalidation. Recent research has been carried out to establish the CPD preferences of this cohort of doctors, how they currently experience the transition to qualified practice and also the provisions made for them by UK deaneries. However, little research has examined how their learning experiences are affected by the current climate and working environment, including the aspects that contribute to an effective or ineffective learning experience.

This qualitative study utilises a constructivist grounded theory approach to explore these areas, addressing the research questions:

What do newly qualified GPs perceive to be their most effective professional learning activities and why?

What has the transition to qualified practice affected experiences of professional learning?

What do newly qualified GPs believe influences their professional learning?

Study participants have been purposively sampled from the cohort of newly qualified GPs in the RCGP East Anglia Faculty region. Data has been collected through a series of semi-structured one-to-one interviews with a further focus group planned to test emerging theories. Analysis of data will be completed and findings reported by October 2011.

Through presenting our findings and suggesting potential strategies to assist learning this study aims to enhance understanding of how newly qualified GPs can be better supported in their further education.

172 - Research

Extending GP training to five years: an analysis of 100 trainees' responses
Damian Godwin Navaratnam1, 1Mersey GP Deanery, Merseyside

Introduction: The current GP training programme is one of the shortest training periods compared to other specialty programmes. In 2008 the Tooke report recommended that training should be extended to five years. We explore GP trainees' perspectives, and training priorities.

Methods: A pre-tested anonymous online survey was circulated via email to all GP trainees from two UK deaneries during February 2011. The first 100 responses were analysed.

Results: Respondents represented all training grades, 93% were aware of the proposal to extend training, 58% support it. Trainees ranked five options for utilising extended training time. Having more GP posts was the first priority for 42% and following this more speciality posts was ranked first by 33%. Developing managerial experience was the lowest ranked at 4.5%. The AKT had been passed by 22%, 4% had passed CSA, and 41% were unsure if current training time and following this more speciality posts was ranked first by 33%. Developing managerial experience was the lowest ranked at 4.5%. The AKT had been passed by 22%, 4% had passed CSA, and 41% were unsure if current training time and following this more speciality posts was ranked first by 33%. Developing managerial experience was the lowest ranked at 4.5%. The AKT had been passed by 22%, 4% had passed CSA, and 41% were unsure if current training time and following this more speciality posts was ranked first by 33%. Developing managerial experience was the lowest ranked at 4.5%. The AKT had been passed by 22%, 4% had passed CSA, and 41% were unsure if current training time

Discussion: Most GP trainees support the proposal to extend GP training to five years, wishing more time in GP posts. Additional training time may allow special interests to develop, and provide valuable time for academic opportunities, and managerial experience. This seems appropriate to the changing role of general practice within the NHS. Trainees are concerned by the inflexibility of rotation allocation, and desire rotations to be tailored to an individual's past experience and training needs. A national enquiry of trainees' perspectives would provide further beneficial information.

173 - Research

Patient attitude to medical student experience in general practice
Helen Cheshire1, Philip Stather1, Chris Ellis1, 1Queensway Medical Centre, Wellingborough

Background: General practice is an important part of medical education. We surveyed patient's attitudes to the presence of medical students during general practice consultations.

Summary of work: A prospective survey of 100 patients in a general practice in Wellingborough.

Summary of Results: 88% of patients were happy to have medical students present in their consultation. Only 80% and 76% were happy to discuss mental health and sexual health issues respectively and only 78% reported feeling confident
A qualitative study to compare the learning experience of full time trainees vs. less than full time trainees
Caroline Rickard1, Tabitha Smith1, Wessex Deanery, Bournemouth

Over the last decade there have been increasing numbers of doctors training flexibly. As these trainees become independent general practitioners the effects of flexible training will be felt within the speciality of general practice. There are potential implications for patient care if the standard of training for less-than-full time trainees differs from that of their full-time counterparts.

In this project I am comparing the training experiences of full-time trainees and less-than-full-time trainees and the impact of their training on their subsequent career development by use of a structured survey.

Areas of particular focus for the research include: assessing GP trainers’ awareness of the educational needs of full-time trainees versus less-than-full-time trainees; comparing the training experiences of doctors within the two groups; and comparing the career aspirations of the two groups. I aim to consider such issues as the difference in learning pace between the two groups, variation in the potential to develop further skills, and time spent in educational activities as a proportion of the working week. I am also interested to discover whether less-than-full-time trainees feel they can provide an adequate continuity of care for their patients and whether they feel they are able to contribute to the management processes and strategic development of their training practices.

This study will provide a valuable insight into the educational needs and training experiences of full-time and less-than-full-time trainees. I hope this will help to facilitate the provision of excellent training to both of these groups in the future.

METRIC study - ME Education, Training & Resources In Primary Care
Louise Fisher1, Sarah Peters2, Alison Wearden3, Karina Lovell4, Lisa Riste5, Colette Bennett5, Carolyn Chew-Graham6, School of Primary Care, University of Manchester, School of Psychological Sciences, University of Manchester, School of Nursing, Midwifery and Social Work, University of Manchester, School of Community Based Medicine, University of Manchester, NHS Central Lancashire, National School for Primary Care Research and School of Community Based Medicine, University of Manchester, Manchester

Introduction: Chronic Fatigue Syndrome (CFS or ME) is a complex multifactorial disorder with an estimated UK prevalence of 0.8%. However, this is likely to be a low estimate as there is evidence that patients may remain undiagnosed. NICE guidelines suggest that management should be predominantly in primary care but some GPs are sceptical about the existence of the condition. There is evidence that CFS/ME is more common but less likely to be diagnosed in people from black and minority ethnic (BME) groups. The aim of this study is to develop an education and training intervention to aid early diagnosis and support the management of people from all ethnic groups with CFS/ME within primary care.

Methods: Qualitative data was collected from patient involvement groups and by semi-structured interviews with patients, carers, primary care practitioners and CFS/ME specialists. Thematic analysis using constant comparison was carried out to highlight the synergies and tensions between the different accounts.

Results: Early diagnosis, framed positively, legitimises symptoms and enables satisfactory understanding of the condition and access to appropriate resources. Models of illness and management strategies varied, but all respondents highlighted continuity of care and flexible, individualised management as important. There was limited recognition of the specific needs of BME patients with CFS/ME.

Discussion: There is a need to improve diagnosis and management of CFS/ME in primary care. We will present the influence of patient, carer and practitioner perspectives on the development of patient and practitioner resources and training, with specific reference to the needs of BME patients.

What is the influence of postgraduate ophthalmology experience on general practitioners’ confidence in diagnosing and managing eye disease in primary care? A cross-sectional questionnaire study across London
Saiji Nageshwaran1, William Coppola2, University College London Medical School, London, Department of Primary Care and Population Health, University College London, London

Introduction: Eye problems account for 1.5% of all presentations to general practice, but represent a significant proportion of referrals to secondary care. Evidence suggests many of these conditions can be managed in the primary care setting. This study aimed to assess the influence of postgraduate ophthalmology experience on GPs’ confidence when diagnosing and managing eye disease.

Methods: 520 GPs working in London were invited to take part in a 55 item postal and web-based questionnaire survey, exploring their confidence in diagnosing and managing 14 eye presentations. Groups were analysed based on reported postgraduate experience in ophthalmology.
177 - Research

Revalidation for General Practice: an evaluation of opinions, readiness and understanding.
Lynsey Murdock1, Peter Watson1, Anna Simpson1, 1University of Aberdeen, Aberdeen, 2NHS Education for Scotland, Aberdeen

The introduction of revalidation will ensure doctors are fit to practice. This paper aims to assess whether the quality and quantity of information obtained by GPs influences their opinions, understanding and readiness towards revalidation.

An online questionnaire was distributed through practice managers and out of hour’s services to all full and part time GPs working across Grampian, Highlands and Islands (ISD statistics estimate 1124 GPs). The questionnaire was available to complete online for 5 weeks. Reminders were sent during weeks two and three. Areas investigated included preparation and readiness for revalidation, and areas for improvement.

A total of 219 GPs replied to the survey. Of these three GPSTs were excluded as they will not currently be affected by revalidation. The results showed that 60.2% had obtained some information on revalidation but only 38.9% felt this was sufficient. 13% felt the information was very useful whilst 13.9% felt that it was no use at all. Participants felt information was lacking in areas regarding final decisions and how revalidation would work in practice in terms of the credit system, multi-source feedback, and protected time/locum cover. These results were not affected by practice locality. The general consensus was that revalidation would negatively impact on work/life balance and would not improve patient care.

Areas suggested to improve revalidation included having more appraisers to offer support and a one-stop website with requirements, an example ePortfolio and links to courses. Overall GPs felt the process should be kept simple and requirements finalised.

178 - Research

Junior doctors’ titles following modernising medical careers: a survey of general practitioners
Shofiq Islam1, Andrew Deekes1, Brian Isgar1, 1Department of General Surgery, The Royal Wolverhampton Hospitals, Wolverhampton, West Midlands

Aim: Modernising Medical Careers created new labels to describe junior doctors. We aimed to investigate the views and understanding of new titles used to describe junior doctors in training amongst a group of general practitioners (GPs).

Method: We sent a questionnaire to 100 randomly selected GPs in the Wolverhampton area. Questions were asked about their views of the current nomenclature. To objectively assess knowledge of the new titles GPs were asked to match equivalent positions with those based on the traditional system.

Results: Forty four replies were received. Only 32% (n=14) of GPs felt that they fully understood current terms in use. Ninety per cent (n=39) felt that it was ‘very or quite important’ that titles accurately convey seniority of the doctor. The most common titles correctly matched was FY1 with House officer (86% n=38). Only 34% (n=15) of GPs correctly matched ST3 with Junior Registrar and 5% (n=2) correctly matched ST7 with Senior Registrar. Only 30% (n=13) correctly identified GP-VTS with the equivalent. GP trainers did not demonstrate greater familiarity with titles when compared to GPs not involved in teaching (p=>0.05). We did not identify a statistically significant association with demographic characteristics (Age, gender, experience) and knowledge of the new terms. More than 93% of the GPs surveyed felt that the terms are confusing and need to be simplified.

Discussion: Our survey revealed that GPs lacked knowledge of the current terminology to describe doctors in training. This may be a hindrance to effective communication between the hospital and general practitioner service.

179 - Research

Exploring the educational impact of GP as perceived by foundation programme junior doctors in the Wessex Deanery: a comparison with other FP specialities
Olga Zolle1, Reg Oddbert1, 1Wessex Deanery, Winchester

The two year Foundation Programme (FP) aims to develop junior doctors through sets of 4 month rotational medical placements. One of these rotations may be spent in GP. The focus of the rotation is not to prepare trainees to become GPs but rather to provide them with an experience of GP. The 4 month experience in GP can be extremely varied from one practice to another. This may also depend on the services offered by the practices.

We explored through group discussions and questionnaires the perceptions from junior doctors and their trainers on their views about the educational impact of the GP experience in FP in comparison with other FP disciplines.
Overall the GP experience is viewed by many junior doctors as being fundamental to their training. The experience is valued by young doctors who may not necessarily wish to follow a career in GP. Some trainees felt that other specialties prepared them in a number of areas such as consultation skills that were previously considered to be of the GP domain by GP trainers. They reported having gained a better insight into these skills through other specialties. Since different trainees choose different specialty rotations in Wessex there is a need to look more closely into how each specialty contributes to the formation of the competent FP doctor.

180 – Research

The adapted use of a ‘knowledge cafe’ approach to explore foundation programme junior doctors’ perceptions on career choice.

