Efficacy of text message intervention for increasing MMR uptake in light of the recent loss of UK's measles-free status

Public Health England (PHE) recommends that children should receive two doses of MMR vaccine, with the first dose at 12 months of age, and the second dose at 3 years and 4 months of age. In 2019, the UK lost its World Health Organization 'measles-free' status, following a 4-year period in which MMR uptake declined.¹ Indeed, 'suboptimal uptake', particularly of the second dose, has been identified as the most important factor by the PHE.² We conducted a full cycle audit of a single practice using a text message intervention, which increased uptake of the MMR vaccine over a 5-month period.

The patient database was searched to determine children aged 3–11 years ($n=1447$) who have received 0, 1, or 2 MMR vaccinations. The lower age boundary was chosen as children are advised to be vaccinated by 3 years and 4 months, prior to commencing school. The upper boundary represented the age within which our practice had permission to send text messages to the respective parents. In August 2019, 8.98% ($n=130$) of patients had only received one MMR vaccination, and 3.73% ($n=54$) of patients had received none. The parents of the 184 patients who were not fully vaccinated were sent a text message stating that the UK is no longer measles free, reminding them to book an appointment for vaccination.

From August 2019 to January 2020, 76 patients from the cohort receiving the text message had contacted the practice to receive one or two MMR vaccinations. Fully vaccinated patients increased from 87.28% ($n=1263$) to 92.47% ($n=1338$).

In the audit period, the population of 3–11-year-olds registered at the practice changed. Our intervention was not implemented for children who turned 3 years old during the audit period, or for newly registered patients ($n=117$). Patients no longer in the age range or who had left the practice ($n=67$) were also not included. Additionally, our audit does not take into account the baseline uptake rate of the MMR vaccination.

In sum, text message interventions

are cost-effective, accessible, and instantaneous for disseminating health information. We recommend the use of text messages for patient notification to improve uptake of the MMR vaccine.

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Our experience of employing a musculoskeletal practitioner in general practice

We read with interest about physiotherapists as an alternative to GPs.¹ We recognised that the management of musculoskeletal (MSK) problems could be improved in our practice. In 2015, we employed an MSK practitioner to work across three practices (total patient population 26 000). It needed to be cost-effective compared with a GP. The salary of an MSK practitioner is around half

that of a GP's. The MSK practitioner should see at least half the number of patients that a GP sees. These patients should not also see a GP for the same problem. The practitioner should provide direct treatment and reduce referrals to physiotherapy and orthopaedics. We evaluated whether our MSK practitioner achieved this and we believe he did.

In March, April, and May 2018 the practitioner saw 789 patients in 58 4-hour sessions, with an average of 13 patients per session. The average number of visits were 1.25. Sixty-two patients were referred to secondary care (8.2%) and 48 to physiotherapy (6.3%).

An audit of 25 peripheral joint injections found 16 carried out by the MSK practitioner and nine by a GP. There were no complications recorded on follow-up.

A 2019 patient satisfaction survey found that 80% of patients preferred seeing the MSK practitioner to the GP or advanced nurse practitioner. Ninety-five per cent said they would see the practitioner again and recommend him to family and friends.

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Deprescribing

Euan Lawson has once again caught the moment with his thoughts and observations.¹ Tackling polypharmacy through deprescribing is certainly to be applauded. As a young partner in the late 1980s I remember being responsible for a small care home. Over a year I worked hard at convincing the patients that they did not need all the drugs they were on. It was a battle and there was some success initially. Over time, through need and the intervention of others, most ended back on

the very drugs that had been stopped. This should not stop one from trying though. It still remains a joy to my ears to hear a patient say, 'Do I really need all these drugs, doctor?'

Ivan Illich should be mandatory reading for all healthcare professionals. It was recommended to me during my training and though out of date in parts has many lessons wrapped up inside it. I have often given a copy as a parting gift to trainee GPs along with William Pickles' biography.

The expansion of social prescribing to include exercise and wellbeing etc. sadly reflects on a society that cannot provide guidance and support through the family or community unit but must have a 'specialist' input.

We encourage expectation of prescription through our very language. 'What may I do for you?' is a common opening line. I am now trying 'What is troubling you?' or even 'Now then'. In the hope that it is understood I will listen but may not necessarily prescribe.

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Potential for placing voice-activated devices to improve patient care in general practices as well as patients' homes

I read with interest this real-world study that shows promise in which voice-activated devices such as Amazon's 'Alexa' can be placed in patient's homes.¹ Clearly Amazon will have performed extensive testing and had user input into its design and functionality given the sales success, with more than 100 million of these devices having been sold.² Beneficial first-hand user experience has been previously

written about for people with health needs.³ It is remarkable to witness an individual with autism interact with a voice-activated device, a device that never loses patience. It has been suggested that individuals with autism can also benefit from voice-activated devices.⁴

Personally, I believe the potential does not just stop within patients' homes but there is great potential for voice-activated devices to be used in primary care systems to improve data quality and coding in health care. Although clearly privacy concerns would need to be addressed, I believe these are not insurmountable.

To explore the primary care user acceptability I sent a national survey across Scotland to primary care teams in November and December 2019. This had 422 responses (GPs 170, practice managers 166, other 86). Of the overall responders, 41.7% (176) stated they would use a voice-activated device, 38.6% (163) stated they don't know, and 19.7% (83) stated they would not.

I had thought that experience of using these devices would enhance acceptability; however, subgroup analysis revealed this was not the case. Results from those with self-declared experience of using a voice-activated device were as follows: 45% (116) would use, 37% (96) don't know, and 18% (46) would not use. Results from those with no self-declared experience showed: that 37% (60) would use, 41% (67) don't know, and 23% (37) would not use. Comparing percentages by performing a χ^2 test⁵ shows that none of these represent a statistically significant difference (would use $P=0.1049$, don't know $P=0.4111$, would not use $P=0.2107$).

I believe there is potential for placing voice-activated devices to improve patient care by not just placing these in patients' homes but also in general practices.

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Corrections

In the Life & Times article by Harrison S *et al*. Bridging the gap between care: is speed dating the answer? *Br J Gen Pract* 2020; DOI: <https://doi.org/10.3399/bjgp20X707513> the following author details were missing: Brian D Nicholson, GP, Senior Clinical Researcher, Nuffield Department of Primary Care Health Sciences, University of Oxford, Oxford. This has been corrected in the online version.

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In the Clinical Intelligence article by Jones NR *et al*. Diagnosis and management of hypertension in adults: NICE guideline update 2019. *Br J Gen Pract* 2020; DOI: <https://doi.org/10.3399/bjgp20X708053> the blood pressure threshold for stage 3 hypertension was wrongly given as 180/110 in the text and in Table 1. It should have been 180/120. Figure 1, Step 1 incorrectly stated 'African or Caribbean family origin', but should have stated 'not of black African or African Caribbean family origin'. These corrections have been made in the online version.

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