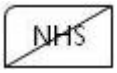
British National Formulary symbols

The list below explains the meanings of the main symbols used in the BNF:

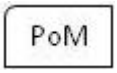
Denotes a preparation that is less suitable to prescribe

Newly licensed medicines

Not prescribable on the NHS



Prescription-only medicine



Controlled drug

Death certification

There is no legal definition of death in the UK although guidelines exist. Current guidance states 'death should be verified by a doctor, or other suitably qualified personnel' which means staff such as nurse practitioners may verify (but not certify) death.

After a patient has died a doctor needs to complete a medical certificate of cause of death (MCCD). There is a list of circumstances in which a doctor should notify the Coroner prior to completing the MCCD.

Some specific points on completing the MCCD:

- 'old age' as 1a is only acceptable if the patient was at least 80 years of age . It can be used if certain conditions are met but is discouraged
- 'natural causes' is not acceptable
- organ failure (e.g. 'liver failure') can only be used if you specify the disease or

condition that led to the organ failure (e.g. 1b: Hepatitis C)

- abbreviations should be avoided (except HIV and AIDS*)

The family then take the MCCD to the local Registrar of Births, Deaths, and Marriages office to register the death. If the Registrar decides that the death does not need reporting to the Coroner he/she will issue:

- certificate for Burial or Cremation
- certificate of Registration of Death (for Social Security purposes)

- if requested. Copies of the Death Register (banks and insurance companies expect to see them)

If the family would like the burial to be outside of England, an Out of England Order is needed from the coroner.

*why this is I'm not sure - probably due to how well known the terms are amongst the general public

Consultation models

Calgary-Cambridge observation guide- Kurtz and Silverman - 1996

- initiating the session
- gathering information
- building the relationship
- giving information, explaining and planning
- closing the session

Stewart - patient-centred clinical method - 1995, 2003

- exploring both the disease and the illness experience
- understanding the whole person
- finding common ground
- incorporating prevention and health promotion
- enhancing the doctor-patient relationship
- being realistic (with time and resources)

Pendleton - The Consultation: an Approach to Learning and Teaching - 1984, 2003

- define the reason for the patient's attendance (ideas, concerns and expectations)
- consider other problems
- with the patient, choose an appropriate action for each problem
- achieve a shared understanding of the problems with the patient
- involve the patient in the management and encourage him/her to accept appropriate responsibility
- use time and resources appropriately
- establish or maintain a relationship with the patient which helps to achieve the other tasks

Fraser - Areas of competence - 1992

- interviewing and history-taking
- physical examination
- diagnosis and problem-solving
- patient management
- relating to patients
- anticipatory care
- record keeping

Neighbour - The Inner Consultation - five checkpoint model - 1987

- connecting
- summarising
- handing over
- safety netting
- housekeeping

Tuckett - meeting of two experts - 1985

- the consultation is a meeting between two experts
- doctors are experts in medicine
- patients are experts in their own illnesses
- shared understanding is the aim
- doctors should seek to understand the patient's beliefs
- doctors should address explanations in terms of the patient's belief system

Stott and Davis - Exceptional potential of the consultation - 1979

- management of presenting problems
- management of continuing problems
- modification of help-seeking behaviour
- opportunistic health promotion

Benefits

Whilst GPs are not supposed to be experts on claimable benefits, a rough understanding is expected

Income support	Aged 16-59 years, on low income, working less than 16 hours per week and not receiving Job Seekers Allowance
Job Seekers Allowance	From 19 years old to state pension age. Claimants must be capable of working and agree to actively seek work
Disability Living Allowance	Tax-free benefit for children and adults who need help with personal care or have walking difficulties because they are physically or mentally disabled
Statutory Sick Pay	For employees unable to work due to illness. Unable to work for > 4 days in a row. Paid up to a maximum of 28 weeks
Incapacity Benefit & Employment and Support Allowance	Employment and Support Allowance replaced Incapacity Benefit for new claimants from October 2008. Claimable by those not entitled to Statutory Sick Pay (SSP), for example self-employed, or when SSP has ended
Retirement pension	State pension may be claimed from 60 years for women* and 65 years for men. State pensions are taxable and paid even if the claimant is still working
Bereavement payment	Lump sum given to spouse if they are under state pension age when their partner died Depends on national insurance contributions Not payable to divorcees
Bereavement allowance	Taxable weekly benefit paid to the spouse for up to 52 weeks from the date of death, if the surviving partner is 45 years or older and less than the state

pension age

*taken from the Direct.gov website:

