would it discourage patients from seeking help and put them at risk of harm? Would this just increase GP workload even more? Could it be that patient education, instead of charging, is the way to reduce unnecessary attendances? Are charges of this kind becoming inevitable in the NHS?

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Quality assurance of appraisal summaries

Objective assessment of whether doctors meet the General Medical Council (GMC) standards for revalidation^{1,2} is a new challenge. In Hertfordshire GP senior appraisers started to quality assure appraisals in January 2013 with the aim of ensuring that they were up to sufficient standard to enable the responsible officer to base revalidation recommendations on their outcomes. A quality assurance form was developed, and all appraisal summaries were allocated to one of seven senior appraisers to be checked against the form. After 3 months the senior appraisers were sent (without knowing it) the same appraisal summary to ascertain whether this process was accurate and objective. The results showed surprising lack of unanimity.

In some areas there was total agreement, for example: whether last year's personal development plan had been reviewed; whether it covered the scope of the doctors work; whether a balance of different types of educational activity was maintained; and whether patient and colleague surveys with reflection were present. However there were complete splits on issues that we had expected to be cut and dried. There were 5:2 splits on whether learning credits were discussed and verified, whether complaints/audits with review and reflection were present, and whether statements were objective and supported by evidence. There were 3:4 splits on whether last year's appraisal summary had been reviewed and discussed, and whether two significant events were present with reflection and learning points.

This is a work in progress. We have discussed these results and revised the wording and the statements on the QA form. Furthermore this is a tiny sample, of one appraisal summary and seven senior appraisers' views of it. However, revalidation is now with us, and our findings suggest that application of the GMC minimum standards for revalidation decisions may be problematic.

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The Wow test in quality

There is usually a Wow factor in the very highest quality. But there is often a Wow factor in the poorest quality. An editorial¹ that suggests that the RCGP first started to define excellence in 2008, focuses on a process of remuneration (the Quality and Outcome Framework) as the current zenith of quality measurement and wants more research so that the concepts of quality should be tested until a consensus emerges of the key domains of components, passes the Wow test.

In 1985 the RCGP *What Sort of Doctor* report was published. This followed 4 years of developing systems to assess the quality of care by matching individual performance against defined and agreed criteria of competence. In the same year, the College published a major policy document *Quality in General Practice*. Subsequently, and for the last 20 years, other RCGP quality schemes with evolving measures of

quality like the Fellowship of the RCGP by Assessment, the Quality Practice Award, and the Practice Accreditation Scheme have continued to do all that is suggested in this new paradigm. It was good idea in 1985 but it's not a new idea in 2013. All that remains is to convince government to reward these schemes that have 30 years experience trying to 'capture general practice quality in all its richness and complexity'.

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Measles targets and herd immunity

Measles epidemics occur in populations with sufficient numbers of susceptible individuals for each infected person to meet and pass on the virus to one or more other susceptible individuals. Herd immunity suggests that if enough people are rendered immune such meetings will be rare enough for the virus not to be passed on and the whole population to be protected. If immunisation rates for the population were high enough we should therefore prevent epidemics such as the current one in south Wales. So if general practice can and does deliver high measles immunisation rates from ages 2–5 years, why do we currently have a problem?

Unfortunately both the model of herd immunity and our immunisation rate markers are flawed. Human communities do not consist of randomly moving particles bumping into each other by chance, they cluster in social groupings. Equally just because 90–95% of 5-year-olds are immunised over a 10-year period does not mean that 95% of people under 15 have been protected. If unimmunised people move into a community the coverage will drop. Moreover if the newcomers cluster together they will form a subgroup at high risk of an outbreak.

In our small inner-city practice in an area of high turnover and immigration,

despite a consistently high immunisation rate, we have discovered an important group of susceptible teenagers we were not previously aware of among whom a measles outbreak remains. Despite immunisation rates consistently over 90%, of our 256 10–16-year-olds, 51 were not fully immunised. The autism fallacy accounts for five people not taking up immunisation, but 46 were new entrants to the UK after the age of 5 years old. In our area therefore, despite high immunisation rates, we are at high risk of an epidemic. Herd immunity does not apply.

