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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REFERENCES

1. Mant D. Health checks and screening: what works in general practice? *Br J Gen Pract* 2014; **64(627)**: 493–494.
2. Caley M, Chohan P, Hooper J, Wright N. The impact of NHS Health Checks on the prevalence of disease in general practices: a controlled study. *Br J Gen Pract* 2014; DOI: 10.3399/bjgp14X681013.
3. Public Health England. *NHS Health Check programme standards: a framework for quality improvement*. February 2014. <http://www.healthcheck.nhs.uk/document.php?o=547> [accessed 6 Jan 2015].
4. Public Health England. *NHS Health Check Competence Framework*. June 2014. <http://www.healthcheck.nhs.uk/document.php?o=664> [accessed 6 Jan 2015].

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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

Clinical Practice Research Datalink (CPRD, formerly the GPRD) record information on issued prescriptions, prescribing analyses and cost (PACT) data records prescriptions that are dispensed. Neither of these methods will record the proportion of prescriptions that are actually taken by the patient and we are unaware of any research studies that have specifically addressed this important question. GPs can record delayed prescriptions using the Vision software system, but it is unclear how frequently this Read Code is used.

However, estimates suggest 80–90% of antimicrobials are prescribed in the community so even if we are overestimating antibiotic use, it is clear that the majority of antimicrobials are prescribed and dispensed in primary care. Research studies based on both issued and dispensed prescriptions using different populations all deliver the same message: there is major heterogeneity in prescribing, and this offers scope to reduce antibiotic use.^{2–4}

There is a clear need for better surveillance data on antimicrobial prescribing and resistance in hospitals and in primary care and this is the rationale behind the English Surveillance Programme for Antimicrobial Utilization and Resistance (ESPAUR).⁵ Optimising antibiotic use is a fundamental part of the response to antimicrobial resistance. This will only be achieved by changing patient and clinician behaviour in the community and in hospitals.

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REFERENCES

1. Weiler R. RE: GP antibiotic overuse and microbial resistance: as bad as we think or much worse? <http://bjgp.org/content/64/629/604.eLetters#re-gp-antibiotic-overuse-and-microbial-resistance-as-bad-as-we-think-or-much-worse> (accessed 6 Jan 2015).
2. Hawker JI, Smith S, Smith GE, *et al.* Trends in antibiotic prescribing in primary care for clinical syndromes subject to national recommendations to reduce antibiotic resistance, UK 1995–2011: analysis of a large database of primary care

consultations. *J Antimicrob Chemother* 2014; **69**(12): 3423–3430.

3. Majeed A, Moser K. Age- and sex-specific antibiotic prescribing patterns in general practice in England and Wales in 1996. *Br J Gen Pract* 1999; **49**(446): 735–736.
4. Shallcross LJ, Davies DS. Antibiotic overuse: a key driver of antimicrobial resistance. *Br J Gen Pract* 2014; **64**(629): 604–605.
5. Ashiru-Oredope D, Hopkins S. Antimicrobial stewardship: English Surveillance Programme for Antimicrobial Utilization and Resistance (ESPAUR). *J Antimicrob Chemother* 2013; **68**(11): 2421–2423.

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End-of-life priorities in practice

Following criticism of the Liverpool Care Pathway (LCP) in an independent review in 2013, it was recommended that it be phased out.¹

The Leadership Alliance for the Care of Dying People published a response to that review in June 2014.² This listed five priorities for care, broadly addressing the importance of an individual, holistic approach, with emphasis on communication, listening to the patient, and recognition of impending death.

In general practice, end-of-life care is delivered in the patient's home, which may be unfamiliar to the doctor, especially out of hours. Time pressure can inevitably increase the stress.

With this in mind, I set out to create a checklist for what GPs actually need to do during the consultation. We often talk about giving the patient TLC, but what does that mean? In this case, it stands for Tailor made, individual care; Listening; and good Communication.

My checklist applies the basic principles of care, but in a structured and practical way. It enables all people involved with the patient, be that a GP, nurse, or carer, to remember the needs of the dying patient and take practical steps to address them, or to ask a clinician to address them:

1. Is the patient dying in their chosen place of death, if possible?
2. Is the patient in pain? Is analgesia prescribed, and is it available today?
3. Is the patient feeling sick or vomiting? Is medication prescribed and available to help with this?

4. Is the patient agitated? Is medication prescribed and available to help with this?
5. Have unwanted medications been stopped?
6. Has a Do Not Resuscitate order been signed, and if so is it available?
7. Is the patient thirsty? Does their mouth need care?
8. Are their bladder and bowels comfortable?
9. Has somebody spoken to the family or other loved ones today?
10. Are there any other concerns which have not been addressed?

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REFERENCES

1. Department of Health. Independent Review Of The Liverpool Care Pathway. *More care, less pathway: a review of the Liverpool care pathway*. July 2013. www.gov.uk/government/uploads/system/uploads/attachment_data/file/212450/Liverpool_Care_Pathway.pdf [accessed 9 Jan 2015].
2. Leadership Alliance for the Care of Dying People. *Once chance to get it right: improving people's experience of care in the last few days and hours of life*. June 2014. www.gov.uk/government/uploads/system/uploads/attachment_data/file/323188/One_chance_to_get_it_right.pdf [accessed 9 Jan 2015].

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Basal cell carcinomas: a growing problem

Over the past number of years there has been a significant rise in the number of referrals regarding sun damaged skin lesions, more specifically basal cell carcinomas, in the head and neck region, to our maxillofacial department for surgical management.

Admirably, our colleagues in primary care are ever vigilant, with the majority of basal cell carcinomas being fortuitously detected at check-up examinations.

The well documented aetiology which includes genetic predisposition and ultraviolet radiation exposure,¹ is of particular relevance in our western population given the fair type 1 and type 2 skin makeup and increased feasibility of travel to hotter climates.² The shift in