- 'Currently, the State Pension age for men is 65. On 6 April 2010, the State Pension age for women started to increase gradually from 60 to 65, to match men's.'
- 'The government has announced new proposals for increasing State Pension age which would affect you if you were born between 6 April 1953 and 5 April 1960.'
- 'The proposals would mean women's State Pension age would increase more quickly to 65 between April 2016 and November 2018.'
- 'From December 2018 the State Pension age for both men and women would start to increase to reach 66 by April 2020.'
- 'The government is also considering the timetable for future increases to the State Pension age from 66 to 68.'

Appraisal

Appraisal has been a requirement for GPs since 2002. It is meant to be a formative process identifying development needs rather than performance management.

Appraisal will eventually provide a regular, structured system for recording progress towards revalidation and identifying development needs

The appraiser should be another GP (principal or non-principal), who will have been properly trained in appraisal. Typically the average time commitment for appraisal is a minimum of 4.5 to 6.5 hours. This includes between 2 and 4 hours for preparation. Primary Care Trusts should provide funds for locum cover to compensate for this time

The content of appraisal is based on the core headings set out in the GMC's Good Medical Practice document:

- good clinical care
- maintaining good medical practice
- relationships with patients
- working with colleagues
- teaching and training
- probity
- health

Access to medical records

A patients right to view their own medical records is governed by the 1998 Data Protection Act and the 1990 Access to Health Records Act

Key principles

- patients have a right to see what is written in their medical record
- competent children may seek access to their records
- parents may request access to their children's (< 16 years) records
- doctors should not release information they feel may damage a patients emotional or physical health

- following the Data Protection Act access to medical records should be given within 40 days. This is the legal timeframe, however Department of Health policy states that access should be given within 21 days
- a fee may be charged

GMC guidance: Good Practice in Prescribing Medicines

Good Practice in Prescribing Medicines was published in 2008. A link is provided to the full guidance, below is only selected highlights:

Principles of prescribing

- doctors with full registration may prescribe all medicines, but not those drugs in Schedule 1 of the Misuse of Drugs Regulations 2001
- you should only prescribe drugs to meet identified needs of patients and never for your own convenience or simply because patients demand them
- avoid treating yourself and those close to you

Keeping up to date and prescribing in patients' best interests

- the guidelines make specific mention of the BNF, NICE and SIGN
- you should inform the Committee on the Safety of Medicines of adverse reactions to medicines reported by your patients in accordance with the Yellow Card Scheme
- if you prescribe at the recommendation of a nurse or other healthcare professional who does not have prescribing rights, you must be satisfied that the prescription is appropriate for the patient concerned and that the professional is competent to have recommended the treatment

Doctors' interests in pharmacies

- you should ensure that your patients have access to information about your own and (where known) your employers' financial or commercial interests in any pharmacy they are likely to use

Prescribing controlled drugs for yourself or someone close to you

- doctors should, wherever possible, avoid treating themselves or anyone with whom they have a close personal relationship and should be registered with a GP outside their family
- you should not prescribe a controlled drug for yourself or someone close to you unless no other person with the legal right to prescribe is available to assess the patient's clinical condition and to prescribe without a delay which would put the patient's life or health at risk, or cause the patient unacceptable pain, and that treatment is immediately necessary to save life, avoid serious deterioration in the patient's health or alleviate otherwise uncontrollable pain

Remote prescribing via telephone, email, fax, video link or a website

- this is supported in the guidelines with obvious caveats
- if you are 'not providing continuing care for the patient', for example doing out-of-hours the guidelines recommend giving an explanation to the patient of the processes involved in remote consultations and giving your name and GMC number to the patient

Data Protection Act

The 1998 Data Protection Act is the main piece of legislation that governs the protection of personal data in the UK. The Act covers both manual and computerised records.