We cannot afford to rest on our laurels. Having reached high immunisation rates overall is good but not good enough especially in areas of high population turnover and immigration. Measles susceptibility is an ever-present danger.

Do we need to routinely do one-third MMR at age 10–12 years old, or immunise all new entrants along with TB screening?

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Are we overusing thyroid function tests?

The prevalence of hypothyroidism in the UK is 2%. It is 10 times more common in women, with incidence figures of 4.1/1000 women/year and 0.8/1000 men/year. Thyrotoxicosis is much less common, with a prevalence of 0.4%. It is also more common in women (0.77/1000 women/year versus 0.14/1000 men/year). The standard investigation if either disease is suspected is blood thyroid stimulating hormone (TSH).

Guidance from the British Thyroid Association (2006) states that TSH should be tested if thyrotoxicosis is suspected, with a normal TSH effectively ruling out hyperthyroidism, and for hypothyroidism it advises that, because the typical signs are often not present, clinical judgement is important in deciding whom to investigate.¹

We studied the yield of thyroid disease obtained from the number of TSH tests requested, in an Exeter, Devon, practice serving an urban population of 18 178. Of the 2717 patients who had TSH testing in 2012, 398 (15%) were already taking thyroxine

for hypothyroidism, and 77 (3%) were on treatment for active thyrotoxicosis or having annual TSH monitoring for previous hyperthyroidism. Thus there were 2267 patients who had TSH testing for diagnostic purposes. These tests identified 48 (2.1% of those tested) patients newly diagnosed with hypothyroidism over the past year. Ten of these were at higher risk: seven patients became hypothyroid while receiving carbimazole treatment for thyrotoxicosis, two after having a thyroidectomy, and one after radioiodine treatment. Arguably, this leaves 38/40 newly diagnosed with spontaneous hypothyroidism. There were seven new diagnoses of hyperthyroidism in the past year.

The study by Vanderpump *et al* provides demographic data on UK thyroid disease incidence and prevalence: using their data we would expect 39 new diagnoses of hypothyroidism and six of hyperthyroidism annually; remarkably close to our observed figures.² Although the high number of tests to identify each case suggests indiscriminate testing, the practice is one of the lowest in Devon for TSH testing (14th out of 108 [personal communication, Professor Chris Hyde, 2013]).

The local cost of a standard TSH test is £1.67 (to which must be added the costs of phlebotomy, transport, and clinic time). Nationally, 10 million thyroid function tests are requested each year, at a cost of over £30 million to the NHS.³

Our study shows a high ratio of TSH testing to each diagnosis of thyroid disease, which could indicate that we are testing for hypothyroidism rather indiscriminately, with significant costs to the health budget. The next question will be to find out how this can be improved.

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Miss Polly had a dolly

The nursery rhyme by Dr Corbett¹ repeats the mischievous myth that GPs are to blame for the pressures on A&E departments. She should consider adding this verse in the interests of balance:

*Miss Polly gave her GP stick, stick, stick,
For not doing a home visit quick, quick,
quick,
But she managed to travel to A&E,
Though it was further than the surgery!
She waited 3 hours and 59 mins
Until the nice nurse called her in,
The nurse explained it's just a cold, cold,
cold,
Just as your doctor told, told, told.*

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Editor's note

The poem was written by a specialty trainee in general practice during maternity leave when her baby son was ill.

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Reducing inappropriate ENT referrals

Cox and colleagues¹ highlight the problem of increasing numbers of outpatient referrals, many of which are thought to be inappropriate. Ear, nose, and throat (ENT) problems are common in primary care² and appropriate referral is crucial. We investigated GP referrals to the one-