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Service users' views of moving on from early intervention services for psychosis

Lester *et al's* paper is timely.¹ Many early intervention in psychosis (EIP) teams have been in action for over 3 years and are refining discharge pathways to primary care. This interface is not just with colleagues but now also with commissioners. While there is robust economic evidence for EIP, this perhaps sits outside the regular reading of most GPs.² This interface needs active management and should not be relied on to grow organically. Every interaction with GPs should name the team and provide opportunity for shared learning, enhanced by the many leaflets covering this area.³ There is a need to help GPs to understand what patients have been experiencing for the preceding 3 years and not just to advise on subsequent management. In a world of ever changing services it is particularly important that they can be supported to navigate their way back in and EIP teams would tend to maintain responsibility for this, sometimes necessitating a brief period of re-engagement to do so. This is added value from an economically justified team. GPs are often left with a client who is still on medication and are quite reasonably asking for how long they may continue, when medication can be safely stopped, and what the considerations and risks in doing so may be. There is a concern that vocational aspects, that are particularly valued by clients, may be among the hardest to access from primary care.

Peter Carter,

Consultant Psychiatrist, Waltham Forest EIP, North East London NHS Foundation Trust, 714 Forest Road, London, E17 3HP.
E-mail: Peter.carter@nelft.nhs.uk

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COPD in primary care

As GPs working for the London Respiratory Team, we were extremely pleased to see the high profile given to COPD in February's *BJGP*^{1–4} since we believe that primary care, as part of an integrated pathway, has a major role both in earlier diagnosis and continued management of this condition. We would like to highlight two concepts from our workstreams:⁵ first that COPD is as important as lung cancer (or TB or other serious illness) and second to view high quality stopping smoking support as the treatment for COPD. We are keen to promote straightforward techniques such as very brief advice on smoking⁶ and simple case-finding techniques⁷ that can be used even in time-limited consultations to provide systematic and opportunistic earlier diagnosis of COPD and maximally effective intervention.

Opportunities to signpost patients in primary care range from receptionists noticing insidiously increasing breathlessness in patients they may have known for years, through to practice nurses who are ideally placed to offer case-finding spirometry to patients at risk of COPD. Increasing fragmentation of care within the NHS often means that the patient's registered GP may be the only healthcare professional in a position to spot recurrent chest infections, for instance, diagnosed out-of-hours or at walk-in centres, or to offer follow-up following an emergency department attendance. Earlier and accurate diagnosis in turn leads to proven interventions such as stopping smoking as a treatment and pulmonary rehabilitation. Per quality-adjusted life year, these treatments are highly cost effective at around £2092 and £2000–8000 per quality adjusted life year respectively.^{8–9}

Within London, we're making the case for change in respiratory services by advocating a value-based approach to COPD health

care. Work is needed across the UK to get the best value from the respiratory programme spend. The coming months will be a key time for clinicians and commissioners to debate where there could be improvements within the existing respiratory budget by maximising the outcomes that people with COPD want through the use of therapies that have proven cost-effectiveness.

Noel Baxter,

GP, Southwark, LRT Co-lead and Stop Smoking as a Treatment for COPD Clinical Lead.

Christopher Cooper,

GP, Islington, LRT GP and Earlier Diagnosis Clinical Lead.

E-mail: chris.cooper@gp-F83015.nhs.uk

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Doctors' behaviours with antibiotic prescribing

We read the study by Colin P Bradley *et al*¹ regarding the influence of patient payment on antibiotic prescribing in Irish general practice. The Republic of Ireland is one of three European countries in which antibiotic use in general practice is increasing.¹ Eligibility for Ireland's primary care services is determined by a means test with General Medical Service (GMS) card holders having access to GP services and medications free of charge. The remainder are private patients who pay a fee to access GP services.

We retrospectively reviewed a 2-week period in September 2011 in a practice with predominantly children and young patients presenting with symptoms that indicated a probable RTI (as in the Bradley *et al* study). The results were presented to the practice GPs and nurse in October and then a second 2-week period in December 2011 was then reviewed. Our results are shown in the table below.

The representation of GMS and private patients in September and December was approximately equal. Our findings show that there were more RTI presentations in December with less antibiotic prescribing overall, fewer antibiotics were prescribed to private patients in December, and higher use of delayed antibiotic prescribing.

As stated in many articles including the Bradley study, there are many external non-clinical factors that influence GPs prescribing such as patient's expectations, time constraints, patient volume, and mode of remuneration.^{1,2,3,4} Our brief audit

Table. Comparison of consultations for September and December 2011

Parameter measured	September	December
% RTI presentations of total consults	22.7	35.8
% antibiotics given for RTI	67.8	60.0
% delayed antibiotics given for RTI	27.9	37.2
% GMS did get antibiotics	53.2	57.6
% PP did get antibiotics	83.7	62.5

GMS = public patients. PP = private patients.

demonstrates that doctors' behaviour can be changed by the use of data on their prescribing activities. The only intervention between September and December was a presentation of September's results to the clinical staff. Whether this will be sustained or not will be the subject of another audit.

John Peters,

Littlepace Medical Centre, Dublin 15, Ireland.

Claire Young,

Littlepace Medical Centre, Dublin 15, Ireland. E-mail: iclaireyoung@yahoo.ca

Tom O'Dowd,

Public Health and Primary Care, School of Medicine, Trinity College Dublin, Ireland.

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Situating general practice training in the general practice context

While I understand and agree with the long-term aim of increasing training time in the GP setting for GP trainees, I am unable to agree with some of the conclusions drawn by Goldie and Morrison.¹

First, the training received in hospitals by GP trainees does not occur in isolation from the general practice setting. Within our vocational training scheme for example, during the time that our trainees are in their

hospital placements our main focus is on putting their experiences into the general practice context. Furthermore, in our local deanery, all trainees do 6 months in GP practices prior to their final ST3 year, and this means that members of each small group are grounded with the perspective of the world they are preparing to enter. The socialisation and cohesiveness of the STs within their small group of GP trainees seems much more important than the more transient bonds formed while on hospital placements.

Second, obstetrics aside, I am sure that there is benefit to be gained by training in many hospital jobs as it allows the building of more specialist knowledge in commonly encountered general practice problems, for instance in sexual health, ENT, or dermatology. This knowledge is subsequently disseminated through peer learning to other members of their vocational training scheme small group and to the practices they work in later.

Finally, quality assurance of hospital posts means that the hospital leads for all our jobs are visited on a rolling cycle. We discuss with our hospital colleagues how our trainees can make the most of their time in hospital training experiencing, for instance, following a patient through a primary to secondary to primary care journey, understanding what makes a good referral from the hospital point of view, and viewing the primary care interface from the secondary care perspective. Given that commissioning is likely to lead to a more focused examination of the grey area between what can be done in primary or secondary care, fully understanding the boundary from all sides is likely to put us in a much stronger position to be able to manage it to the profession's best advantage.

Leaving aside the economic and logistical arguments of how to base training fully in primary care, arranging service provision in hospitals, or longer training in general practice, I strongly support extended training for GP STs within a primary care setting. I would, however, anticipate that an extra training year in the GP setting after completion of MRGCP would alleviate many of the concerns raised.

Tom Pelly,

Training Programme Director, Bristol Vocational Training Scheme, Severn Deanery, Horfield Health Centre, Lockleaze Road, Bristol, BS7 9RR. E-mail: tompelly@doctors.org.uk