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PRIMARY COLOUR

Helen Salisbury: Keeping vaccinations local

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We started the vaccination rollout with intense activity, preparing to use a whole pack of Pfizer-BioNtech vaccine (1170 doses) within 3.5 days of delivery, with short notice about when it would arrive. Late on a December evening our GPs worked through lists of older patients, ringing to offer appointments to use the precious sixth dose in each vial that had just been sanctioned.

Anxiety kept some of us awake the night before our first clinic: could we really vaccinate 900 people in a day? We had 55 chairs, spaced two metres apart throughout our building, and six vaccination teams consisting of an admin person and a clinician. We had two dilution teams, two organisers, and greeters from our patient participation group. After hearing multiple reports of problems with Pinnacle (the IT package we were meant to use to record the vaccinations) and fearing that glitches would slow us down, we opted for an old fashioned but reliable paper system, inputting the data later.

It was a long, tiring, and joyous day. I hadn't fully realised how much I missed the hubbub in the waiting room and seeing patients and colleagues from other practices face to face. Since then we've repeated the operation with our second Pfizer batch, with slightly fewer staff now that we all know what we're doing.

We're now receiving the Oxford-AstraZeneca vaccine, which is much easier to handle. It can be stored in an ordinary fridge for six months, and we can use one vial at a time, containing 10 (or possibly 11) doses. Best of all, there's no requirement to observe patients for 15 minutes after they receive the vaccine, so we can set up walk-through clinics. This reduces the risk of virus transmission and speeds up our delivery. It also takes up less of the building, so we can have vaccine clinics on weekdays with less disruption to normal work.

The limiting factor is now supply. We'll receive 300 doses this week, but we could use many more. There are reports on social media of primary care networks that have had no supply at all. I understand that the vaccine should be shared out evenly if there's a supply problem, so that the most vulnerable people are treated in each area. What I don't understand is the rationale for mass vaccination centres. Patients are receiving invitations to book in at centres many miles from home. Unless they can drive themselves, journeys will require sharing a car or public transport, both of which are infection risks.

General practices have excellent databases of their patients, as well as knowledge about their particular needs—who is deaf, who needs help with mobility, or who has cognitive impairment—and contact details of relatives or carers where relevant. We are trusted, local, ready and willing, waiting to give vaccines. If supply is limited, why is it going to distant, anonymous mass vaccination hubs, rather than the practice down the road?

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