Olga Zolle1, Reg Odbert1, 1Wessex Deanery, Winchester

Junior doctors must make a choice of medical specialty towards the end of their two year Foundation Programme (FP) training. We explored their perceptions on this important transition particularly with respect to how prepared they felt they were to embark on their specialty of choice.

We adapted the use of the ‘knowledge cafe’ tool from management research for the interpretation of group perceptions on various aspects related to career choice; such as reasons for choosing a particular specialty; perceived barriers to making the choice; perceived impact of the training received through the different specialties in FP on their career choice.

The Knowledge Cafe offers an in-depth exploration of group perceptions in a thorough fashion. It allows to brainstorm concepts in groups before being discussed as a group. It is also an interactive approach that allows visual, kinaesthetic and auditory participation. Young doctors rotate around tables providing feedback on each aspect explored before discussing as a group. The data gathered was analysed using cognitive drawing, discursive and mind mapping techniques.

We found that junior doctors prefer having a period of time for making this important choice for the future rather than having to do this whilst having started one of their rotations. Many junior doctors felt they were not prepared to move on to their career of choice for a number of reasons such as not having had an opportunity to train in their specialty of choice as part of their FP training.

181 – Research

Exploring learning needs assessment in doctors

Sonny Powar1, 1Severn Deanery, Bristol, 2Cardiff University, Cardiff

Following the merger between the Postgraduate Medical Education and Training Board (PMETB) with the General Medical Council (GMC) last year, the (GMC) emphasise a shift in training towards a competency based framework, whereby clinicians are expected to engage regularly in revalidation. Integral to this task lies the important task of conducting regular learning needs assessments.

This study set out to identify how doctors identify and achieve their learning needs, exploring what factors affect a junior doctors learning and proposing recommendations on how trainees in a variety of disciplines can benefit from a more effective learning experience.

Qualitative methodology was used through individual semi-structured interviews with twenty-eight Foundation doctors. Each interview was digitally recorded and transcribed verbatim then manually coded in order to inform subsequent discussions. Data analysis utilised thematic coding in order to generate the key themes used to achieve the aims of this study.

Results from this qualitative study identified key emergent themes including: learning needs assessment, learning preferences, factors affecting learning and continued professional development all of which are discussed in the context of a clinician’s learning.

The research concluded that participants were familiar with the importance of conducting regular learning needs assessments, however required additional input into exploring the diverse range of formal methods available to them, in order to complete this process effectively and its role in helping them to achieve specific training competencies. The study discusses how this diverse range of learning needs assessment methods can be implemented into clinical practice, whilst simultaneously proposing recommendations on how to make learning experiences more effective in a variety of clinical settings.

182 – Research

The use of the internet to search for education and information: the views of musculoskeletal professionals

Thomas Margham1, David Walker1, 1Arthritis Research UK, Chesterfield

Background: The internet is a huge source of educational and other material, but it is un-controlled, un-edited and contains information of variable quality.

Aims: The aim of this qualitative study was to seek information and views on what professionals and students look for and value in web-based educational resources.

Method: A qualitative study was commissioned comprising focus groups and interviews to sample searching strategies and what makes a good website. The sample group comprised 2 rheumatologists, 2 trainee rheumatologists, 4 nurses, 6 AHPs, 3 GPs and 1 orthopaedic surgeon.
**Research Poster Presentations**

**183 - Research**

**What is it like to be a doctor in the NHS? An exploration of the narrated experience of doctors in a changing NHS**

Sharon Bell1, University of Liverpool, Liverpool

A state of perpetual change and shifting goals in the services provided by the NHS over the past 25 years provides the backdrop for my exploration of the working lives of doctors across a range of settings.

From a GP background, my links to these continually evolving situations have facilitated a rapid rapport with participants who have been working in NHS posts in Primary and Secondary care for more than 25 years. This natural platform forms an excellent base from which to gather stories which are less readily shared outside professional circles. I have conducted individual narrative interviews, allowing each interviewee to choose their preferred means of conveying much richness and detail from memories of their career. These narratives were subjected to probing and reflection-inducing questions, drawing further details and amplifications which became helpful in analysis and interpretation.

The resulting prominent features of work experience allow greater insights into the roles undertaken by doctors and the impact of these features on practical work situations, levels of job satisfaction and the ability of clinicians to meet multiple and at times contradictory expectations. I maintain a strong link between these richly detailed accounts and the contexts in which they emerge, but also aim to present the interviewees as credible individual actors in these various situations.

This poster presentation outlines important aspects of research from the inside and begins to present re-told stories which at times depart from public perspectives of the medical arena thereby challenging aspects of established discourses around medicine.

**184 - Research**

**Medical student perspectives of what makes a high quality teaching practice**


Aims: The RCGP (2011) aims to develop high quality general practitioners. Providing students with quality experience in primary care may help to encourage top undergraduates into a career in general practice (Wass, 2007). The GMC (2009) recommend that medical students gain clinical experience in general practice. Cotton et al (2009) produced a national consensus list of quality criteria for community based teaching, developed using a variety of medical education stakeholders. In response, this project aims to improve understanding of medical student perspectives about what makes a high quality teaching practice. This study uses a novel design to achieve this, being the first of its kind to be conducted across more than one medical school.

Methods: Focus groups were held at three medical schools, conducted using third and fourth year medical students with experience of primary care placements for their current academic year.

Results: 17 participants took part in 4 focus groups. Framework analysis identified 5 themes: GP tutor quality; student involvement; learning environment; organisational factors and patient involvement in teaching. An interesting result was the emphasis that students placed on the value of patient involvement in teaching and the advantages of gaining informed consent.

Conclusions: There are several factors that contribute towards a high quality teaching practice. Patient involvement in teaching is important because without it students would not be able to learn effectively. Involving patients in the planning of primary care teaching supports the RCGPs (2011) value of working in partnership with patients to provide holistic care.

**185 - Research**

**CBT-based guided self-help led by medical students: their views on how it influences their education and future careers**

Nicola Warren1, Alison Croft2, University of Oxford Medical School, Oxford, Psychological Services and Oxford Cognitive Therapy Centre, Oxford Health NHS Foundation Trust, Oxford

Background: Most medical students have little experience in their training of managing a patient over several encounters, despite this being a crucial aspect of many areas of medicine, especially general practice and psychiatry. At Oxford University Medical School, some students can opt to conduct a short course of cognitive behavioural therapy (CBT)-based guided self-help with a patient, under supervision, in a primary care setting. An earlier study evaluated this as a method of delivering training in CBT skills to students.

Objectives: To collect student's views on conducting a course of CBT in terms of its impact on their general medical education and career plans. To establish students' motivations for taking part.
Research Poster Presentations

**Methods:** Fifth year students from two successive years were surveyed by written questionnaire. Responses were analysed qualitatively.

**Results:** Some common themes emerged amongst the responses. Students were motivated to take part by the chance to develop a relationship with a patient over several sessions, to take some responsibility for management and gain experience of CBT. Beneficial outcomes included gaining direct experience of managing a patient, structuring consultations, and guiding patients to their own solutions. Difficulties included frustration at not solving all of a patient’s problems, and feeling unprepared if the consultation took an unexpected turn. Students were currently interested in a variety of careers; the most commonly stated being general practice.

**Conclusions:** Most students found conducting CBT to be a beneficial addition to their medical education. Students felt it had not influenced their future career plans.

**186 - Research**

**Workforce planning; First5 career intentions on place and quantity of work**

Jonathan Rial¹, Samantha Scallan¹, Johnny Lyon-Maris², Simon Newton¹, ¹Mid-Wessex Patch, Primary Healthcare Education, The University of Winchester, Hampshire, ²Southampton Patch, GP Education Unit, Southampton University Hospital Trust, Hampshire

**Background:** Research demonstrates that Newly Qualified General Practitioners (NQGPs) have different career expectations to those of senior colleagues. No longer is full-time principalship the next step on completion of training; instead NQGPs look to working in short term posts, to meet learning needs that remain on completion of training. The First5 initiative looks to support NQGPs, however local evidence is lacking which may inform this process.

**Summary of Work:** A small-scale pilot survey of 38 GP ST2-3’s was carried out in the Wessex deanery using an electronic questionnaire. The survey was intended to gather information about the trainees’ post-qualification career intentions.

**Summary of Results:** The findings of the survey reflect the national trends in career intentions of newly qualified GPs, which will be highlighted in the poster.

- Only 27% planned to become a principal.
- Only 51% intended on working full-time.
- Of those intending to become principles, only 33% intended to work full time.
- 87% intend to stay in Wessex.
- 65% planned to form small group learning sets from their current DRC.

In addition they pose interesting questions regarding the transition from being in training to independent practice, and how best to support the change.

**Conclusions /Take home messages:** These results pose important questions for future workforce planning and the provision of support:

- As part-time working continues to expand there will not be enough practitioners to retirement vacancies.
- NQGPs recognise the need for continuing educational support, but lack knowledge of the available structures.

**187 - Research**

**The views and experiences of female GPs on professional practice, childcare support and career planning**

Clare Wedderburn¹, Samantha Scallan¹, Clare Whittle², Anthony Curtis², ¹Wessex School of General Practice, Winchester, Hampshire, ²Severn Deanery School of Primary Care, Bristol, Avon

**What is already known:** Previous research into career paths and national workforce demographic data demonstrate an increasing feminisation of the GP workforce. With female general practice specialty trainees (GPSTs) outnumbering males, this trend is set to continue. The changing composition of the GP workforce presents new challenges in terms of how best to support the needs of this sector of the workforce in an evolving healthcare delivery context.

**What this research adds:** This large-scale study of female GPs in a well-defined geographical area shows that childcare is a particular challenge for respondents. Those aged under 49 reported significantly more difficulties in managing their childcare needs than older colleagues.

Marital status, number of children and employment status did not moderate the effect of childcare difficulties.

Female GPs report working more hours with increasing age, whether by choice or circumstance, but they are not necessarily represented in more senior positions as a consequence.

Younger female GPs with childcare responsibilities are less likely to be involved in teaching and training, and even less likely to be involved in roles linked to primary care trusts, medico-political issues, hospital service delivery, special clinical interests or deanery education management.

A significant majority of the sample which experienced problems with managing childcare and work reported that family commitments were currently encouraging them to make early retirement plans.

**Conclusions:** Female GPs perceive a need for more support in terms of both their childcare and professional career development, in order to enable them to take on senior practice roles.
188 – Research
We also need support
Maryam Rafique1, 1King’s College London, London

Addiction is a common problem affecting many members of society and rates are ever increasing. Help for families who live with someone with a substance misuse problem have merely concentrated on providing remedies for the problems without sufficient evaluation as to the underlying cause. Instead the focus of treatments has been on either helping the user with policies directed towards their needs at an individual level. In doing so, the health care professionals are failing to address the needs and concerns of the millions of family members affected by living with a relative with substance misuse.

This poster will concentrate on two types of interventions: available: - the ‘5-step’ intervention and the Social Behaviour and Network Therapy (SBNT). These acknowledge the role that families could play in influencing the course of the addict’s drug and alcohol problem and the contributing role they can play in helping the user to advance and progress in treatment. These are providing a platform for families to come forward and express their concerns whilst receiving advice on a number of coping mechanisms, information and enabling them to gain support on a social and network level.

There are hurdles in place, however, which need to be addressed before the positive developments of these strategies can fully be recognised.

