be added to the avoidance by the patient and care givers. We have very recently run a study to explore views of healthcare professionals and patients on end-of-life decisions, and found that both sides were not comfortable in talking about end-of life or even filling in a questionnaire on this topic. This remains as a challenge to overcome.

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Why all GPs should be bothered about Billy

The 2014–2015 QOF overhaul[1] retires three critical cardiometabolic indicators from the severe mental illness (SMI) domain, keeping only blood pressure. Yet cardiovascular disorders, rather than suicide, remain the single biggest contributor to 15–20 years reduced life expectancy. Two decades of cardiometabolic risk prevention has successfully reduced cardiovascular mortality in the general population but sadly eluded those with SMI.[2]

Potentially modifiable cardiometabolic risks, often appearing within weeks of commencing antipsychotics, ultimately translate into 1.5–3-fold increased rates of diabetes, obesity, and dyslipidaemia than in the general population. By age 40 years metabolic syndrome becomes four times commoner and about 40% of individuals are biochemically at high risk of diabetes. Furthermore the National Audit of Schizophrenia[3] found only 29% of 5091 patients from across England and Wales had cardiometabolic risk adequately assessed in the previous 12 months (weight, smoking status, glucose, lipids, BP). Weight was unrecorded in 43%. Moreover when cardiometabolic complications are discovered, too often these are ignored in clinical practice particularly when compared with patients without mental illness.

Responding to this evidence of inequalities in care, the Lester Positive Cardiometabolic Resource[4] embraced these to-be-retired QOF measures with the message 'Don't just screen, intervene'. This was endorsed by the RCGP/RCPysch/RCP/RCN/Rethink/Diabetes UK and recommended by NICE (NICE CG 155) and the Schizophrenia Commission. The resource's lead author, the late Professor Helen Lester, key scientific advisor to the QOF until her death this year, challenged us to be 'Bothered about Billy'[5] in the RCGP James McKenzie Lecture 2012.

QOF aims to universalise good quality care. The challenge is in its translation from checklist to the human being in front of us. Has anyone explained to a real person with SMI or their relatives why these indicators are being removed? Ultimately our responsibility is to First do no harm and provide a service that makes sense. This decision does neither.

We would ask the 2014–2015 GP contract negotiators to join us in being bothered about Billy too.

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Competing interests

David Shiers is a current member of the Guideline Development Group for NICE guidance for adults with psychosis and schizophrenia; David Shiers and Carolyn Chew Graham are members of NCCMH board

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Improving out-of-hours handovers

As a recently qualified academic GP working out-of-hours (OOH) shifts, I read with interest the debate and analysis section of the October *BJGP* dedicated to the problem of OOH service provision. How should urgent primary care be provided? Who are the key players and how should they form an effective OOH team? Dr Drinkwater pointed out the two key areas where patients can actively help in alleviating pressure on OOH services: self-management and information. Dr Greenhow emphasised creating a national quality contract running through all providers to ensure coherent clinical governance. Professor Mason

proposed the simple solution of a co-located emergency centre staffed with GPs, nurse practitioners, and emergency medicine doctors.

Handover between OOH and in-hours GPs has been defined as 'one of the most perilous procedures in medicine, and when carried out improperly can be a major contributory factor to subsequent error and harm to patients'.[1] In-hours care accounts for 50 hours/week while OOH care accounts for 118 hours/week. Handovers matter and should be quality-assured. How and when do in-hours providers check OOH providers' reports? How often do in-hours providers act upon suggestions made by their OOH colleagues, provided suggestions are made. How confident are OOH providers that their in-hour colleagues will give timely attention and act upon the suggestions made? A common strategy adopted by OOH providers is to encourage patients to contact their practices and draw attention to the suggestions made by OOH providers. Is this safe enough? Is there scope for a quality assurance process applied to OOH handovers, and will this contribute towards forming a more effective OOH team?

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Tackling the alcohol issue in France

Excessive alcohol consumption remains a significant problem around the world and in France, with a 30% prevalence of hazardous and harmful drinkers.[1] GPs are a mainstay of the health organisation and can have a significant impact on alcohol misuse.

A project conducted in 2007 revealed that French GPs questioned only 11% of their patients about their alcohol consumption.[2] We performed a representative observational survey of 69 fee-for-service GPs in the department of Puy-de-Dôme between May and October 2011. The WHO alcohol thresholds were known by less than one-quarter of the GPs, 42% of them were familiar with Screening Brief Intervention (SBI) and 10% felt SBI use was effective in their practice. The GPs felt that their prescribing role was more important (87%) than tackling the alcohol issue (48%). Questions about alcohol were asked mainly in the event of abnormalities being revealed by blood tests (63%). They thought their role in dealing with alcohol misuse was legitimate but also expressed a low level of confidence and work satisfaction. The three incentives most often identified by GPs as likely to improve SBI involved government (100%), patients (95%) or health organisation (95%).

Alcohol was not perceived as a disease risk factor by the GPs in their routine practice, and preventive procedures will be held in check as long as GPs find it easier to fulfil their prescribing role. The GPs had an ambivalent attitude, recognising that they could legitimately question and advise their patients, but at the same time complaining about the lack of education and suitable tools to help them.[3]

Consequently, a change in mentality and ways of thinking about primary health care and prevention is needed. French GPs do not consider that screening for hazardous and harmful drinkers falls within their remit. It is time to implement an effective preventive policy in France, highlighting patient-centred medical homes organisation[4] and payment system.

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Anal fissures; first do no harm

Referrals of younger patients with 'painful piles' who have already applied steroid cream are common.

Ninety per cent of acute anal fissures heal, but in nearly all those that do not, topical steroid cream has been applied to treat presumed piles. There is no evidence that any cream has improved the natural history of piles, but it is recognised that steroids reduce healing of acute fissures, and can create a chronic condition.

Anal fissure can be easily seen without any equipment other than a torch. When a fissure is seen the patient can be told piles are not the cause of their symptoms (a tearing sensation with pain for 30–60 minutes following bowel opening). Avoiding constipation with or without any cream (not containing hydrocortisone) allows healing, but if the problem has not settled in 6 weeks colorectal referral may be required excluding other pathology.

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Corrections

In the June issue of the *BJGP*, the letter Piggott L. GP nomenclature. *Br J Gen Pract* 2013. DOI: 10.3399/bjgp13X668122 included address details that should have instead been presented as: GP, Brighton. E-mail: liam.piggott@doctors.org.uk. The online version has been corrected.

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In the December issue of the *BJGP*, the article Rodrigues JN, Mabvuure NT, Nikkhah D. Tips for GP trainees working in plastic surgery. *Br J Gen Pract* 2013; **63:** 667-669 DOI: 10.3399/bjgp13X675629 the name of the author Dariush Nikkhah was incorrectly spelt. We apologise for this error. The online version has been corrected.

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