

## REFERENCES

1. Gidding LG, Spigt M, Winkens B, *et al.* PsyScan e-tool to support diagnosis and management of psychological problems in general practice: a randomised controlled trial. *Br J Gen Pract* 2017; DOI: <https://doi.org/10.3399/bjgp17X694109>.
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## Author response

Thank you for your letter and your interest in PsyScan.<sup>1</sup> We are glad to answer your questions. The participants were randomised before they had to sign the detailed informed consent. This was very important to us because we did not want the research to cause any delay in treatment, especially in the case of the participants in the control group. The numbers of participants who were excluded because they did not sign the informed consent were similar for both groups. This information is already given in the article, and we described that we used block randomisation and that the included numbers of participants were similar for both groups.

Second, the three-question distress screener has no direct influence on the advice and treatment the participants received. The diagnostic and therapeutic advices were based on the 4-Dimensional Symptom Questionnaire that has been researched extensively in general practice.

Third, we agree that Table 1 is crucial to understand the probable working mechanism of PsyScan. This table combined with the significant reduction of patient-reported symptoms indicates that PsyScan's effect seems to be based on using more appropriate treatments for specific patients at specific times, resulting in better patient–treatment combinations.

Fourth, we ended the follow-up after 12 months. The presence of a statistically significant effect only after 12 months could indicate that PsyScan creates longer-lasting effects as opposed to usual care. As you pointed out, PsyScan indeed seems to create a better understanding between patient and GP.

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1. Gidding LG, Spigt M, Winkens B, *et al.* PsyScan e-tool to support diagnosis and management of

psychological problems in general practice: a randomised controlled trial. *Br J Gen Pract* 2017; DOI: <https://doi.org/10.3399/bjgp17X694109>.

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## Skill-mix change and the general practice workforce challenge

The recent editorial on skill mix ('Skill mix change and the general practice workforce challenge')<sup>1</sup> demonstrated a depressing recycling of familiar themes that have been around since at least the start of the century.<sup>2</sup> Inevitably, there will be major challenges when attempting to configure a system where there are conflicting demands of efficiency (what gives value for money?), equity (what is a fair distribution of our limited resources?), and affordability (how much have we got to spend?); that needs to be both resilient and innovative; and is free at the point of entry.

The editorial concludes with a more useful challenge, that 'if changing skill-mix is the answer, what is the question?' I'd like to suggest two. First, Is current healthcare research a self-sustaining activity that has an imperceptible impact compared with the resources invested in it? Second, why has a historically determined mix of skills continued that seeks to force the NHS into the disciplinary matrix rather than the more logical converse?

A more useful approach may be to view the meaningless policy imperatives such as transformation, modernisation, sustainability, and skill mix as defensive devices — gestures designed to avoid the harsh realities of our situation with its challenges, ambiguities, and paradoxes. At least we can then be in a better position to start an honest debate about the best way forward.

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DOI: <https://doi.org/10.3399/bjgp18X695429>

## WAP plan

I notice the plan starts with emollients etcetera before going on to topical steroids.<sup>1</sup> I understand this complies with NICE guidelines and has been normal practice since the sixties.

However, I have not been able to find any evidence for their efficacy and it seems that they are more of a tradition than a useful treatment. Would children do just as well by starting treatment on the most appropriate topical steroid?

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DOI: <https://doi.org/10.3399/bjgp18X695441>

## Author response

Dr Michael makes the very astute observation that, despite emollients forming the cornerstone of all guidelines and recommendations regarding the treatment of (atopic) eczema/dermatitis, the evidence base for their effectiveness is limited. He may be interested in the recently published Cochrane review by van Zureen and colleagues,<sup>1</sup> which, although limited by the quality and relevance of published trials to NHS general practice, does provide some reassurance that moisturisation is effective. What there is even less certainty about is whether one emollient is clinically or more cost-effective than another, and linked to this the acceptability of different types of emollients (lotion, cream, gel, and ointment being the main ones) to patients and their carers. This is the subject of an ongoing NIHR HTA-funded trial ('Best Emollient for Eczema', [www.bristol.ac.uk/bee-study](http://www.bristol.ac.uk/bee-study)), due to report in late 2020.

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