189 – Research
Exception coding in Quality Outcome Framework: does it relate to health outcome?
Richard Sekula1, Eugenia Lee1, Jackie Davidson1, 1NHS Greenwich, London

Introduction: Quality Outcome Framework, a payment for performance system in primary care includes the concept of exception reporting. Allowing practices to pursue the quality improvement agenda and not be penalised for factors beyond their control. It is viewed that those who are excepted, in particular for non-attendance, are those who are more likely to have greater needs and poorer outcomes. This paper sets out to analyse whether, in Greenwich, exception reporting rates have any relationship to health outcomes.

Method: Exception reporting rates (asthma, AF, cervical cancer, CHD, CKD, COPD, diabetes, heart failure, Stroke/ TIA) were extracted. Health outcome data analysed included mortality (all age, premature, specific to ICD 10 codes), admission data (including emergency, elective, non elective), outpatients activity and prescribing data. Correlations were calculated between exception reporting rates at a practice level to the health outcomes, specific to each condition when possible.

Results: There are significant levels of variations in exception reporting in practices within Greenwich. For all 9 exception reporting categories only CKD had a significant relationship with all age mortality from CVD (Spearman (45)= -40, p<.01) and premature mortality from CVD circulation (Spearman (45)= -32, p<.05) in Greenwich.

Conclusion: Whilst there are significant variations in exception levels across practices in Greenwich, the extent of this, from our analysis, suggests that this does not appear to significantly affect health outcomes locally. However, there are many other contributing factors that need to be considered and further analysis and research on a far wider scale is required.

190 – Research
Lena Barrera1, Christopher Millet1, Marta Blangiardo1, Utz J. Pape1, Azeem Majeed1, 1Imperial College London, London

Background: Blood pressure control is defined as the achievement of blood pressure targets. In UK, the Quality and Outcome Framework (QOF) target of 150/90 mm Hg and the National Institute and Clinical Excellence (NICE) target of 140/90 mm Hg are used in primary care. We examined differences in being classified as hypertensive controlled patient (HCP) using these targets.

Methods: We performed a cross-sectional study using data collected from 28 practices in Wandsworth, London in 2007. The proportion of HCP was calculated. Logistic regression models were used to assess patient characteristics with the probability of being classified as HCP. Relative excess risk due to interaction (REI) of age-sex was quantified.

Results: The proportion of HCP was 79.5% with the QOF target and 60.7% with the NICE target. For both targets, those prescribed one antihypertensive drug and with cardiovascular comorbidity had higher probability of being classified as HCP (27%, P = 0.004 and 45%, P = 0.000). Compared to 17-44 years female, 17-44 years and 45-65 years male were less likely to be classified as HCP. Using the QOF target, >65 years male had OR 1.59 95%CI (1.15 - 2.17) REI 44.6% and OR 0.62 95% CI (0.49 - 0.79) REI 52.7% with the NICE target.

Conclusion: Each target produced different proportions of HCP. The higher probability in those with cardiovascular comorbidity may be due to the lower targets recommended for them. Age-sex interaction effect on being classified as HCP was reported. Greater consistency is needed between the QOF and NICE targets.
Craig Leaper¹, Lena Barrera¹, Utz J. Pape¹, Azeem Majeed¹, Christopher Millet¹, ¹Imperial College London, London

Background: Hypertension is a modifiable cardiovascular risk factor. Lower rates of hypertensive patients on treatment have been reported worldwide. In UK, guidelines on hypertension treatment were produced by National Institute for Health and Clinical Excellence (NICE) in 2004 and modified in 2006.

We examined trends in hypertensive patients on treatment in general practices in Wandsworth (London) between 1998 and 2007.

Methods: Data from 28 general practices in Wandsworth, London was analyzed. Hypertensive patients aged over 17 years with ethnic origin recorded were included. We compared proportions of newly registered patients on recommended NICE treatment between before (2000-2003) and after (2004-2007) periods using linear regression.

Results: From 1998 to 2007, the number of hypertensive patients registered increased from 5065 to 15160. 54.3% were female, 59.9% White, 57.6% were >55 years, 21.4% of them had diabetes. Over the study period, patients on treatment increased from 50.6% to 86.5%. Before and after variations in recommended monotherapy prescribing rates were 71.4% to 73% in Black patients, 45.6% to 60.9% in the <55 years no Black patients, and from 52.8% to 54.7% in the >55 years no Black patients. There was not significant variation in the proportion of patient on correct treatment (slope 0.06 P=0.410) between periods.

Conclusion: Increases in number and percentages of hypertensive patients on treatment in Wandsworth between 1997 and 2008 are reported. Publication of the NICE guidelines may account for some of this trend, although many hypertensive patients were receiving recommended drug treatment before the implementation of the guidelines.

Improving cardiometabolic risk whilst reducing secondary care costs - PCT and pharmaceutical industry working together: results of the NHS Greenwich “Evidence Into Practice” pilot
Lewis Beake¹, Jackie Davidson¹, Junaid Bajwa¹, Simon Hussain¹, Richard Sekula¹, Chima Olughu², ¹MSD, Hoddesdon, ²NHS Greenwich, Greenwich

Introduction: Greenwich has substantial health inequality. Circulatory disease accounts for 24% of premature mortality. Diabetes is under-diagnosed and sub-optimally treated. Evidence into Practice (EIP) is a fully-facilitated change management program, provided by MSD, comprising a current performance audit, analysis of practice confidence and implementation of a training program.

Methods: 14 practices took part, based on health inequality markers. Each underwent baseline audit of achievement against NICE CG87 standards and mapping of clinician confidence of diabetes management. Gaps were met with face-to-face training from secondary care and review of “critical event” patients as learning opportunities. Patient pathways were defined in line with PCT & NICE guidelines. Virtual consultation exercises, reviewing 10-15 patients with secondary care took place to improve decision making. These changes were incorporated into daily practice.

Results: Six months after the program was initiated, improvements in proportion of diabetes patients achieving NICE targets (standardised to account for growth in diabetic population) were as follows:
- HbA1c <6.5% increased by 14.7%
- BP <130/80 increased by 7.3%
- Total Cholesterol <4mmol increase by 7.9%

Pilot practices showed greater improvement than non-EIP practices in all but one (DM18) of the QoF DM categories (2009/10 - 2010/11). EIP practices showed a reduction in secondary-care diabetes outpatient attendances by 5% (11% increase in non-EIP) and CVD admissions by 1% (13% increase in non-EIP). The cost savings (actual and avoided) was £201,119 across EIP practices with projected opportunity savings across the PCT of £731,688.

Conclusion: The EIP is an innovative program which delivers improvements in quality of care, with productivity savings driven by more appropriate use of secondary care.

Carolyn Deighan¹, Wendy Armitage¹, Louise Taylor¹, Michelle Clark¹, ¹Heart Manual, NHS Lothian, Edinburgh

Introduction: ‘Commissioners are accountable for ensuring the services provided to local patients are equitable, accessible, acceptable, safe, effective and efficient.’ (RCPGP, Centre for Commissioning).

In this time of change within the NHS, the challenge is to secure services for patients which meet the above criteria. The Royal College of General Practitioners (RCPGP) has issued a competency framework which, as well as indicating the skills and knowledge required in effective commissioning, highlights the foundations for effective commissioning. These guiding principles will have an impact on the choices commissioners make when securing services.

This presentation illustrates, through the inclusion of The Heart Manual Programme and The Stroke Workbook, how commissioners are able to satisfy these requirements, and provide patients with a cardiovascular rehabilitation service that is ‘equitable, accessible, acceptable, safe, effective and efficient’.
**Practice/Project Poster Presentations**

The Heart Manual is a facilitated rehabilitation programme with a robust evidence base for people post myocardial infarction or revascularisation and is recommended in NICE and SIGN guidelines. Similarly, The Stroke Workbook is evidence based facilitated intervention to enhance the functional recovery of stroke patients.

**Methods:** The benefits of using these cardiovascular rehabilitation programmes are presented using the RCGP's foundations for effective commissioning as a framework.

The programmes enable commissioners to provide
- Improving outcomes
- Patient empowerment
- Evidence based practice in a cost effective way
- Community mobilisation
- Sustainability

**Conclusion:** When sourcing rehabilitation services for cardiovascular patients, The Heart Manual programme and The Stroke Workbook affords commissioners to meet the requirements necessary for successful health care.

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**194 – Practice**

**An analysis of the pattern of home blood pressure monitoring in patients with previous strokes or TIsAs**

Lucy Salmons1, Sally Kerry1, 1Barts and the London, School of Medicine and Dentistry, London

**Background:** Hypertension is an important risk factor for strokes and TIsAs that can be readily treated to reduce risk of recurrence. Home blood pressure monitoring (HBPM) can decrease BP by a clinically significant amount.

**Methods:** A secondary review of a community based randomised controlled trial by Kerry et al to analyse compliance in patients over one year of HBPM. The intervention group (n=187) were required to record their BP three times on one day each week in booklets collected after one year. Missing data was assessed to see how compliance varied. Percentage of readings missed was analysed with age, gender, disability and stroke/TIA event, index of multiple deprivation (IMD) and anxiety. Patient and researcher readings were compared. Patients that did not return booklets (n=83) were compared to those that did by last month BP readings (if recorded by patients).

**Results:** Compliance steadily deteriorated over time, correlation: 0.94. Older patients missed fewer readings (50 to 60 year olds compared to 80 plus, P-value 0.04). Gender, IMD, disability, stroke /TIA and anxiety were not found to affect compliance. Significant differences between average patient BP readings and researcher recorded readings were found at baseline, 6 and 12 months. At 6 months, researcher's readings were 6.4mmHg higher (95% CI: 1.52 – 11.28). At 12 months, 8.1mmHg higher (95% CI: 2.83 – 13.37).

**Conclusion:** Older patients were more compliant with HBPM. Other factors were not found, likely due to bias and small sample size. There was a significant difference between researchers and patient's recorded BP.

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**195 – Practice**

**Conquering the cultural canyon – the work of aboriginal community health workers in chronic disease management.**

Jacqueline Harris1, 1Derbarl Yerrigan Aboriginal Health Service, Western Australia, Australia

Globally awareness is building that cultural gaps exists between primary care doctors and their patients. This gap can adversely affect the possibility for lifestyle change, uptake of medical services and hence the control of preventable chronic disease1.

This gap has been obvious at Derbarl Yerrigan Aboriginal Health Service, Western Australia since foundation in 1973. DYHS is a community controlled health service. It runs three well-funded clinics in urban Perth to serve a well-integrated Aboriginal population. However it still witnesses the high morbidity and mortality from preventable chronic disease experienced by indigenous people throughout Australia.

Two programmes, making extensive use of community based Aboriginal Health Workers, were specifically designed to target cardiovascular disease. The ‘Heart Health’ programme targets patients with known cardiovascular disease, while the ‘Marmun Pit Stop’ aims to detect and then reduce risk factors in indigenous men.

Aboriginal Health Workers are trained only to a basic level in community health, but their ability to bridge the social and cultural divide between doctors and patients offer new possibilities in the prevention and management of chronic disease, and may be more cost-effective than doctor-led interventions.

The diversity between GPs and patients may be less obvious in the UK, but often a frustrating awareness of a cultural divide exists. Perhaps we could learn from initiatives such as these to promote healthy lifestyles and timely access to cost-effective and life-saving treatments.