There are 8 main principles of the Data Protection Act:

- data must be used for the specific purpose it was collected
- data must not be disclosed to other parties without the consent of the individual whom it is about
- individuals have a right of access to the information held about them
- personal information may be kept for no longer than is necessary and must be kept up-to-date
- personal information may not be transmitted outside the European Union unless consent has been given
- all entities (e.g. a GP surgery) that process personal information must register with the Information Commissioner's Office
- adequate security measures must be in place. Those include technical measures (e.g. passwords, firewalls) and organisational measures (e.g. staff training)
- subjects (i.e. patients) have the right to have factually incorrect information about them corrected

Revalidation

Revalidation introduces a change in the way doctors are licensed and certificated. Currently UK doctors automatically receive their licence to practise if they have paid their annual fee and have no limitations on their registration (e.g. Following a GMC ruling). To practise as a GP doctors must also be on the GP Register - a process known as certification.

Following the introduction of revalidation doctors will be required to prove their fitness to practise to allow them to continue to work as a doctor. Revalidation will occur every 5 years and in one process combine relicensing and recertification. Annual appraisals will continue as before but there will be a focus on whether the doctor is making sufficient progress towards their revalidation portfolio.

The type and amount of evidence required will be similar to that needed for appraisals currently. The RCGP is creating an ePortfolio for the process and proposes that it should contain the following (please see the link for more details):

- description of your work
- description of any special circumstances (e.g. Prolonged illness)
- details of previous appraisals
- current personal development plan
- review of previous personal development plans
- evidence of continuing professional development - at least 50 'learning credits' are required per year
- multi-source feedback
- patient questionnaire surveys
- significant event audits
- review of any formal complaints
- probity/health statements

Learning credits

- minimum of 1 credit for each hour of education
- however, if the hour of education can be shown to lead to improvements in patient care then it will count as 2 credits

Submitting the evidence for revalidation

- the ePortfolio will be submitted electronically for review
- the review will be done by a 'Responsible Officer'
- the Responsible Officer is likely to be advised by a GP assessor and a trained lay person
- if the submitted evidence is considered sufficient the Responsible Officer will recommend to the GMC that the doctor is both relicensed and recertificated

Revalidation is due to be phased in from 2011 to 2016.

Benefits: chronic illness and cancer patients

Patients who have a chronic illness or cancer, which results in a disability severe enough to need help with caring for themselves, are entitled to claim the following benefits:

- Disability Living Allowance: for patients under the age of 65 years
- Attendance Allowance: for patients over aged 65 years and over

Disability Living Allowance

Disability Living Allowance (DLA) can be claimed by patients who normally have needed help for at least 3 months and be likely to need it for at least a further 6 months. It is tax-free, not means tested and divided into two components:

- Care component
- Mobility component

Attendance Allowance

Attendance Allowance (AA) is a tax-free allowance for people aged 65 or over when they claim who need help with their personal care. To claim AA patients should normally have needed help with care for 6 months. Like DLA it is not means tested

Terminally ill patients

Patients who have a terminal illness (where there is an expectation that the patient will not live for more than 6 months) are eligible to be fast-tracked through the system for claiming DLA or AA. A **DS1500** form is completed which ensures the application is dealt with promptly and that the patient automatically receives the higher rate

Quality and Outcomes Framework

The Quality and Outcomes Framework (QOF) is the annual reward and incentive programme detailing GP practice achievement results. It was introduced as part of the new General Medical Services (GMS) to incentivise not only the management of chronic disease such as diabetes but also to improve the organisation of the practice and patient experience

Other points

- for clinical indicators the value of a point is determined by the prevalence of that condition in the practice
- participation in the QOF is voluntary
- 5% of practices should be visited at random to help prevent fraud. The PCT visiting team will normally consist of a PCT management representative, a GP and a patient representative

The table below shows the four key areas on which the QOF is based

Clinical indicators	697 points	Standards linked to the care of patients suffering from chronic diseases
Organisational	167.5 points	Standards relating to records and information, communicating with patients, education and training, medicines management and clinical and practice management
Additional services	44 points	Covering cervical screening, child health surveillance, maternity services and contraceptive services
Patient experience	91.5 points	Based on patient surveys and length of consultations

Patients may be 'exception reported' in the following situations:

