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NEWS2: supporting and enhancing clinical judgement?

My patient of two decades phoned me one Friday afternoon, saying she felt very ill. She travelled for an hour to my clinic. She has immunosuppression, multimorbidity including steroid-induced type 2 diabetes mellitus, and morbid obesity. Careful physical examination was entirely normal, including pulse, blood pressure, SpO2, temperature, and mental state. Prior to NEWS2 I didn't routinely measure all six physiological parameters.[1] Her respiratory rate was 28, NEWS2 score of 3. Doubting myself, I checked and rechecked her respiratory rate. This was the sole basis of my referring her to ED. Later that day, the CT thorax, abdomen, and pelvis revealed a large intra-abdominal abscess. She made a full recovery.

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COVID-19

The transformation that our GP practices have had to make during the COVID-19 outbreak has surpassed the entirety of changes I have seen in primary care over almost 30 years as a family doctor.

As a GP and Director of SSP Health, the largest GP federation in the North of England, I have been incredibly heartened by the positivity that our staff, and our patients, have shown towards these very necessary alterations to how community care is provided.

Along with many other GP surgeries across the nation, we moved swiftly to limit the number of face-to-face appointments our clinicians were carrying out to cut their potential exposure to coronavirus and also to keep our patients safe.

Within just a few days, almost all our appointments, be it with a GP, pharmacist, AP, ANP, practice nurse, or other clinician, were being done via the phone or through video. Many of these appointments are now carried out from home.

Some of our clinicians who previously had reservations about telephone appointments understood that the pandemic necessitated this new way to treat patients. Each has embraced and adapted to the changes with professionalism and positivity.

Despite the shift away from routine face-to-face appointments, vital services such as childhood immunisations and post-natal checks continue. We are pleased to report that we continued to be on target to achieve our usual high Quality and Outcomes Framework scores, with extremely low levels of exception reporting. For 2019–2020, 23 of our practices achieved 100%, four were above 99%, and one was on 97.5%. Our data team continues to track these quality standards and NHS targets as they will provide an invaluable measure of how telephone appointments have performed. Initial analysis — and anecdotal evidence from our GPs — shows they have been incredibly successful.

We are still in the middle of the pandemic and it is too early to consider how primary care may have permanently transformed due to COVID-19, but it seems likely that some of the changes that have been implemented could and should be here to stay.

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Child care in the primary care environment

Newson falls into his own trap of seeking 'evidence' to reinforce his own prejudices. There are many more possible explanations for his anecdotal diagnostic delays than training or skills of individual GPs. With regard to his case:[1]

- How many GPs were consulted?
- Crucially, what was the appointment system?
- Did he report as a significant event to the referrer?
- What were the lessons?

With regard to Duchenne's, I wonder if diagnostic delay has any relationship to the reduction in routine health checks, and a scarcity of health visitors.

I suspect any secondary care specialist could make what they feel is a justified case for taking their own area of work out of general practice. This is the kind of denigration of general practice that has been well recorded in medical schools.

Both Newsom and Ridd's articles[1,2] are doctor-centric, and ignore the critical issue of building personal continuity into appointments systems (though that is a challenge in an era of less than full-time professional working).

Sanjay Patel's article offers an interesting, alternative, constructive, and cooperative approach.[3]

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