### 196 - Practice

**Vitamin D deficiency in BME communities: implementation dilemmas in detection, treatment and prevention in Liverpool**

Katy Gardner1, William Fraser2, Kate McFadden3, Topping Joanne4, Qassim Taher5, Michelle Cox6, Lynne Garforth7, James Bunn8, 1Liverpool Community Health NHS Trust, 2Royal Liverpool and Broadgreen University Hospitals NHS Trust, 3Liverpool Primary Care Trust, 4Liverpool Women's NHS Foundation Trust, 5Liverpool Primary Care Trust, 6Liverpool Primary Care Trust, 7Liverpool Community Health NHS Trust, 8Alder Hey Children's NHS Foundation Trust, Liverpool

Following reports of osteomalacia in Liverpool Somalis (2004) a study of 307 Somalis found 82% had severe Vitamin D3 deficiency (<15nmol/L), 33% having increased PTH. Deficient participants were given vitamin D and calcium by Somali community health workers. Re-test showed 23/27 were still severely deficient indicating low adherence. Concurrent research indicated the Somali diet was low in Vitamin D and a targeted food map was produced.

The PCT convened a group to create guidelines for Vitamin D deficiency (2005) and developed community education with BME communities. One GP practice developed treatment guidelines using high dose Vitamin D, which subsequently became unavailable. The Women’s Hospital initiated antenatal testing in their interpreter based clinic and recently extended testing to all BME women.

An audit found very different rates of testing for Vitamin D deficiency in practices with similarly diverse populations (2008). Testing increased following GP education.

Optimal concentrations for vitamin D were increased in 2009, requiring guideline revision. However Vitamin D formulations were limited, though Healthy Start vitamins became available for children and pregnant mothers. Access required a complex process and uptake is still low. The PCT considered universal supplementation of at risk groups unaffordable. Cases of rickets and neonatal hypocalcaemia are still being seen locally.

Work is ongoing to identify acceptable means of reducing this reemerging problem, particularly, in BME populations. This is most likely to be a combination of universal supplements and high dose oral vitamin D, recently available on prescription, for those identified as deficient.

### 197 - Practice

**A local hill is as good as a treadmill**

Colum Farrelly1, John Purvis1, 1Altnagelvin Area Hospital, Londonderry

The ability to walk up Derry’s main street (the hilly Shipquay Street) excludes ischaemic heart disease.

A study of patients referred by GPs for exercise stress testing found that those patients who could walk up Shipquay Street without inducing their symptom all had normal cardiac tests.

Details of the gradient of the hill and the effort required to walk it are compared to the effort required to perform a Bruce Protocol treadmill test.

Thus IHD can be excluded by GPs who have a similar hill for their patients to test themselves on. Referrals reduced!

### 198 - Practice

**Lifestyle matters - improving engagement for older people**

Jill Davison1, Lesley Carr1, Joanne Crighton1, 1Gateshead PCT, Gateshead Tyne and Wear

**Introduction:** A fourteen week programme for older people experiencing difficulty engaging in activities or social interaction.

**Aims:** Examine the link between activity and wellbeing

Identify barriers to engaging in activity

Use individual goal setting overcome barriers to engagement in activity

Equip people with the skills to independently set goals and problem solve post the group

**Method:** The group was led by occupational therapists working in health and run in partnership with local authority staff, to implement NICE public health guidance (NICE guideline 16).

Members had a range of difficulties e.g. anxiety, low mood, and low self esteem or reduced mobility. Progress of the group was re-evaluated weekly by facilitators following the group to discuss member’s progress. The group focused on peer support and shared learning therefore group members were encouraged to identify and celebrate their own achievements within the group and share their goals. This process reinforced their commitment to achieve their goals and pulled the group together by identifying that they all had barriers to overcome.

**Results:** Initial evaluation has shown members had increased confidence and widened their engagement in activity following the group. Further evaluation is planned three months following the group to ensure progress was sustained and people continued to increase confidence and engage in activity.

**Discussion:** Participation in a lifestyle matters group can assist people to independently engage in activity improving wellbeing. Research shows that engagement in activity impacts positively on health and wellbeing resulting in reduced GP contacts and hospital admissions.
**Practice/Project Poster Presentations**

### 199 - Practice

**Young-onset dementia: clinical review and service needs**
Asiya Maula1, Mohammed Faysal Malik2, Balamurugan Ganesan1, Queen's Medical Centre, Nottingham University Hospitals NHS Trust, Nottingham, 1Queen's Hospital, BHR NHS Trust, Romford

**Background:** Young-onset dementia is a term used for anyone diagnosed with dementia under the age of 65. Alternative terms are ‘early-onset’, ‘working-age’ and ‘pre-senile’ dementia. Prevalence varies worldwide, with 18% (95% CI 15.1 to 21.1 per 100,000) to 86.1 (95% CI 81.1 to 118.0 per 100,000) per 100,000 in the UK; a likely underestimate.

**Discussion:** Symptom presentation and aetiology varies with age groups and is distinctly different to dementia in the elderly where Alzheimer's dementia is predominantly seen. There is a vast differential diagnosis: familial Alzheimer's, metabolic disease, frontotemporal, alcohol-related and other inherited dementias, amongst others amenable to treatment. A careful history with an emphasis on the pattern of cognitive impairment, disease temporal profile and family history in combination with laboratory testing will aid diagnosis. Causative gene identification in inherited dementias has increased understanding of molecular pathology, leading to potential treatment applications in dementia at any age. Its insidious onset results in delays in adequate care service provision, which traditionally has focused on older patient populations and may consequently lead to cases where the complex needs of a younger patient may not be met, particularly occupational difficulties. The impact of such a diagnosis at a young age presents a particular challenge in primary care with a variety of psychosocial problems for the patient and caregivers, especially in patients with young children.

**Conclusion:** Early assessment and awareness with interagency collaboration is required with a pragmatic estimate of service needs to develop services with a specialist, age-appropriate and patient-centred model of care.

### 200 - Practice

**Psychiatric co-morbidity in autistic spectrum disorder: a role for routine specialist referral**
Mohammed Faysal Malik2, Asiya Maula1, Queen's Medical Centre, Nottingham University Hospitals NHS Trust, Nottingham, 1Queen's Hospital, BHR NHS Trust, Romford

**Background:** Aspergers syndrome (AS) is a high-functioning form of Autism, part of the autistic spectrum disorder (ASD); a pervasive developmental disorder. Due to its early age of onset and under-recognition and familiarity in primary care, AS in clinical practice persists for many years undiagnosed. This leads to patients presenting directly to adult psychiatric services with a variety of psychopathological symptoms.

**Discussion:** Common psychiatric disorders are seen in young patients with AS, in up to 94% of cases, ranging from psychotic symptoms to general anxiety and mood disorders; particularly major depressive disorder. Patients with ASD may not have the language skills necessary to verbalise symptoms, especially those related to mood disorders. Psychotic symptoms may therefore be misinterpreted as schizophrenia. Although the prevalence of schizophrenia in ASD is variable, both share similar social cognitive deficits, with conflicting evidence of whether they are related or on two ends of a disease spectrum. Consequently, this predominantly young population may not be referred onto adult psychiatric services early where any required interventions can be instituted. Early referral from primary care is emphasised as further detailed assessment of additional psychiatric disorders is needed in this population. Such co-morbid conditions will limit the level of independent functioning and services need to be directed to manage this.

**Conclusion:** Increased awareness of AS and its associated psychiatric disorders is needed in primary care to better target early interventions, thereby minimising associated morbidity. Routine evaluation for psychiatric co-morbidity in AS is recommended with emphasis on early primary care referral.

### 201 - Practice

**Multidisciplinary consensus for the future development of ADHD Services**
Hani Ayyash1, Honor Merriman2, Sachin Sankar2, Carsten Vogt3, Prudence Allington-Smith4, Tina Earl5, Kiran Shah7, 1Doncaster Royal Infirmary, Doncaster, 2NHS Oxfordshire, Oxford, 3CAMHS, Northampton, 4CAMHS, Reading, 5Brooklands Hospital, Birmingham, 6Demford Hospital, Plymouth, 7Redbridge PCT, Ilford

**Aim/Objectives:** To define a set of standards and validate them as a road map for future development of ADHD services in the UK.

**Methods:** A multidisciplinary group of clinicians involved in the treatment of patients with ADHD met to define a set of appropriate consensus statements that would define the ideal structure and direction of improving service development in the UK. Forty statements were agreed, covering 10 topics, ranging from commissioning of ADHD services to optimisation of the care pathway. The statements were collated into a questionnaire and passed to other professionals at multidisciplinary meetings around the UK. The questionnaire data was analysed and scores produced for levels of agreement with each statement. Respondents were grouped into child & adolescent psychiatrists, paediatricians, nurses, trainees and other staff.

**Results:** 122 respondents scored each statement on a questionnaire and levels of agreement were summed and analysed. Of 40 statements, only 4 scored less than 90% agreement (Table 1A), with all statements achieving greater than 74.9% agreement. All other 36 statements achieved greater than 90% agreement while six out these statements achieved greater than 99.1% agreement (Table 1B).

**Conclusions:** All 40 statements therefore have broad support across the ADHD clinical and professional community and reflect strong agreement about what constitutes best practice in the management of ADHD and the direction for future development of services.
Practice/Project Poster Presentations

202 - Practice  

Supporting GPs to provide cost effective solutions for patients with mental health illness.  

Vandita Chisholm1, Peggy Frost1, 2College of Occupational Therapists, London  

Occupational therapy is one of the five key professions successfully assisting in the recovery of people with mental health problems (CSIP and NIMHE 2007). By using occupational therapists, GPs can improve their service delivery for people with mental health problems, such as stress, depression, psychosis and substance abuse. Occupational therapists support mental health patients to recover by identifying occupational focussed goals (COT 2007). The occupational therapy intervention enables patients to fulfill satisfying routine of everyday activities that creates a sense of direction to life. This provides self-perpetuating recovery that in the long term reduces the need for costly and high resource intervention such as psychiatric consultation or hospital admission.

Occupational therapy can help people with mental health problems to improve independent living and remain/return to work. In an audit, 60% of mental health patients who received occupational therapy met their self care goals (Morley 2010). Occupational therapists can also support GPs with assessing fitness to work and managing return to work pathways. Occupational therapy enabled mental health patients to return to work three months earlier, and work longer than standard psychiatric interventions. 50% of service users with mental health problems who returned to work as a result of occupational therapy intervention, were still in employment 42 months later (Schene et al 2007).

This paper will provide evidence on how occupational therapy can provide GP practice with affordable and effective mental health care for their patients.

203 - Practice  

Substance abuse challenges in rural general practice  

Sarah Mills1, 1University of Edinburgh, Edinburgh  

Introduction: Drug and alcohol use in rural communities is a particular challenge in rural general practice. To compare two of the world’s largest national health systems, I studied rural general practice in both British Columbia, Canada and Argyll, Scotland.

Methods: GPs were given a questionnaire comprising structured answers and free-text sections, supplemented by semi-structured interviews with GPs, nurses and AHPs. Interviews focused on interviewees’ perceptions of the challenges facing rural practice.

Results: Drugs: In Canada, consultations regarding drug and solvent abuse far outnumbered those for alcohol dependence. Drugs were frequently grown or imported onto the island communities (which lacked police officers) and as such were readily available and used. The GP practice led a very successful methadone programme, which reduced the social impact of drug use.

In Argyll, services for drug dependence were more limited – without a methadone programme, patients with opiate dependence could only be prescribed week-long supplies of codeine. There was no formal programme for long-term support or stabilization of drug use.

Results: Alcohol: In Argyll, alcohol dependence was encountered more commonly by GPs than substance abuse. A nurse-led alcohol support service with weekly follow-up was very effective.

In Canada, alcohol abuse was common on the Native American reservations, but formed a very minor part of practice consultations off the reservations. The GP practice did not have any formal arrangements for supporting alcohol abstinence.

