

annual review of patients with hypertension, and the advent of the GPs' new contract provides opportunities for this to be done.

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Hepatitis B vaccination

We were pleased to hear of another primary health care team actively vaccinating intravenous drug users against hepatitis B.¹ We have also found hepatitis B vaccination in primary care to be feasible and effective, but we have modified our practice through a number of audit cycles. We provide an outreach service to homeless patients in Leicester and we began by offering bloodborne virus screening to all intravenous drug users before offering vaccination on the traditional 0, 1- and 6-month schedule. We audited the outcomes for all drug users starting a methadone treatment programme over a 6-month period. The first audit of 23 patients treated in the 6 months to September 2000 found that only 48% were screened; nearly all of our patients are long-term intravenous users and gaining venous access is often difficult. This delayed vaccination so that only 65% received it. As a result we decided to offer opportunistic vaccination if screening was not achieved after 8 weeks, a computer prompt was set up at the start of each treatment programme to remind the clinician at each consultation. Our second audit of 31 patients starting treatment in the 6 months to September 2001 found that 97% had received the hepatitis B vaccine during the audit period but only half had completed three doses. Bloodborne

virus screening had been performed for 65% of patients with another 32% screened elsewhere (e.g. criminal justice system or genitourinary medicine clinic.) Forty-five per cent of our intravenous drug-using patients were positive for hepatitis C. As a result of this audit we decided on three modifications to our practice; we would use combination hepatitis A and B vaccine on the grounds that nearly half of our patients were hepatitis C-positive, even if they did not yet know it, and so would warrant hepatitis A protection, and we decided to use the accelerated schedule with doses given at 0, 7 days, 21 days and 12 months, starting the schedule opportunistically at the first contact without waiting for blood screening. Our argument was that giving the vaccination to patients who had already had hepatitis A or B disease would not be harmful. Instead the vaccine would only be ineffective, but delay for unsuccessful blood screening could leave patients exposed to risk. Our third audit of 22 patients starting treatment in the 6 months to September 2002 found that 20 (91%) received three doses of vaccine with two patients declining consent to vaccination. However, we had increased vaccination uptake at the expense of blood screening; only 68% of this group of patients had had bloodborne virus screening in the previous 2 years. The most recent audit of 31 patients treated in the 6 months to September 2003 showed that we had maintained a high level of vaccination with 27 (87%) having 3 or more doses of hepatitis B vaccine and 26 (84%) fully vaccinated against hepatitis A. During this period we had also increased the rate of bloodborne virus screening to 81%.

A key component of achieving such high vaccination rates for a chaotic and hard to reach group was the provision of a well stocked vaccine fridge in every consulting room, so that the consulting doctor or nurse could offer immediate vaccination when the patient presented rather than waiting for a separate clinic. We have found that homeless drug users are concerned about their health and generally keen to accept vaccination if it can be offered opportunistically when they are already consulting about a more pressing issue.

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How would patients like to be addressed? A brief survey

All of us who see patients have to call them somehow, and most will have long since given up on asking how they prefer it. We distributed 151 questionnaires among patients of our small, urban, deprived surgery. Most of them (85.4%) preferred first names. This did not vary with age, but our sample was too uniformly white and poor to comment on social class or ethnicity. Doctors seem unlikely to cause offence by using first names.

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To integrate or not to integrate?

Jewell addresses an important issue in questioning the benefits and risks of closer integration between the primary and acute care sectors.¹ In a desperate search to explain poor health system performance, many commentators have seized upon the lack of vertical integration in the UK as A Problem Needing a Solution.

At face value, they are correct. Of course it is essential that from the patient's perspective care is delivered in as seamless a way as is possible. However, I wonder if those who call for