- patients who have been recorded as refusing to attend review who have been invited on at least three occasions during the preceding 12 months
- patients for whom it is not appropriate to review the chronic disease parameters due to particular circumstances e.g. Terminal illness, extreme frailty
- patients newly diagnosed within the practice or who have recently registered with the practice, who should have measurements made within 3 months and delivery of clinical standards within 9 months e.g. Blood pressure or cholesterol measurements within target levels
- patients who are on maximum tolerated doses of medication whose treatment remain sub-optimal
- patients for whom prescribing a medication is not clinically appropriate e.g. Those who have an allergy, another contraindication or have experienced an adverse reaction
- where a patient has not tolerated medication
- where a patient does not agree to investigation or treatment (informed dissent), and this has been recorded in their medical records
- where the patient has a supervening condition which makes treatment of their condition inappropriate e.g. Cholesterol reduction where the patient has liver disease
- where an investigative service or secondary care service is unavailable

Fitness to fly

The Civil Aviation Authority (CAA) has issued guidelines on air travel for people with medical conditions; please see the link provided.

Cardiovascular disease

- unstable angina, uncontrolled hypertension, uncontrolled cardiac arrhythmia, decompensated heart failure, severe symptomatic valvular disease: should not fly
- uncomplicated myocardial infarction: may fly after 7-10 days
- complicated myocardial infarction: after 4-6 weeks
- coronary artery bypass graft: after 10-14 days

- percutaneous coronary intervention: after 5 days

Respiratory disease

- pneumonia: should be 'clinically improved with no residual infection'
- pneumothorax: absolute contraindication, the CAA suggest patients may travel 2 weeks after successful drainage if there is no residual air. The British Thoracic Society used to recommend not travelling by air for a period of 6 weeks but this has now been changed to 1 week post check x-ray

Pregnancy

- most airlines do not allow travel after 36 weeks for a single pregnancy and after 32 weeks for a multiple pregnancy
- most airlines require a certificate after 28 weeks confirming that the pregnancy is progressing normally

Surgery

- travel should be avoided for 10 days following abdominal surgery
- laparoscopic surgery: after 24 hours
- colonoscopy: after 24 hours
- following the application of a plaster cast, the majority of airlines restrict flying for 24 hours on flights of less than 2 hours or 48 hours for longer flights

Haematological disorders

- patients with a haemoglobin of greater than 8 g/dl may travel without problems (assuming there is no coexisting condition such as cardiovascular or respiratory disease)

Controlled drugs

When prescribing a controlled drug the following must be present on the prescription:

- name and address of the patient
- the form, and where appropriate the strength, of the preparation

- either the total quantity (in both words and figures) of the preparation, or the number (in both words and figures) of dosage units to be supplied

- the dose (cannot write 'as directed')
- prescribers name, signature, address and current date

The 2001 Misuse of Drugs Regulations act defines who is authorised to prescribe controlled drugs. It divided drugs of potential abuse into 5 categories ('schedules') each with own rules on prescribing, supply, possession, record keeping etc

Schedule 1	Cannabis, lysergide

Schedule 2	Diamorphine, morphine, pethidine, amphetamine, cocaine
Schedule 3	Barbiturates, buprenorphine, midazolam*, temazepam**
Schedule 4	**Part 1**: Benzodiazepines (except midazolam and temazepam) and zolpidem **Part 2**: Androgenic and anabolic steroids, hCG, somatropin Controlled drug prescription requirements do not apply and Schedule 4 controlled drugs are not subject to safe custody requirements
Schedule 5	Includes preparations which because of their strength are exempt from the vast majority of Controlled Drug requirements other than retention of invoices (e.g. Oramorph 10mg/5ml)

Further selected points

- Schedule 2 and 3 drugs are marked 'CD' in the BNF
- a prescription for controlled drugs in Schedules 2,3 & 4 is valid for 28 days
- a pharmacist is generally not allowed to dispense unless all the information required by law is given. With Schedule 2 and 3 drugs a pharmacist is allowed to amend the prescription if 'it specifies the total quantity only in words or in figures or if it contains minor typographical errors, provided that such amendments are indelible and clearly attributable to the pharmacist making them'