Conclusions: Within two very similar geographical and socioeconomic settings, there existed huge differences in the patterns of substance use.

204 - Practice  

Quick guideline for management of “Self harm patients”  

Farshad Shaddel1, Marjan Ghazirad1, 2Oxford University, School of Psychiatry, Oxford  

Aim: About 150,000 people each year present themselves to NHS after an episode of self harm. Making proper decision about admitting or treating the patient in community with help of available psychiatric services is an important role of GPs and liaison services. This project has tried to provide an easy, step by step guideline to help the assessor to make safe and rational management plans for self harming patients in an acute setting.

Methods: A flowchart was designed on the basis of current literature, guidelines and consulting with few experienced psychiatry consultants. Then it’s validity and reliability was tested in three small pilot studies. Anonymous cases studies were used for these pilot studies.

Results: The flowchart divides patients to five groups from “No risk” to “Definite risk to self/others” on the basis of assessor’s observations and reports by patient, carer and other medical professionals. In next step, answering to these three basic questions: “Is there any history of previous serious self harm with similar presentation?” “Is there a supportive adult at home?” and finally “Is there any severe mental illness in patient?” would lead the assessor to one of these management plans: “Admit,” “Home with crisis team support;” “Home and CMHT referral” and finally “Home with GP follow up.”

Conclusion: The preliminary results suggest some potentials for clinical use of this guideline by GPs, psychiatry liaison services and others. However this guideline is not and shall not be used as a replacement of doctor’s clinical judgment and seeking proper advice. Further clinical studies on real cases is required to confirm validity of above findings.
205 - Practice  
**Alcohol day detoxification: a new nurse-led service in Southampton**

Louise Dubras¹, Anya Farnbrough¹, Pamela Campbell¹, Ann Spooner¹, ¹Solent NHS Trust, Southampton

Alcohol detoxification is traditionally offered by specialist secondary care based services, and usually follows one of two models; residential or home. Accessibility is limited by access into and through Tier 2 services. Patients' suitability for home detoxification is limited by a number of social factors, thus relatively few can be offered safely. Residential detoxification is expensive and can be unacceptable to patients who cannot or do not wish to be away from home.

We have developed a nurse-led primary care day detoxification service. Following a comprehensive assessment, suitable patients will start a 7 day detoxification on a Monday. Patients attend daily for five days and are assessed (CIWA, physical examination and breathalyser) and given medication. On Fridays patients are given enough medication to last the weekend. Detoxification is stopped if the patient drinks alcohol. The service is also available to patients to continue a detoxification started in an acute hospital or residential setting thereby maximising clinical safety and ensuring most cost-effective use of resources.

Southampton is a pilot site for personal health budgets in alcohol treatment services. Following assessment patients are allocated an indicative budget and given choice in how to spend it. This has allowed for creative support tailored to patients' needs. One example is the provision of night support where the patient lives alone and a day detoxification would otherwise not have been possible.

There are now plans to allow GPs locally to refer patients directly for detoxification.

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206 - Practice  
**Screening spirometry in general practice in smokers presenting with a cough: does it increase COPD diagnosis and smoking cessation?**

Eugenia Lee¹, Martin Dachsel¹, Fiona Holmes¹, David Wheeler¹, Niraj Patel¹, Lia Cristofoli¹, ¹Thamesmead Medical Associates, London

**Introduction:** Screening spirometry is used as a smoking cessation tool with improved smoking cessation success rate. There has been no study done for COPD screening. Thamesmead Medical Associates has a reported versus expected ratio of 0.33, with a predicted under-diagnosis of 302 cases.

**Method:** TMA has undertaken a screening spirometry pilot for smokers who presented with a cough from March to November 2009. Each consultation room has a handheld spirometer all smokers were informed of their reading including their % of predicted FEV1 and lung age. Smoking cessation advice was given with visual prompts of lung age.

**Results:** 278 patients were screened, 101 (36.33%) had FEV1 < 80%, of these, 55 (54.46%) attended a follow up spirometry, 11 new cases (20%) of COPD were diagnosed due to the follow up consultation. 81 (29.14%) patients took up smoking cessation with a documented 21 quitters at 4 weeks confirmed with CO monitoring, giving a success rate of 26%.

**Discussion:** Handheld spirometry targeting smokers presenting with a cough have improved smoking cessation attempts and subsequent quit rate. 20% of patients who were identified to have a reduced predicted FEV1 were later confirmed to have COPD. Lower than expected handheld spirometry screening were done as 6 out of 17 consultation rooms handheld spirometers were broken, of all 22 staff, only 9 (20.9%) carried out more than 5 spirometries; despite continuous reminders. Patient education regarding the implication of low FEV1 needs to be improved.

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207 - Practice  
**Improving dermatology care in general practice - the impact of in-house peer review before referral**

Jacqueline Tavabie¹, Simon Tavabie¹, ¹Ballater Surgery, Orpington

A Cochrane systematic review has suggested that providing a second opinion before referring from primary to secondary care may improve the referral process. Changing general practitioner (GP) behaviour requires addressing the complex decision-making process around referrals, and most work to date has focussed on education of GPs and use of additional skills or resource, such as telemedicine or GPs with special interests. This study of dermatology referrals in one practice demonstrates a positive impact of in-house peer review by GPs with no specialist knowledge of dermatology, reviewing patients together at the time of consultation. Referrals made were followed-up after referral for appropriateness and diagnostic accuracy. Benefits included discussion and learning by GPs, including locum doctors; greater patient involvement in decision-making; and a 24% reduction in unnecessary referrals; sustained over 3 years. This was without any compromise in patient care or safety, and no missed significant diagnoses. Time invested was considered worthwhile by participants and compensated by reduced time generating referrals.

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208 - Practice  
**Key issues from a medication errors and safer prescribing workshop**

Mark Dinwoodie¹, ¹Medical Protection Society, London

Medication errors in primary care are common, some of which result in patient harm, occasionally with severe consequences. They can also result in hospital admissions. While a patient's response to a medication can be idiosyncratic, much of this drug related morbidity is preventable. Management of long term conditions, therapeutic advancements and an ageing population have resulted in increasing use of medicines.

Most of the errors at the individual practitioner level relate to prescribing, while high risk areas where system failures are likely to occur include: repeat prescribing; anticoagulation; care homes; discharge and admission to hospital and monitoring of medication. IT innovations can and do help to reduce errors, but aren't enough on their own.
**209 - Practice**

**A review of use of low strength buprenorphine patches (BuTrans) in a large semi-rural GP Practice in South Norfolk**

Caroline Thurlow1, *Wymondham Medical Practice, Wymondham, Norfolk*

**Introduction:** NHS Norfolk has one of highest prescribing rates for low strength (5mcg/hr, 10mcg/hr, 20mcg/hr) Buprenorphine patches in the country. Annual cost for opioid analgesics for NHS Norfolk exceeded three million pounds (March 2009-February 2010). Low strength Buprenorphine patches accounted for 22% of cost. BuTrans is indicated for treatment of non-malignant pain of moderate intensity requiring opioid analgesia.

**Aim:** To gather information on current prescribing practice to identify BuTrans’ place in therapy and reasons for high spend. To facilitate development of pain prescribing guidelines.

**Method:** Searches identified all patients at large semi-rural GP practice in South Norfolk who had been prescribed Buprenorphine patches between July-December 2010. Data collection involved scrutinising selected patients’ electronic records. Information was recorded: place of residence, indication for prescription, neuropathic pain, initiation in primary/secondary care, date commenced, initial dose, current dose, analgesia prior to initiating Buprenorphine, whether still prescribed, additional analgesia, pain control.

**Results:** Searches revealed 61 patients for inclusion. 70% had Buprenorphine initiated in primary care. Reasons for initiating Buprenorphine included swallowing difficulties(7%), compliance(3%), side-effects from other analgesia(21%), patient request(7%), other(33%). 46% patients had neuropathic pain. 36% patients had documented improved pain control with Buprenorphine. Whilst on Buprenorphine need for NSAIDs (Ibuprofen, Naproxen) reduced. Analgesia for neuropathic pain also reduced (Amitriptyline, Carbamazepine). 15% patients required no additional analgesia.

**Conclusion:** More comprehensive documentation for reasons initiating and stopping BuTrans was needed. Few patients reported adverse side-effects. Results awaited from other Norfolk GP practices for comparison. This review of prescribing practice will facilitate development of local guidelines.

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**210 - Practice**

**Developing an anticipatory prescribing protocol for end of life care**

Angela Kirby1, *Yorkshire and Humber postgraduate Deanery, Sheffield*

**Aim:** To gather information on current prescribing practice to identify BuTrans’ place in therapy and reasons for high spend. To facilitate development of pain prescribing guidelines.

**Method:** Searches identified all patients at large semi-rural GP practice in South Norfolk who had been prescribed Buprenorphine patches between July-December 2010. Data collection involved scrutinising selected patients’ electronic records. Information was recorded: place of residence, indication for prescription, neuropathic pain, initiation in primary/secondary care, date commenced, initial dose, current dose, analgesia prior to initiating Buprenorphine, whether still prescribed, additional analgesia, pain control.

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**Conclusion:** More comprehensive documentation for reasons initiating and stopping BuTrans was needed. Few patients reported adverse side-effects. Results awaited from other Norfolk GP practices for comparison. This review of prescribing practice will facilitate development of local guidelines.

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**211 - Practice**

**Audit of benzodiazepine and ‘Z’ drug prescribing: one practice’s experience in planning for safer prescribing**

Katharine Rowell1, *The Scott Practice, Doncaster, Yorkshire and the Humber Postgraduate Deanery*

**Introduction:** Two significant events within our practice highlighted problems with benzodiazepine prescriptions, raising concerns about substance misuse, safe prescribing and stress to practice staff. Our practice population of 13500 is in the lowest UK deprivation quintile with a high incidence of drug and alcohol addiction and mental illness.

**Aim:** To review benzodiazepine prescribing and implement change if required.

**Methods:** Premier computer search produced a list of benzodiazepine prescriptions issued during March 2011. Data on type and length of prescription was obtained. Benzodiazepine prescriptions from March 2009 - 2011 were analysed to identify trends in prescribing and comparison with PCT equivalent practices using data from the NHS business authority.

**Results:** During March 2011 453 benzodiazepine prescriptions were issued, of these 43 were acute for <4 weeks, 98 were from a series of multiple acutes >4weeks and 312 were long term repeat prescriptions. 3802 benzodiazepine prescriptions were issued March 2009-10 equal to a PCT equivalent practice. March 2010-11 PCT equivalent rose to 3866 and our practice 4275 prescriptions.

**Discussion:** A high proportion of benzodiazepine treatment courses are for more than 4 weeks and so outside of recommended guidelines. Benzodiazepine prescribing at the practice over the last year has risen disproportionately; the reason for this is not clear and requires further investigation. We have taken action to prescribe these drugs in line with NICE guidance using clinical meetings, developing a prescribing protocol and a patient contract.
212 – Practice  
**Primary care treatment of Hepatitis C**  
Tina Atkins1, Diane Exley1, Jayne Wilkie1, 1Brownlow Group Practice, Liverpool

Through PBC efficiency savings our neighbourhood of 3 practices, with high incidence of Hepatitis C prevalence, invested in a Hepatitis C Specialist Nurse who is employed by primary care and supported by secondary care through robust governance structures. Following a period of development we are now in our second year of successfully fully treating patients in primary care with genotypes 1, 2 and 3. This development was the first primary care led treatment service in the UK.

