All letters are subject to editing and may be shortened. General letters can be sent to bjgpdisc@rcgp.org.uk (please include your postal address for publication), and letters responding directly to *BJGP* articles can be submitted online via **eLetters**. We regret we cannot notify authors regarding publication. For submission instructions visit: bjgp.org/letters

Editor's choice

I am a GPST2 trainee in a highly organised training programme in south west England that treats trainee doctors with respect and works from a basis of patient-centred holistic care. We regularly consider the underlying issue or hidden agenda that has brought the patient to the consultation, and continue to develop our communication skills in order to elicit this invaluable information. Although this may be perceived as a 'soft skill' it is crucial to all types of consultation, hospital or community based. GP training prepares us for competent independent medical practice with a broad knowledge base and clinical skills that transfer beautifully to many environments, particularly those with minimal technology. We are community doctors carrying out 90% of all NHS consultations. This should be celebrated, well supported, and aspired to by junior doctors. General practice is currently the most flexible specialty to train in, making family life much more achievable.

The scope to develop a special interest in fields such as acute medicine, palliative care, and minor surgery should be more widely promoted, with clearer pathways for achieving special interest status. It seems unreasonable to expect Foundation doctors to move into a potentially life-long career having had minimal experience in the field. The current training system is too streamlined and deprives the trainee of the wealth of experience that could be gained from spending more time flexibly rotating through other specialties. A broader training programme that incorporates medicine, emergency medicine, and general practice could encourage more trainees into the speciality and increase the amount of doctors available to work in emergency medicine or general practice.

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The status quo is not an evidence-based option

Mant¹ acknowledges the pressing need for earlier identification of cardiovascular (CVD) risk, hypertension, diabetes, and kidney disease (CKD). He identifies some questions raised by recent research but underlines that evidence is inconsistent. He suggests that the NHS Health Check should be abandoned, but offers little alternative beyond usual primary care. We would challenge that an approach dependent on the status quo can be justified when, despite almost universal registration with a GP, around 5 million people in England have undiagnosed hypertension, 1.6 million have undiagnosed CKD and 700 000 undiagnosed diabetes.

The editorial suggests that the NHS Health Check should be abandoned partly because it is inefficient at case finding. The evidence for this derives from a single study² whose authors reported that the NHS Health Check was no better than usual care at case finding. This study had significant limitations (not randomised, underpowered and low health check uptake) and the findings do not justify abandonment of the NHS Health Check, but should generate questions about fidelity of the intervention: are we reaching the right populations, is there sufficient uptake, is the NHS Health Check quality assured, and is there appropriate follow up in primary care?

We agree that there is a dearth of evidence for the NHS Health Check as an integrated-delivery method. We want to learn from and improve the implementation and impact of the NHS Health Check programme. For this reason we have established an Expert Scientific and Clinical Advisory Panel whose remit includes ensuring the programme responds to emerging evidence, and advising on changes to content and delivery to optimise uptake and effectiveness and to reduce health inequalities. We will shortly be publishing a priorities for research paper to articulate the key research questions. We have also published a set of standards³ and competencies⁴ for NHS Health Check providers.

However good the uptake and quality of delivery, achieving the anticipated benefit will only happen if people identified as having high CVD risk or clinical abnormality are

added to disease registers and receive appropriate management. We will continue to work closely with primary care colleagues to understand how best we can support GPs and their staff to ensure that the primary care component of the NHS Health Check pathway is delivered effectively.

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GP antibiotic overuse and microbial resistance

Weiler correctly highlights some of the limitations of primary care prescribing data:¹ Research databases such as the