Flu jabs in general practice

I have just finished our first flu jab clinic of the year. I have enjoyed the banter from the patients, ‘you should line us up like they used to in the army’ and other such comments. I have enjoyed the competition with the other clinicians; who can give the most in the time! Most of all I have enjoyed the essence of general practice. Seeing my patients a year on, I notice which patients are well and which ones are not moving as well, or who seem a little frailer.

So why am I writing this, having been one of the quiet GP partners trying to keep going in increasingly troubled times? I am writing this as, in their great wisdom, NHSE and PHE felt that pharmacies should get in on the flu jabs. I am sure this is appropriate to increase the uptake, but the knock-on effect of poorly thought-through plans are beginning to show.

NHSE insist that we order enough flu jabs for our at-risk population. Fine, but then the pharmacy receives their flu jabs 3 weeks before us from the producers as the retailers can place larger orders. Pharmacies in our area had a 3-week head-start on us. Our nurses must have annual immunisation update training. Do the pharmacist and technicians? We have full resuscitation equipment on site. Do pharmacies? The pharmacy has to inform us that they have given the flu jab but not the batch number or expiry date. So, if they have a reaction, which of course we will have to see, we do not have this information to report the adverse reaction. And to add insult to injury the pharmacies get paid 96p more for each flu jab.

If we make a loss this year, we will not be sacrificing our Saturday mornings that are indeed still relatively unusual and we agree that the bulk of the home visits are made by GPs in GMS/PMS models of service with all the competing pressures that Gupta describes. What the Herts Urgent Care [HUC] model did was to give us a reliable method to link a specific visit request to a geographical location and date, so we could make a reliable link to weather data, which is both time and geographically dependent and highly variable, as every GP with wet shoes knows. With the plethora of GP IT systems and GDPR regulations, linking these data would have been very difficult to do for specific practices, CCGs, or indeed regionally.

The temporal link between season of the year and reduced visiting in the summer was found in our study (see Table 1) but we were able to drill down further and show that there were no clinically important differences on cold and wet days. The study was originally called ‘GPs get there whatever the weather’, which could possibly be justified from our data. A better understanding of the vital role home visiting in primary care plays is essential as it is the clinical ‘glue’ holding together community services that enables frail and older people to receive care in their home, that if it were not provided would rapidly overwhelm NHS services.

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Effect of weather on GP home visits

This was a good study;¹ however, to play devil’s advocate, I wonder if it would have been worth exploring or discussing the study’s limitations in more detail. For instance, this study is based on data not from traditional general practice, which is probably still by far and large the major provider of GP home visiting, but from a service that appears to be resourceful and designed for in-hours visiting and might not have the competing priorities that the average GP surgery might have.

A future study might want to look at total visit requests in traditional general practice (and bespoke services like this one), and the proportion that were responded to by visits, and track that proportion as a priority compared with net numbers, over the seasons, since overall visit requests (and demand for competing everyday practice tasks, such as prescription and document processing workloads) may be lower in summer in any case.

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Author response

Thank you to Gupta for his critique of our paper with points that are well made. In the online full-text version, we were able to discuss the strengths and weaknesses of our methods and analysis in greater detail.¹ Delegated home-visiting services are indeed still relatively unusual and we agree that the bulk of the home visits are made by GPs in GMS/PMS models of service with all the competing pressures that Gupta describes. What the Herts Urgent Care [HUC] model did was to give us a reliable method to link a specific visit request to a geographical location and date, so we could make a reliable link to weather data, which is both time and geographically dependent and highly variable, as every GP with wet shoes knows. With the plethora of GP IT systems and GDPR regulations, linking these data would have been very difficult to do for specific practices, CCGs, or indeed regionally.

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Undergraduate exposure to GPs with Extended Roles

GP with extended roles (GPwERs) may be
attractive to those drawn to primary care in their medical school career but who perhaps also have specialist interests that are often associated with secondary care medicine. However, the undergraduate curriculum seems devoid of any introduction to GPwER, limiting future consideration. As final-year medical students trained in both Welsh and English institutions it is apparent that even during GP placements little information is provided about extended roles and the training available after CCT.

The shortage of GP and allied healthcare professionals is a serious problem.1 The NHS Long Term Plan includes prioritising the increase of community-based health interventions, reducing those carried out in secondary and tertiary centres, stressing the need for more GPs, particularly with extended roles.2 The duration of each clinical rotation does not necessarily correlate to the future uptake of that specialty. Therefore, increasing the awareness of GPwERs should be considered in medical schools to try to attempt to address the growing need for more GPs.3

As the number of junior doctors engaging in general practice training pathways remains low compared with other specialties,4 ensuring medical students are well equipped with the knowledge of job possibilities in primary care should be a medical education priority. Minor issues including the transition in name from GP with a specialist interest to GPwER are likely to deter students from exploring potential careers in general practice because of sparse and ambiguous information that is difficult to source in a time-critical period of training. This highlights that the devil is often in the detail as a 10-minute ‘GPwER GP-student appointment’ may help inspire and recruit desperately needed GPs. Heightened awareness of GPwER among medical students is unlikely to solve the staffing crisis but may be a crucial element in a concerted effort to bolster the future primary care workforce.

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Another marker of underlying pathology

The recent discussion regarding the utility of the inflammatory markers erythrocyte sedimentation rate (ESR), C-reactive protein (CRP), and plasma viscosity2 is very interesting as we have often noted them to be normal despite underlying pathology.

In our local laboratory, serum globulin is presented as part of the liver function test panels calculated by subtracting the total protein from albumin concentration from the serum total protein. We have found raised levels of total globulin to be a very useful marker of underlying blood-borne virus (BBV) infections, monoclonal gammopathy of unknown significance (MGUS), and multiple myeloma. In our two South East London practices (total population approximately 15 000) we reviewed two late diagnoses of HIV and myeloma and noted a chronically raised globulin that had been overlooked. We therefore invited patients who had a raised globulin result in their latest liver function tests from the last 3 years for a blood-borne virus screen (HIV, hepatitis B, and hepatitis C) and myeloma screen (protein electrophoresis and immunofixation). The search and recall found that across both practices 223 patients had a raised globulin of >35 g/L with no known cause in the last 3 years. Consenting to the further blood tests were 173 patients. Subsequently 39/173 (22.5%) patients were found to have underlying pathology: seven new cases of myeloma were detected, one of which required immediate treatment, and 15 patients were found to have previously undiagnosed HIV, hepatitis B, or C. The other 17 patients have been diagnosed with MGUS and are now being followed up. Interestingly, most of the above patients had normal CRP and ESR where it had been tested. We believe that this overlooked marker of underlying inflammation deserves further investigation and its utility highlighting. We have noted that there is a trend to remove globulin from routine biochemistry liver profiles as part of demand management and on cost grounds. This could potentially result in missed opportunities to diagnose cases earlier.

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The challenges of understanding differential attainment in postgraduate medical education

I have two questions about this article’s differential attainment in postgraduate medical education.1 One is the pluralism of evaluation; the other is the fairness of evaluation. Regarding the pluralism of evaluation, the way mentioned in the article to evaluate achievement is examination. Is this theoretical or practical examination? In addition to theory and practice, should students’ achievements