Not only is the treatment of patients important but also the assessment of patients to consider whether they are suitable for treatment. In the early stages before treatment in primary care began the assessment of patients was key and saved the most money. In 2 years we seen and assessed almost 200 patients across our neighbourhood and had these assessments been carried out in secondary care it would have cost up to £216k.

Cost saving is important but the outcome of treatment in primary care is impressive - since employing the nurse we have successfully treated 16 patients in primary care and a further 21 have been referred for treatment in secondary care.

213 – Practice  
**Engaging patients with Hepatitis C in primary care. Treatment and compliance; a systematic review**  
Gagandeep Bola1, Rachael Fear1, Ewan Barron1, Natasha Lovell1, 1University of Leeds, Leeds

**Introduction:** Estimates show that 250,000 people in the UK are infected with hepatitis C (HCV). Evidence shows that few patients complete the management process. With the General Practitioner being a gateway for treatment and key to patient engagement of services, it is important to understand why completion of treatment is low.

**Methods:** A systematic review of literature was performed, identified using the online databases: MEDLINE, EMBASE and HMIC. Mesh and text terms were used, and reference lists of retrieved articles, reviews and books examined. Systematic data extraction and assessments of quality were carried out, and a sample of studies considered for inclusion was examined by a second reviewer independently.

**Results:** Pronounced dropout rates are in initial stages of management, with studies identifying apathy and prolonged waiting times as major causes. After initiation of medication, adverse side effects are the primary cause of dropout. All studies identified highlight the association between injecting drug users and poor compliance.

**Discussion:** The HCV treatment process is complex, with six appointments prior to initiation of treatment, hence timeframe is a major causality of dropout. Research identifies that primary care physicians refer patients who do not wish to engage. This is a cause of non-attendance post referral, however is also a confounding factor affecting waiting times for HCV treatment. Likelihood of attendance should be considered when physicians refer to secondary services, to optimise utility of current services and reduce waiting times.

214 – Practice  
**Improving MMR vaccination rates: herd immunity is a realistic goal**  
Philippa Cockman1, Luise Dawson2, Rohini Mathur3, Sally Hull4, 1St. Stephen’s Health Centre, Bow, London, 2Department of Public Health NHS Tower Hamlets, London, 3Queen Mary University of London, London

**Introduction:** Measles is a highly infectious disease. It is recommended that 95% or more children receive a first vaccination with MMR before two years of age and a booster before five years to achieve herd immunity and prevent outbreaks. Reported vaccination rates for England have improved since a low in 2003-4 but remain below 95%. This paper describes an intervention aimed at improving vaccination rates.

**Methods:** This was an observational time series study.

The key target was to reach 95% coverage for the first MMR before 2 years of age.

Financial support was provided for the development of geographically based networks of GP practices.

A Network Improvement Service was commissioned setting network level vaccination targets of 95%.

Innovative use of Information Technology enabled robust call-recall, active follow up of defaulters and increased knowledge about the demography of the hardest to reach.

**Results:** The development of networks of practices facilitated collaborative working among primary care clinicians, peer review of achievements and an element of healthy competition.

Improvements in uptake were demonstrated for all childhood vaccinations to herd immunity levels for most. Uptake of the first MMR before 2 years of age rose from 80% to 94% between September 2009 and March 2011.

**Discussion:** Achieving herd immunity for childhood vaccinations is an achievable target in an ethnically mixed, socially deprived inner city borough. The ability to identify characteristics of the hard to reach groups, including significant differences in uptake across different ethnicities, will allow targeted interventions that may further improve overall coverage.
215 – Practice

Promoting fair and ethical procurement in one general practice - the first steps
Kieran Dinwoodie1, Graeme Bingham1,2Calderside Medical Centre, Blantyre

Background: The annual NHS procurement budget is over £30 billion. Many medical products used in the NHS are produced in unhealthy and dangerous conditions in the developing world and purchased in unfair ways. General Practices can harness their purchasing power to advocate for ethical procurement practices to bring health benefits to vulnerable workers.

Methods: The BMA’s Ethical and Fair Medical Trade Group survey which demonstrated 80% support for ethical procurement principles amongst health care staff but only 10% awareness was disseminated in the practice.1 The practice made a commitment to ethical procurement and made a start with fairly traded consumables.

Results: The practice has adopted a fair and ethical procurement policy and is undertaking a review of medical procurement practices. These actions have been recognised at national level through inclusion as a case study in the new Ethical Procurement for Health Guide supported by the BMA, Department of Health and has received publicity from the BMJ2,3

Conclusions: There are challenges in changing policy and practice. The RCGP’s sustainability agenda is important in setting the principles for policy and practice. The first steps taken at Calderside Medical Practice provide encouragement for further expansion of ethical procurement in a primary care setting.

References:
3. Wise, J. “NHS should lead in ensuring goods it buys are produced ethically,” BMJ 2011;342:d3107

216 – Practice

Sustainable action planning in general practice
Sally Aston1, French Weir Health Centre, Taunton

As Sustainability scholar in the Severn Deanery I have 20 days throughout my ST3 GP training year to undertake a project supported by the Centre for Greener Healthcare on the subject of Sustainability. Sustainability has the aim of reducing our detrimental impact on the world both now and for future generations. It involves limiting the destruction of nature and finite resources, and tackling climate change.

The aim of my project is to advocate sustainable healthcare and Sustainable Action Planning. Sustainable healthcare involves the rational use of our resources to deliver effective medical care today without compromising provision in the future. It involves preventative medicine and health promotion and giving patients responsibility for their health. It promotes streamlined, efficient referral pathways and services, evidence based medicine and low carbon technologies. All of these principles have the potential to improve patient outcome or experience of care, while increasing carbon- and cost-efficiency.

Sustainable Action Planning is a programme which supports clinical teams in taking action towards sustainability.

My advocacy role is achieved through giving presentations to healthcare colleagues, leading by example and implementing Sustainable Action Planning in my practice.

My experiences during this project have highlighted the fact that a move towards Sustainability forces us to seriously debate those ethical dilemmas regarding resource allocation and, in fact, to rethink what healthcare should be. In some areas it involves drastic behavioural change, and barriers will need to be broken down in order to achieve truly sustainable healthcare.

217 – Practice

Sharing GP electronic health records with a UK nursing home
Benjamin Brown1, Amir Hannan1, Sarah Thew1, Iain Buchan1, The University of Manchester, Manchester, Haughton Thornley Medical Centres, Manchester

Introduction: Sharing patient information between providers features prominently in UK health policy, most recently in Andrew Lansley’s ‘Information Revolution’. In nursing homes GPs can be limited by the information available to them. Research suggests avoidable hospital admissions and medication errors involving nursing home residents may be reduced if patient information is shared appropriately.

Methods: We are enabling staff at a 100-bed nursing home to access the electronic health record (EHR) of a GP practice serving one third of its residents. Nurses have been trained in information governance and will access the EHR when appropriate. Evaluation is taking place through qualitative interviews before and after implementation, usage diaries, and quantitative data on the nursing home accessing health services.

Results: At the time of writing, baseline interviews have been completed and the service is about to ‘go live’. Our research indicates a feeling of disempowerment amongst nurses (n=10). They feel the current system is inefficient, particularly when ordering medication and obtaining health information. They report inaccurate medical histories and out of hours GPs being unfamiliar with patients, which may impact on care quality. GPs (n=3) describe dissatisfaction particularly when ordering medication and obtaining health information. They report inaccurate medical histories and research indicates a feeling of disempowerment amongst nurses (n=10). They feel the current system is inefficient, particularly when ordering medication and obtaining health information. They report inaccurate medical histories and out of hours GPs being unfamiliar with patients, which may impact on care quality. GPs (n=3) describe dissatisfaction particularly when ordering medication and obtaining health information. They report inaccurate medical histories and out of hours GPs being unfamiliar with patients, which may impact on care quality. GPs (n=3) describe dissatisfaction particularly when ordering medication and obtaining health information. They report inaccurate medical histories and out of hours GPs being unfamiliar with patients, which may impact on care quality.

Discussion: We report for the first time in the UK to our knowledge, the enablement of nursing home staff to access their residents’ full GP EHR. Anticipated benefits are improvements in care quality, efficiency and safety. This may be a cost-effective alternative to other proposed methods of EHR sharing.
Practice/Project Poster Presentations

218 - Practice  Towards a flourishing practice
Peter Toon, 1Barts and the London Medical School, London

The medical press is full of regretful criticisms of the current state of health care. Some if this may be "O tempora, O mores" thinking which is ever-present, but there may also be a more fundamental problem underlying these views. Alisdair Macintyre in "After Virtue" suggested that our society is in a state of moral fragmentation, as a result of what he calls "The Enlightenment Project", which make moral discourse confused and interminable. Health care may be suffering from this fragmentation in values.

The conflict between deontology and consequentialism has dogged moral philosophy for almost two hundred years, and both frameworks are used in different aspect of health care. More recently legalism, managerialism and consumerism have had an increasing impact on health care. These fragments of moral discourse produce inconsistent and illogical thinking in many issues in health care.

Macintyre suggests that "a partial solution" to this problem lies in focussing on the virtues, cultivated in "practices" which produce internal goods and contribute to the narrative unity of a life. Health care is one such practice, in which professionals (doctors, nurses, other clinicians, managers, administrators) and patients fulfil their different role in producing the internal goods of health and understanding of illness. Looking at health care in this way has implications for our understanding of disease, of education and training, and of the institutions within which the practice is conducted.

It makes the interpretative function of general practice central to the development of flourishing narratives.

219 - Practice  Generalism, meaning and healing
Geoff Riley, 1The University of Western Australia, Australia

If particular patient-centredness and attention to the subjective experience of illness inheres in the rubric of 'Generalism', then success in healing will be a key expression of that focus. For Eric Cassell healing is the relief of suffering. This presentation posits that suffering, regardless of its origin, is the result of perturbation of meaning, and that the relief of suffering requires the restoration or rehabilitation of personal meaning.

Accordingly in the face of a crisis, healing involves restitution of the familiar, of normality, and integrity of previously effective coping styles and defenses. In doing so, continuity of experience of self and the world, and so meaning is restored. If the crisis involves irreversible loss or change, such as death of a loved one, then this will mandate constructing a new configuration of self and the world – a new meaning.

The implication for Generalists is that the art is not simply that of understanding and responding to illness in parallel with pathophysiology, but of a genuine willingness to understand the whole. The particular benefit of the consultation-based model of general practice is that it provides for the possibility of listening for, and understanding of, the threatened or perturbed meaning.

220 - Practice  Methods and impact of expert practice-based contributions on the development of high-quality national care maps
Jeff Dienhart, 1Jessica Daniels, 1Miriam Kingsley, 1Map of Medicine, London

Introduction: Care maps provide a starting point for improving quality of care and productivity as well as defining and communicating healthcare services both locally and nationally. National care maps cannot be solely derived from published information; more often, they must also be informed by those with expert practice-based knowledge. This is especially true in the areas of diagnosis and prognosis where high-quality information can be sparse.

Methods: National care maps are developed with quality-assessed guidelines and critically appraised meta-analyses and systematic review. The high-quality evidence is then supplemented with practice-based contributions from:
- National clinical bodies such as the Royal College of General Practitioners (RCGP)
- Multidisciplinary team (MDT) contributor groups led by an expert Clinical Facilitator
- Selected members of a Board of Fellows

Contributors assess the clinical usability of care maps and are asked to ensure maps follow a logical flow and contribute to the content where gaps in the evidence base are apparent. They are encouraged to add articles to the evidence used in a map, especially if it is primary research. These articles are critically appraised to determine whether they should be used, and clearly marked as being chosen by the contributor group. Each contributor completes a conflict of interest declaration, which is published alongside the care map.