*midazolam was changed from schedule 4 to 3 in 2008

**temazepam is excluded from the prescription requirements

Cremation forms

Basics

- the Ministry of Justice have issued new cremation regulations which came into effect on 1st January 2009
- there is a new right of inspection of medical forms to the applicant of cremation
- 2 doctors are required to confirm both the identity and that the cause of death was not suspicious
- form B is replaced by **Cremation 4**. This should be completed by the patient's own GP or a doctor looking after them during their last illness e.g. Hospital doctors
- form C is replaced by **Cremation 5**. This should be completed by an independent doctor who must have held a full GMC registration for more than 5 years. The doctor is expected to discuss the case with the patient's GP and view the body
- the form Cremation 5 doctor cannot be a partner or work colleague of the form Cremation 4 doctor or a relative of the deceased; the two doctors must be independent of one another, i.e. Not on the same team in hospital or at the same GP surgery
- a fee is payable to each doctor

Removing patients from the practice list

The following is based on the 2004 Royal College guidelines.

Examples of situations that may justify removal:

- unacceptable behaviour: for example violence, sexual harassment, stalking, racial abuse

- crime and deception: for example fraudulently obtaining drugs, stealing from the practice
- distance: a patient moves outside the catchment area

Examples of situations that do not normally justify removal:

- clinical matters:? patient choice, for example refusing to attend for health screening or not bringing their child for immunisations
- critical questioning and/or complaints

Removal is never justified in the following situations

- where there is an exacting or highly dependent patient, condition or disability
- patients with a high levels of anxiety or demand about perceived symptoms
- due to age, gender, ethnic origin, religion or sexual orientation

Further guidance is given on exceptional situations where there is an 'irretrievable breakdown' in the doctor-patient relationship. It is important that a formal process is agreed to try and rectify this problem rather than unilaterally declaring an irretrievable breakdown without giving any reasons to the patient.

Removing a patient from the practice list involves the following steps:

- give warning to the patient
- inform the Primary Care Trust in writing
- write to the patient

The patient's family should not be automatically removed although in practice this may be necessary.

Yellow Card scheme

The Yellow Card scheme has become the standard way to report adverse reactions to medications. It is run by the Medicines and Healthcare products Regulatory Agency (MHRA).

The following should be reported (taken from the MHRA website)

- all suspected adverse drug reactions for new medicines (identified by the black triangle symbol) should be reported
- all suspected adverse drug reactions occurring in children, even if a medicine

has been used off-label

- all serious* suspected adverse drug reactions for established vaccines and

medicines, including unlicensed medicines, herbal remedies, and medicines used off-label

Other information

- Yellow Cards are found at the back of the BNF or reports can be completed online (www.yellowcard.gov.uk)
- any suspected reactions (not just confirmed) should be reported
- patients can report adverse events

- Yellow Cards are sent to the MHRA who in collate and assess the information. In turn the MHRA may consult with the Commission on Human Medicines (CHM), an independent scientific advisory body on medicines safety

*reactions which are fatal, life-threatening, disabling or incapacitating, result in or prolong hospitalisation, or medically significant are considered serious.

Prescription charges

The following information applies to England. Wales and Scotland have abolished prescription charges.

Who is entitled to free prescriptions?

- children (< 16 years old)
- aged 16, 17 or 18 and in full-time education
- elderly (aged 60 or over)
- if the patient or their partner receives: income support or jobseeker's allowance
- if the patient has a prescription exemption certificate

Prescription exemption certificate

Women who are pregnant or have had a child in the past year are entitled to free prescriptions after the issuing of a prescription exemption certificate. Patients who have the following chronic medical conditions are also entitled:

- hypoparathyroidism
- hypoadrenalism for which specific substitution therapy is essential (e.g. Addison's Disease)
- diabetes insipidus and other forms of hypopituitarism
- diabetes mellitus except where treatment is by diet alone
- myasthenia gravis
- hypothyroidism requiring thyroid hormone replacement
- epilepsy requiring continuous anti-convulsive therapy
- a permanent fistula requiring continuous surgical dressing or requiring an appliance
- undergoing treatment for cancer. This includes treatment for the effects of cancer or for the effects of cancer treatments

