Letters

The *BJGP* welcomes letters of no more than 400 words, particularly when responding to material we have published. Send them via email to **jhowlett@rcgp.org.uk**, and include your postal address and job title, or if that's impossible, by post. We cannot publish all the letters we receive, and long ones are likely to be cut. Authors should declare competing interests.

Influenza vaccine

The letter by Ashwell *et al*[1] emphasises the importance of targeting influenza vaccination to those groups most at risk of influenza complications, and highlights the need for sufficient vaccine capacity to provide coverage for them.

Current targets for vaccine coverage even in highest risk groups are relatively conservative,[2] and increasing vaccination rates closer to 100% will place additional strain on vaccine stocks even without increased uptake by groups less likely to benefit from vaccination.

An audit in our practice of 12 000 patients evaluated influenza vaccine uptake among patients on the COPD register. Patients with COPD are at high risk of complications from influenza and there is a considerable body of evidence supporting the benefits of vaccination in this group.[2]

During 2004 the practice influenza immunisation strategy focused on the whole target population for influenza vaccination rather than specific risk groups. The rate for COPD patients was 82.6% (n = 109). We implemented an intervention strategy in 2005 targeting COPD patients who had not attended for immunisation in 2004. In addition to the routine vaccine invitation letter sent to all over 65s, further written and telephone contacts were made, offering information and discussion about influenza vaccination. This was reinforced by updating staff about the benefits of vaccination in this high risk group.

In 2005, the influenza vaccination rate among COPD patients was 92.2%, a 10% increase in uptake over 2004. Overall rates of influenza vaccination remained stable within the practice at around 81% of the over 65s.

The aim of vaccination strategies should be to maximise coverage of at-risk groups and we agree with Ashwell and colleagues that there must be sufficient vaccine capacity for these priority patients.

We have shown the effect of a simple intervention in increasing uptake in a group with already high rates of vaccination. We achieved an increase of 10% among COPD patients, giving over 90% coverage. This approach could be applied to other high risk groups, resulting in greater requirement for vaccine. GPs have the potential and the incentive to vaccinate well over the minimum target of 70% of at-risk patients,[3] and vaccine supplies must be adequate to support this.

Sassa Calthrop-Owen

John Fullbrook
Clarendon Lodge Medical Practice,
16 Clarendon Street, Leamington Spa.
E-mail: sassa@clear.net.nz

REFERENCES

1. Ashwell G, Aslam A, Griffin J, *et al*. Audit of influenza vaccination in primary care. *Br J Gen Pract* 2006; **56:** 461.
2. Poole P, Chacko E, Wood-Baker R, Cates C. *Influenza vaccine for patients with chronic obstructive pulmonary disease* (Cochrane Review). The Cochrane Database for Systematic Reviews 2000, Issue 3.
3. NHS Confederation and BMA. Specification for a direct enhanced service. Influenza immunisation for those in the 65 and over and other at-risk groups. In: *New GMS Contract. Investing in general practice, supporting documentation.* London: NHS and BMA, 2003. 1–2.

Comparing costs

The article comparing nurse practitioner (NP) and GP cost in the July issue of the journal[1] is timely as my practice is considering this choice to balance our primary healthcare team. Several issues remain unanswered however:

1. What sort of clinical problems are managed by the NP and GP?

Nurses skilled in chronic disease-management areas are experts in their own field, as are nurses triaging acute diseases 'booked on the day'. But it is rare to find a nurse with knowledge and experience in all clinical areas.

2. Patient satisfaction will depend on the ease of booking, the process during and the end result of the consultation.

Patients may self-select their practitioner for problems with differing complexity. Satisfaction may be easier to achieve if the problem is easy to identify and self limiting.

3. Cross referral within an established multidisciplinary team may result in achieving the best of both worlds.

Patients may be offered an initial assessment by GP or NP and then a three way discussion about the best option for the patient, combining the strengths of all concerned to achieve the best possible result and avoiding unnecessary investigation.

James Lee

Leek Health Centre Fountain Street, Leek, Staffordshire ST13 6JB.
E-mail: James.lee@northstaffs.nhs.uk

REFERENCE

1. Hollinghurst S, Horrocks S, Anderson E, *et al*. Comparing the cost of nurse practitioners and GPs in primary care: modelling economic data from randomised trials. *Br J Gen Pract* 2006; **56:** 530–535.

BJGP discussion forum

The online Journal discussion forum is now up and running, and we welcome your comments. Current topics include:

- Shared decision making
- Increase in antidepressant prescribing in Scotland
- Spiritual healing and asthma
- Voluntary euthanasia

If you would like to comment on these topics or give us one of your own, please do so at:
http://www.rcgp.org.uk/bjgp-discuss