Results: Expert practice-based contributions add critical, up-to-date UK-specific recommendations and practical clinical guidance outside the remit of some guidelines. Care map review and accreditation by stakeholder groups, such as Royal Colleges adds further credibility to the care map content.

221 - Practice  The playground of the page: a writing continuum from creative play to writing as therapy
Pauline Cooper, 1Oxleas NHS Foundation Trust, Dartford Kent, 2University of Sussex, East Sussex, 3King’s College London, London, 4Higher Education Authority, London, 5British College of Occupational Therapists, London

This abstract describes a doctoral research project and subsequent development of using Writing in a National Health Trust setting within one south-east London/Kent borough. The study concentrates on different models of writing.
Practice/Project Poster Presentations

used in community facilities and in-patient settings: Using Writing As Therapy (UWAT) and Creative Writing (CW). This qualitative study utilises a post positivist, subtle-realist paradigm using qualitative methodologies: action research and participant observation, by an occupational therapist.

The purpose was to understand and clarify how writing works in recovery from illness and as a method of support and creativity to wellness with clients suffering symptoms of depression with flawed identity and low self-esteem. Ongoing development reveals a continuum from creative play through expressive writing and into writing as therapy.

The results indicated that UWAT clients found particular benefits from belonging in a group using the page to re-organise or play with memories and experiences. D.W. Winnicott’s (1971) “potential space” and Wilfrid Bion’s (1962) notion of “containment” provided a theoretical base for understanding these concepts.

UWAT clients reported cognitive changes and an increase in self-knowledge through reflectively exploring their stories through writing. CW clients used writing to distance themselves from painful emotions by writing their feelings.

This project will be of interest to practitioners working with clients or staff with a need to explore thoughts, problem-solve issues, develop a clearer sense of self and gain insight. Dr Cooper has found that writing using across the continuum has benefits for carers, the public, and staff stress and change management.

### 222 – Practice
Pilot on training GP to use CBT in their 10 minute consultation in North Wales.
Juanita Convill1, 1Cardiff University, Cardiff

The aims in providing this pilot workshops to GPs were:

1. To Empower GPs: To be able to apply the learned principles of CBT in consultation.
2. To Empower Patients: Patients can also learn to use this techniques to have a better understanding of their own situation and maintain a better state of mental health
3. To Improve the Mental Health service locally.
4. To Comply with guidance and evidence base management of anxiety and depression

After the four consecutive weekly meetings the first and second aims were met. The other two aims may need to be evaluated a later stage to prove achievement.

I was very impressed with the interest and commitment that all the GPs showed.

The feedback after this practical course was excellent. GPs started practicing after each session and part of the following session was dedicated to share the experience and to offer collective solutions. Then a short presentation on the theoretical aspects of CBT was given.

The course was based on a CBT Model of consultation which can be applied to various scenarios: i.e. depression anxiety, addictions, chronic conditions, problem solving.

The main problem identified was being able to carry out the consultation within the 10 minutes usual allocated time. This could be a matter of experience and it is hoped that when the expertise is developed, time will be less of a constrain.

CBT can also be used for personal development and even to reflect on learning outcomes as follows: (see poster).

### 223 – Practice
Communication between secondary and primary care: evaluation of the Electronic Discharge System (EDS) within Blackpool Teaching Hospital
Joanne Simpson1, Gukaran Singh Samra1, Thomas Warburton1, 1Blackpool Teaching Hospital, Lancashire

Introduction: Accurate handover between Secondary and Primary Care following hospital admission is vital to ensure continuity of care. Following hospital discharge, a summary of events should be completed by a junior member of the parent team and delivered to the responsible General Practitioner (GP) in a prompt, concise and legible manner.

Aims:
- To assess suitability and user satisfaction with the current EDS.
- To evaluate the standard of documentation within discharge summaries.

Methodology: Formal questionnaires were distributed to a group of 18 Foundation Year 1 (FY1) Doctors and 10 local GPs to assess their views on form layout and content and satisfaction with the current system.

An audit is ongoing, evaluating 90 completed summaries on 3 occasions to assess the effects of practical experience and formal teaching on the quality of documentation.

Results:
- FY1 Doctors are generally satisfied with the EDS but feel that formal teaching would be useful.
- GPs are not satisfied with the present system, reporting poor documentation in most areas of the discharge summary.
- Preliminary audit results suggest practical experience in completing discharge summaries does not improve quality of documentation. (Further data will be collected following delivery of formal teaching on the EDS)
- Radiology and Pathology results are poorly documented.
Micro-commissioning decisions in everyday general practice - the financial analysis of the provision of minor surgery in a Derbyshire general practice
Carter Singh1, Royal College of General Practitioners, London

Introduction: Commissioning in the NHS is the process of ensuring that the health and care services provided effectively meet the needs of the population. General Practitioners make commissioning decisions every day ranging from signing prescriptions, making referrals and in some cases, involvement in Practice-based Commissioning (PBC) groups and the newly emerging GP-led Commissioning Consortia.

Methods: This poster provides a description of the minor surgery services in general practice and is a basic financial depiction of how services (in this case the provision of minor surgery services can be analysed in terms of demand management, costings (using practice/local and regional data) and then applied in practice using the basic principals of commissioning. The setting was a multi-site Derbyshire General Practice with a list size of approximately 18,000 patients.

Results: General practice minor surgery services are associated with shorter waiting times between referral and treatment, less time and money spent by patients attending for treatment, higher levels of patient satisfaction with their treatment and lower costs of procedures. This poster showed that the provision of minor surgical services can be profitable.

Discussion: It is hoped that by reading this poster General Practitioners will feel empowered to become involved in commissioning at whatever level they feel comfortable.

General practice minor surgery services are associated with shorter waiting times between referral and treatment, less time and money spent by patients attending for treatment, higher levels of patient satisfaction with their treatment and lower costs of procedures. This poster showed that the provision of minor surgical services can be profitable.

Health care provision to the homeless; what are the barriers?
Alice Lee1, University of Manchester, Manchester

The average life expectancy of a homeless person is 40.2 years; a shocking 39.7 years less than the average life expectancy in the UK. Studies in the US show that the main causes of death are common and treatable illnesses, and with approximately 40,500 people in the UK deemed ‘homeless’ in 2010, 464 sleeping without any form of shelter on any night of the year – there is a clear and desperate need to close this inequality in health.

A literature review as well as interviews conducted with homeless people in central Manchester shows that the inequality lies within the homeless’ ability, or more accurately, inability to access mainstream health care in both the hospital and primary health care settings.

The inverse care law in 1971 denoted that care demands are inversely proportionate to medical services available. In the present, 83% of homeless people will suffer from a mixture of physical illness, mental illness and substance abuse yet well over a third are not receiving any medical care. Clearly, the inverse care law is still as relevant 40 years on due to privatisation of medical services, barriers in health care models as well as stigmatisation and exclusion from mainstream general practices.

From another perspective, £85 million pounds is currently going towards secondary health care to the homeless each year. Hence, there is both a moral and economical drive to integrate the care needs of the homeless into primary care settings.

Improving access to GP services for a diverse population
Donna Evans1, Tina Atkins1, Dawn Brayford1, Brownlow Medical, Liverpool

Brownlow Health is an inner city GP practice in Liverpool with a diverse population of approximately 26,000 patients. This includes a large student group, asylum seekers, patients with drug and alcohol problems, homeless patients and sex workers.

Analysis of practice services highlighted that 29 booked appointments per day were wasted as a result of patient non-attendance (DNA/ did not attend). The DNA rate is possibly related to a myriad of factors, reflective of the patient population. This issue and other demands suggested a change was required to increase accessibility to GP services,
reduce DNA rate and A&E attendance whilst improving Practice Based Commissioning (PBC) targets.

To meet these demands, a dramatic change in service provision began in August 2010 with a new walk-in service offered every weekday from 8:30am to 4pm. This service change has resulted in a DNA rate reduction of 18%, reduction in A&E attendance by 25.65% of our patient cohort. Local walk-in centres have similarly reported a reduction in attendances from our patients by 13%.

There are limitations to the service including the effect on clinicians when the service is particularly busy and lack of continuity with some patients.

Additionally, a telephone consultation service is available between 8:00am and 6.30pm. Email consultations are also available for simple non-urgent queries. There are also booked appointments and extended hour appointments for patients with work commitments.

The ongoing development of this service aims to make access to GP services as simple as possible for each and every patient.

**227 - Practice**

**Outreach: primary care and public health in partnership**
Richard Jenkins1, Permjeet Dhoot2, 1OneMedicare Ltd, Yorkshire, 2NHS Sheffield, Yorkshire

The Outreach programme is an innovative development operating from our Sheffield NHS Walk In Centre designed to reach out to the local population who are unable, unwilling or lack the knowledge to access health care in an appropriate way. It is developed in partnership with local Public Health and designed to both reduce health inequalities, the burden of undiagnosed disease and improve patient's access to care, both routine and unscheduled.

Our teams work with Public Health using observatory data to identify those who are most disadvantaged and who are likely to benefit from the programme. Such areas include:
- Voluntary sector organisations
- Community groups
- Religious groups
- Those who find it difficult to access primary health care services

The outreach team is made up of experienced nurses and health care assistants trained in how to engage with these groups in the most effective way.

**Benefits Achieved:**
- Access to those patients most at need and least likely to use established primary care services but often high users of services
- Reduction in health inequalities
- Improved responses to education when delivered in patients own community or environment with those trained in building relationships within such groups
- Case finding undiagnosed disease such as hypertension and high CVD risk supporting future reduction in health care need
- Supporting signposting and choosing well in when, where and how to access health care
- Building a team relationship with Public Health
- Integration of many components of the primary care and unscheduled care agenda

**228 - Practice**

**The deaf community - are our services accessible to all?**
Mohammed Amin, Imad Ahmed1, Naeem Ahmed1, Faheem Ahmed1, Shafiu Amin1, Anne Stephenson1, 1King’s College London, London

**Background:** In the United Kingdom one in seven of the population are hard of hearing. Previous research has found that 42% of respondents who had visited hospital had found communication with NHS staff difficult. We aimed to see if the health service in a Primary Care setting had become accessible for this marginalised community.

**Method:** We held a group discussion with 13 participants from a deaf community group in London. The session, facilitated by British Sign Language (BSL) interpreter, explored participant’s experiences accessing services.

**Results:** 13 participants, 3 classified their level of deafness as moderate and the rest as profound. Most (n=8) had visited their GP within the last year, 5 hadn’t. Those that hadn’t either difficulty contacting the surgery (n=2) or difficulty communicating with staff at the surgery (n=3). Almost all (n=12) had to make bookings in person to see a GP and very few (n=2) practices had alternative methods of booking such as text to phone or online booking services. Most of the group (n=9) attributed communication problems as causing them to miss an appointment having arrived at the surgery, to leave unclear about their condition and their medication.

**Conclusion:** The Disability Discrimination Act 2005 requires health service providers to make all reasonable adjustments to enable patients to access services. Accessing healthcare in a primary care setting remains difficult for the deaf community. Providers should be encouraged to provide greater support through alternative booking systems and BSL interpreters to make their services more accessible.
**User perceptions of a GP led walk-in centre**  
Santosh Gholkar¹, Florence Mukuna², ¹City Health Centre, Manchester, ²University of Manchester

City Health is a GP led Centre in Central Manchester managed by GTD. It opened in December 2009 and demand has outstripped the service on both the walk-in side (actual 120 patients/day vs 60 expected) and registered side (3200 patients vs 2000 at one year).