Pre-payment certificate

Pre-payment certificates (PPC) are for patients not entitled to free prescriptions but who receive frequent prescriptions. They are cheaper if the patient pays for more than 14 prescriptions per year

DVLA: neurological disorders

The guidelines below relate to car/motorcycle use unless specifically stated. For obvious reasons, the rules relating to drivers of heavy goods vehicles tend to be much stricter

Specific rules
first seizure: 6 months off driving*. For patients with established epilepsy they must be fit free for 12 months before being able to drive

- stroke or TIA: 1 month off driving
- multiple TIAs over short period of times: 3 months off driving
- craniotomy e.g. For meningioma: 1 year off driving**
- pituitary tumour: craniotomy: 6 months; trans-sphenoidal surgery 'can drive when there is no debarring residual impairment likely to affect safe driving'
- narcolepsy/cataplexy: cease driving on diagnosis, can restart once 'satisfactory control of symptoms'

Syncope

- simple faint: no restriction
- unexplained, low risk of recurrence: 4 weeks off
- explained and treated: 4 weeks off
- unexplained: 6 months off

*previously rule was 12 months. It is now 6 months off driving if the licence holder has undergone assessment by an appropriate specialist and no relevant abnormality has been identified on investigation, for example EEG and brain scan where indicated

**if the tumour is a benign meningioma and there is no seizure history, licence can be reconsidered 6 months after surgery if remains seizure free

Benefits: bereavement

Whilst GPs are not supposed to be experts on claimable benefits, a rough understanding is expected

Funeral payment	One-off payment to the partner or parent of the deceased if they are on benefits to help pay for a funeral
Bereavement payment	Lump sum given to spouse if they are under the state pension age when their partner died Depends on national insurance contributions Not payable to divorcees
Bereavement allowance	Taxable weekly benefit paid to the spouse for up to 52 weeks from the date of death, if the surviving partner is 45 years or older and less than the state pension age
Widowed Parent's Allowance	Payable to a parent whose husband or wife has died. Eligibility • surviving partner is bringing up a child < 19 years of age and receiving child benefit • deceased partner had made adequate national insurance contributions

- also if the woman was expecting her late husband's baby
- divorcees and those who remarry are not eligible to claim

Local Medical Committees

Local Medical Committees (LMCs) represent the interests of GPs on a local level. They were established as part of Lloyd George's National Insurance Act in 1911 to try and ensure that GPs had a say in the running of the government's health insurance scheme. At the same time a committee was established within the British Medical Association (BMA) to represent GPs on a national level to the government. This was initially known as the Insurance Acts Committee but is now called the General Practitioners Committee (GPC) and has authority to negotiate with the government on matters such as pay and contracts. It is recognised by the Department of Health as the GP's sole negotiating body.

The GPC meets annually with the representatives of the LMCs, who may submit motions for the conference. This motions may then go on to form GPC policy.

LMCs are funded by a statutory levy on GPs. Each LMC may cover the area which corresponds to one or more Primary Care Trusts. LMC members are elected and include partners, salaried doctors and GP Registrars from both GMS and PMS practices .

Statement of Fitness for Work

In 2010 sick notes became fit notes, or more formally the Statement of Fitness for Work. They have been introduced to reflect the fact that in the majority of cases patients do not need to be 100% fit before returning to work. The major change is allowing a doctor to advise that a patient 'may be fit for work taking account of the following advice'.

This information is taken from the Department of Work and Pensions website. Please see the link for further details.

Other changes

- the Statement of Fitness for Work replaces the Med3 and Med5 in one form
- the Med4, Med6 and RM 7 forms have been withdrawn due to the replacement of Incapacity Benefit with the Employment and Support Allowance
- telephone consultations are now an acceptable form of assessment
- there is no longer a box to say a patient is fit for work. There is however an option to state if you need to assess your patient's fitness for work again at the end of the statement period
- there is increased space for comments on the functional effects of the condition, including tick boxes for simple

things that may help a patient back to work
- during the first 6 months of an illness the new statement can be issued for no longer than 3 months.. After this time it may be issued for an indefinite period

Things that stay the same

- can only be completed by a doctor
- you can still the advise a patient that they are not fit for work (of any type)
- the advice on the statement is not binding on employers

