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Adverse effects for patients in big group practices

Peter Edwards' letter in your September issue is important.¹ It is an irony that NHS policy continues to encourage GPs to form ever larger practices when the evidence is clear that these provide less good access for patients who have significantly lower satisfaction with them.

In addition, there is a third important feature of general practice that also generally reduces in quality as list sizes increase — continuity of GP care. Indeed, this may be the mechanism through which patient satisfaction falls as there is a significant association between increasing list size and reduced continuity received by patients.^{2,3} The association between continuity and patient satisfaction has also been established, particularly when patient-reported measures of continuity are used.⁴

Edwards describes Baker *et al* (1995)⁵ as a 'seminal' publication. We agree. In addition to reporting that patient satisfaction was lower in bigger practices, they also first found that patients had greater satisfaction when their practice used personal lists.⁵ Personal lists are the only evidence-based way that GP continuity can now be preserved in bigger practices.

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Short-acting beta-agonists and asthma

Having initially worked in an era when we were told we were missing asthma (then the so-called cough-variant asthma), we move to a time of overdiagnosis and National Institute for Health and Care Excellence (NICE) guidelines to prove or disprove, such as unavailable FeNO concentrations, and risk of other labels such as silent reflux ...

There is no doubt that overuse of short-acting beta-agonists (SABAs)¹ is dangerous, costly (especially if salbutamol is used or substituted by the pharmacy), and environmentally harmful, but what does the author suggest for a person who only wheezes on exposure to cats, such as when visiting a relative? A standby SABA or a long-acting muscarinic antagonist (LAMA)/inhaled corticosteroid (ICS), noting that they may not be used for months or years on end and then just once or twice?

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Author response

To respond to the letter from Dr Sharvill, the National Institute for Health and Care Excellence (NICE) asthma guideline published in 2017 is contentious.¹ It is driven by cost-minimisation and not by clinical need, and does not recognise the limited availability of FeNO testing in the UK, let alone in primary care. It has caused much confusion as it differs markedly from other approaches.² Recommendations written by clinicians, such as the Scottish Intercollegiate Guidelines Network (SIGN)/British Thoracic Society (BTS)³ or Global Initiative for Asthma (GINA),⁴ are more relevant and clinically useful. GINA is updated annually.

With regards to the clinical conundrum presented, the allergy to cat dander, which is described here, is a classical Type 1 allergic response. Currently there appears to be no licensed allergen immunotherapy licensed for Fel d 1, the dominant allergen, in the UK. In the absence of immunotherapy, the best strategies are avoidance or pharmacotherapy. The patient described clearly has asthma in response to cat dander. Pre-emptive use of a rapid-acting/inhaled corticosteroid combination medication (not a medication containing salmeterol) prior to the visit and for any symptoms during and after the visit would probably be the most appropriate approach. The patient should probably be assessed when asymptomatic, by 2 weeks of twice-daily peak flow readings to determine whether there is a low-level background asthma, which if present should be addressed (personal view).

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Ambulance response times — improved communication between clinical teams may offer a solution

Nada Khan¹ articulates familiar difficulties facing colleagues in the ambulance service that have a direct impact upon GPs and their patients. We believe that improved communication between clinicians at the point of contact between the ambulance crew and the patient in the community can lead to different care pathways that do not necessitate conveyance to hospital.

During the COVID pandemic, Suffolk GP Federation (a not-for-profit owned by 57 GP practices) created a 'Hub' within the out-of-hours service, manned by a senior clinician with access to GPs' clinical records. Clinicians working with the ambulance service were able to access advice, often providing an alternative clinical pathway for the patient to the usual conveyancing to the

Emergency Department. Electronic transfer prescriptions, referral to community services, and other interventions became possible.

We are aware that accessing the patient's own GP for similar advice during normal working hours can prove difficult or impossible. Digital communication solutions such as 'Medic bleep' used at West Suffolk Hospital have been demonstrated to improve communication within clinical teams, saving time and money.²

What perfect communications between clinical teams in the community look like we do not yet know. We plan to undertake a project to answer this question and find the right technology. In time we hope that we can redesign care pathways in ways that improve care for patients, help ambulance crews to create timely solutions for the individuals they are called to see, and ultimately provide a gateway into virtual community wards for selected patients.

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parkrun unintended benefits

I started parkrun¹ in 2014. My son who was 12 years old was a good runner and was keen for us both to try it. The experience was uplifting. Each week we would embark on the 5 km course with friendly camaraderie among our fellow runners. My times improved over 18 months and I passed the 50 parkrun milestone fitter than I had ever been.

However, I then found that my times plateaued at around 26 minutes. I couldn't improve. My son who attended parkrun with me regularly commented that I wasn't moving my left side properly when I ran. My left arm was not swinging and my left leg was dragging. I had not noticed.

I went to my GP, who referred me for a neurological opinion following a normal MRI scan. The neurologist diagnosed Parkinson's disease and a dopamine scan (DaT scan) confirmed the condition with sparse take-up of dopamine in the basal ganglia. So parkrun aided in identifying my early symptoms of Parkinson's.

The parkrun, a 5 km timed run, is a good challenge for everyone and can, as well as improving long-term health conditions, unmask conditions such as Parkinson's disease.

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