As part of a needs analysis, we undertook a questionnaire survey of our users, with the aim of obtaining detailed demographic data on our users on the walk-in side, so that we could tailor the service to their benefit, and consider ways in which we improve the service we offer.

A pragmatically designed questionnaire was used over the course of one week, with 504 respondents (56%). 79 percent of these respondents were working in the city centre on the day that they used it. 43 percent of patients felt that their problem was urgent enough to be dealt with there and then. The data also confirm what is already known about walk-in centres, namely that it is used because of ease of access and inability to access their GP on that day. However, the interpretation of the data set in its entirety is not clear with more emphasis in the GP press being placed on ease of access rather than urgency of the problem.

What the data does show is that walk-in centres are satisfying a need within society, and future research into this area needs to look at how general practice can provide this service whilst maintaining its traditional strengths.

**Diversity of general practitioners within Wales**  
James Kerrigan¹, Seema Bhatt¹, Timothy Evans¹, Sonia Taneja¹, Sara Kahrobaei¹, Suneetha Siripurapu¹, Jason Fitchett¹, ¹Swansea Bay GP Training Scheme, Swansea

With a population of 3 million, a mix of urban and rural areas, two official languages and a rich cultural history, Wales is as diverse as any part of the UK. Serving this population is a group of general practitioners whose backgrounds, interests, qualifications and working environments are equally as diverse.

**Aim:** To appreciate the diversity of general practitioners across the country

**Methods:** Emails were sent to all doctors within general practice on the Welsh NHS email system, inviting them to participate in a confidential, anonymous online multiple-choice survey. A range of questions were asked relating to personal demographics, employment and other activities, both medical and non-medical.

**Results:** A 27% response rate was achieved from 1500 email invitations. The age range of Welsh general practitioners spans 5 decades, with their primary medical qualifications originating from Wales, other UK medical schools and abroad. Working environments range from 1% working single-handedly to a maximum of 17 doctors working together in a practice. Over 70% hold the MRCGP qualification and more than 60% have 2 or more postgraduate qualifications. A large number of doctors surveyed are involved with some form of teaching and many gave a wide variety of examples of how their activities and interests outside work make them a better doctor.

**Conclusions:** A large number of general practitioners have shown, through differing responses, qualities that prove workforce diversity in Wales and we believe that this can only be a benefit to the Welsh population now and in times to come.

**What patients want: a patient questionnaire on general practice opening times**  
Matthew Tabinor¹, ¹The University of Nottingham, Nottingham

**Aims:** The hours a general practice is open can hinder patient access to medical care. This patient survey of a practice in Nottingham, which serves approximately 3000 patients, identifies how they would like their practice to deliver care.

**Method:** A patient satisfaction survey was issued to all patients attending the surgery over a one-week period in July 2011. Questions were asked regarding the opening hours and accessibility to services, and responses were recorded using a likert satisfaction scale. Data was analysed in Microsoft Excel 2007.

**Results:** 122 questionnaires were issued, with 121 patients (99%) responding. 83 (69%) were satisfied/very satisfied with opening hours and 21 (18%) were unsatisfied/very unsatisfied. 71 (60%) found making an appointment with a doctor easy, but 23 (19%) found booking an appointment difficult. 79 (75%) found accessing the practice nurse easy, with 7 (6%) finding this difficult. 95 (79%) favoured lunchtime opening.

**Discussion:** In the course of a week, 4% of the total practice population was sampled. Whilst the majority of patients were satisfied with accessibility to the practice, around one-fifth of patients have difficulty accessing their GP. Patients liked the idea of lunchtime opening, with those not favouring lunchtime opening not actually benefiting from the proposed change.

**Recommendations:** Opening over lunchtime improves accessibility to primary care services and is something patients approve of. Where relevant, practices should educate patients about local extended opening hours access.
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232 – Practice

A project on palliative care communication to out of hours (OOH) services
Aruna Sanikop1, Peter Thomas1, Aneurin Bevan Health Board, Newport, Uni of Wales, Cardiff University, Cardiff

The aim of this project is to share information and improve communication between General Practitioners (GPs) and other organisations involved in the care of palliative patients in Aneurin Bevan Health Board (ABHB) OOH.

GPs were encouraged to fill specific information in an existing ABHB special notes. This form was sent along with the needs analysis questionnaire to OOH and in-hours GPs. In addition a poster and opinion leaflet was displayed and distributed to GPs at All Gwent Continuous Professional Development session. The project was presented to specialist nurses in ABHB and discussed with nurses in hospices in Gwent. OOH doctors were encouraged to be proactive in requesting the missing information.

The number of special notes increased by 277% in 2010 when compared to the notes sent during 2009. 56% of ABHB special notes were filled. Furthermore 93% of surgeries sent information with an increase in 46%. Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) notification increased by 3%. In addition GPs discussed with patients their diagnoses and their preferred place of care in 63% of cases. 69% of patients were aware of their diagnoses. GPs also sent information about the last days of their patients’ lives in 38% of notes.

This project has raised significant awareness amongst GPs and other services to share information with OOH. The special notes has encouraged GPs to inform and communicate effectively as recommended by General Medical Council and End of Life Strategy. It has encouraged GPs to discuss preferred place of care and DNACPR thus avoid inappropriate CPR and unwanted admission.

233 – Practice

How to measure triage - defining a gold standard for the T1 battle casualty
Ryan Ewbank1, Simon Horne1, British Army, NHS Forth Valley, Stirlingshire

Introduction: Triage is the system used to rank patients by clinical priority, where number of casualties outmatches clinical resources.

We set out to assess the accuracy of the ‘Triage SIEVE’ which is used in major incidents but has no gold standard with which to compare it.

Methods: We used a Delphi type process to build a list of life and limb saving interventions to define a T1 casualty in terms of the resources they required, this was based on previously published data and was cycled around the consultant cadre at the UK hospital in Afghanistan.

Results: We came up with a list of 14 interventions. Patients requiring one or more of the interventions within 1 hour of arrival or who died in the department were defined as T1. A walking patient equates to T3, all others are T2.

Summary: On Military Operations, where casualty evacuation and treatment resources are often limited, it is vital that any tool used has an acceptable sensitivity for serious injury, but without excessive rates of over-triage. The accepted tools for triage have all derived from patient populations which have predominantly suffered blunt trauma. In conflict, where the rates of penetrating and blast trauma are high, these tools may perform unexpectedly. By defining a triage category in terms of the resources needed by the patient at the hospital, we have designed a framework which allows measurement of the accuracy of triage tools in a military environment.

234 – Practice

Guidance for commissioning integrated urgent and emergency care - a "Whole System" approach
Agnelo Fernandes1, LMC in Croydon, Croydon, NHS Direct, NHS Pathways, Intercollegiate Clinical Governance Board for NHS Pathways, Croydon Federation of General Practices, Chair of the Croydon Healthcare Consortium, DH Urgent and Emergency Care Governance Board, DH Programme Board for NHS 111, Emergencies Services Committee, Royal College of Paediatricians

Good commissioning places patients at the heart of the process. It is about improving people’s lives and providing high quality services that are designed around the individual.

The RCGP Centre for Commissioning has defined commissioning as:-

“A continual process of analysing the needs of a community, designing pathways of care, then specifying and procuring services that will deliver and improve agreed health and social outcomes, within the resources available.”

Going forward, new clinical commissioners need to have an overview of the commissioning processes as a "whole system" and what this means in practice so that they can develop strategies which ensure: a coherent 24 hour seven day urgent care service with greater consistency, improved quality and safety, improved patient experience, greater integration and better value for the taxpayer.

Commissioning Consortia, local authorities and others need to work together to plan and deliver better integration of local services.

Good urgent and emergency care is:

- Patient-focused
- Based on good clinical outcomes, e.g. survival, recovery, lack of adverse events and complications
Practice/Project Poster Presentations

- A good patient experience, including ease of access and convenience
- Timely
- Right the first time
- Available 24/7 to the same standard.

We need to adopt a strategic approach which is:

- Needs led
- Patient and public centred
- Commissioner led
- Developed in conjunction with providers
- Supports innovation
- Focuses on improving clinical outcomes through ‘service integration’

This unique guidance helps develop the strategic outlook of clinical commissioners and provides practical examples of where and how services can be redesigned.

235 – Practice

**Urgent care clinical dashboard: proactively managing care**

Anne Talbot1, 1NHS Bolton, Bolton, Greater Manchester

The Urgent Care Clinical Dashboard provides GP practices with close to real-time information on unscheduled care activity, including A&E attendances, emergency admissions and discharges, Walk In Centre attendances and GP out-of-hours contacts. This information is displayed in a graphical, user-friendly dashboard, enabling practices to improve and proactively manage their patients’ healthcare, especially the most vulnerable patients and those with long-term conditions. Typically the Urgent Care Clinical Dashboard will not contain any more information than GP practices already receive, but the dashboard delivers the information in a more timely way and displays it together to present a more complete picture.

The first Urgent Care Clinical Dashboard was piloted in NHS Bolton and has enabled changes in practice and service redesign. The dashboard has contributed to reductions in A&E attendances and non-elective hospital admissions which equate to an efficiency saving of over £600,000.

Evidence from NHS Bolton’s dashboard pilot has led to the Urgent Care Clinical Dashboard becoming part of the national QIPP Urgent and Emergency Care workstream. Currently the national team are working with a range of follow-on Pioneer sites throughout England to develop and introduce their own Dashboards, and these are now going live. Each dashboard development is led by local clinicians, and so each dashboard is different, using existing local technology and addressing local needs and priorities.

The poster will feature an overview of the Urgent Care Clinical Dashboard concept, and case studies and screenshots from the Bolton dashboard and from Pioneer sites.

236 – Audit

**An audit into the compliance of urgent referral guidelines for colorectal cancer by general practitioners and cancer detection rates following colonoscopy**

Shueh Hao Lim1, Satvinder Chauhan1, Paul Fisher1, 1University of Aberdeen, Aberdeen

**Background:** The Scottish Referral Guidelines for Suspected Cancer (SRGSC) published in 2002 have listed signs and symptoms which should alert a physician to refer the patient urgently to secondary care physicians for possible colorectal cancer.

**Objectives:** The primary aim of the audit is to identify the detection rate of lower gastrointestinal cancer using colonoscopy in patients who have been referred as urgent according to the SRGSC protocol. The secondary aim is to identify if the referrals protocols set out under the guidelines are followed by the general practitioners.

**Methods:** A retrospective review of case notes was carried out on 68 patients who underwent colonoscopy between December 2009 to September 2010. The urgency of referral and indications for referral by the general practitioners were compared with SRGSC. Information on cancer detection rate was obtained through post operative colonoscopy and pathology report.

**Results:** 36 patients were referred as urgent and 32 as non urgent to the surgical department. Of the 32 patients who were referred as non urgent, 22 patients were upgraded to urgent by the surgical team. The percentage of urgent referral diagnosed with colorectal cancer using colonoscopy was 1.47% (n=1). 59% (n=40) of the total patients referred to the clinic did not follow the criteria set out by the guidelines.

**Conclusions:** This audit has shown that current guidelines resulted in significant number of patients undergoing unnecessary colonoscopy. This is made worst by the poor compliance of referral protocol by GPs which may be influence by their personal clinical judgment when deciding on referral.