The statement may be issued:

- on the day that you assessed the patient
- on a date after you assessed your patient if you consider that it would have been reasonable to issue a statement on the day of the assessment
- after consideration of a written report from another doctor or registered health care professional

There are 4 'tick boxes' included on the form which represent common approaches to aid a return to work. One or more may be ticked. Other approaches can be suggested in the comments box. The options are:

- a phased return to work
- altered hours
- amended duties
- workplace adaptations

Patients may self-certify for the first 7 calendar days:

SC1 Self-certification, for patients not eligible to claim statutory sick pay (e.g. Unemployed or self-employed). For the first 7 calendar days of an illness

SC2 The 'standard' self-certification form, for patients eligible to claim statutory sick pay. For the first 7 calendar days of an illness

GP contract: Carr-Hill formula

The Carr-Hill allocation formula is used to adjust the global sum total for a number of local demographic and other factors which may affect Practice workload. For example, a Practice with a large number of elderly patients may have a higher workload than one which primarily cares for commuters. The Carr-Hill formula replaced the Jarman index

Factors included in the Carr-Hill formula

- age and sex of patients
- nursing and residential home patients
- list turnover: adjusted for number of new registrations
- additional needs: Standardised Mortality Ratio and Standardised Long-Standing Illness for patients under the age of 65 years
- staff market forces factor
- rurality
- London weighting

DVLA: visual disorders

The guidelines below relate to car/motorcycle use unless specifically stated. For obvious reasons, the rules relating to drivers of heavy goods vehicles tend to be much stricter

Visual field defects

- driving must cease unless confirmed able to meet recommended national guidelines for visual field

Monocular vision

- must notify DVLA
- may drive if acuity and visual field is normal in the remaining eye

Blepharospasm

- consultant opinion is required

NHS structure

A simplified structure of the NHS in England is presented below:

- Department of Health, is responsible for:
- 10 Strategic Health Authorities, who are responsible for:
- 150 Primary Care Trusts

The Primary Care Trusts commission services from the following providers:

- primary care services: usually independent contractors such as GP practices, dental practices
- acute hospital trusts and NHS foundation trusts

- mental health trusts
- ambulance trusts
- community health services (e.g. District nursing, health visitors)

In Scotland there are 14 area Health Boards rather than Trusts. In Wales there are 22 Local Health Boards. The system in Northern Ireland is currently in the process of change

Scoring systems

There are now numerous scoring systems used in medicine. The table below lists some of the more common ones:

CHA_2DS_2-VASc	Used to determine the need to anticoagulate a patient in atrial fibrillation
ABCD2	Prognostic score for risk stratifying patients who've had a suspected TIA
NYHA	Heart failure severity scale
DAS28	Measure of disease activity in rheumatoid arthritis
Child-Pugh classification	A scoring system used to assess the severity of liver cirrhosis
Wells score	Helps estimate the risk of a patient having a deep vein thrombosis
MMSE	Mini-mental state examination - used to assess cognitive impairment
HAD	Hospital Anxiety and Depression (HAD) scale - assesses severity of anxiety and depression symptoms
PHQ-9	Patient Health Questionnaire - assesses severity of depression symptoms
GAD-7	Used as a screening tool and severity measure for generalised anxiety disorder
Edinburgh Postnatal Depression Score	Used to screen for postnatal depression
SCOFF	Questionnaire used to detect eating disorders and aid treatment
AUDIT	Alcohol screening tool
CAGE	Alcohol screening tool
FAST*	Alcohol screening tool
CURB-65	Used to assess the prognosis of a patient with pneumonia
Epworth Sleepiness Scale	Used in the assessment of suspected obstructive sleep apnoea
IPSS	International prostate symptom score
Gleason score	Indicates prognosis in prostate cancer
APGAR	Assesses the health of a newborn

	immediately after birth
Bishop score	Used to help assess the whether induction of labour will be required
Waterlow score	Assesses the risk of a patient developing a pressure sore
FRAX	Risk assessment tool developed by WHO which calculates a patients 10-year risk of developing an osteoporosis related fracture

*FAST is also mnemonic to help patients/relatives identify the symptoms of a stroke

Can you think of any other commonly used scoring systems?