- Consider the Common Assessment Framework (CAF) as a friend. It is the best tool we have for analytical assessment of complex cases not unlike the landmark RCGP trial I mentioned above.⁴
- Look at the RCGP/National Society for Prevention of Cruelty to Children Toolkit for Safeguarding Children and Young People (section on Child Protection Conferences, page 36).⁵ You will note that it highlights the three main headings of the CAF: child's developmental needs, parenting capacity, and family and environmental factors. The Toolkit goes on to consider key points to include from a GP perspective. Perhaps use this to set up your own template.

If we manage to contribute to make even one or two children's lives better per GP per year through safeguarding, we may be rewarded by seeing their health and wellbeing improved and may even be thanked by future GPs who have one or two adults less scarred forever by child abuse and neglect.

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Busy doing different things

I have worked in practices serving both affluent and deprived patient populations. Therefore, I have no hesitation in stating that GPs across the board are busy. However, it strikes me that we are often busy doing different things.

I recognise the challenges associated with caring for relatively affluent older patients¹ and those with good health-literacy skills.¹ I also have no doubt that 'Deep End' practitioners² aspire to the core values of general practice, namely; to be excellent medical generalists who provide whole person medicine and patient advocacy.³ However, Deep End GPs are often constrained by limited resources in the context of deprivation, making consistent attainment of such values hard to achieve.

GPs serving more affluent populations arguably face a heavy workload but in a very different social context, that, albeit a potential challenge to the delivery of health care, is less likely to lead to detrimental health outcomes. The latest 'report card' on health inequalities in Scotland serves to emphasise this reality, when compared to the most affluent quintile: healthy life expectancy for males in the most deprived quintile is 18.8 years lower, and those aged 45–74 years are 4.7 times more likely to die from coronary heart disease, 9.2 times more likely to die from an alcohol-related disease, and are twice as likely to die of cancer.⁴ The Deep End project serves to remind us that these practices are battling against the odds in the face of real and significant health needs. Such statistics cannot be ignored and a focus on 'workload,' with practitioners assessing how busy they are compared to their peers, risks obscuring these harsh facts.

Health inequalities cannot be solved by the NHS alone. However, the delivery of health care in Scotland, where a flat-line distribution of resources persists despite differential health needs, is clearly not best serving the population. The recent report on the quality of primary care in England⁵ suggested that before quality can start to improve, GPs and their teams will need to look beyond their surgery walls. Addressing health inequalities is another context where we need to consider the 'bigger picture'. Arguably to date, we have failed as a professional group to rise to this challenge.⁶

We must fully appreciate the extent of the problem and be under no illusions that while we may feel that 'we're all in at the deep end paddling hard to keep afloat',¹ the statistics tell a different story.

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GP commissioning can unlock the full potential of research within the NHS

Jonathan Graffy's editorial on research for commissioners is very welcome.¹ He is right to identify GP commissioners' potential role around research governance and how they may benefit from collaboration with researchers to develop and evaluate their services. There is, however, good reason to consider, whatever their eventual form, that the birth of these new commissioning organisations is a once-in-a-generation opportunity to integrate a comprehensive culture of research within the NHS.

GP commissioners are in a position to routinely specify, in contracts, that their providers deliver research-responsive services ensuring that recruiting people to research studies is core and becomes everyday practice. Currently, whether or not a service provider gives patients access

to research studies is too often down to individual doctors or managers, leading to widespread inequity in patients' access to research and a marked failure to make the most of the NHS infrastructure. If GP commissioners grasp this opportunity to induce a step change in the quantity and generalisability of NHS research, the National Institute for Health Research has the resources to support it.

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Development and validation of a clinical prediction rule for breast cancer

I commend the attempt of McCowan and colleagues¹ at developing a prediction rule for an important condition. If validated it will be a welcome addition to the armoury of GPs trying to rule out breast cancer confidently in women presenting with breast symptoms.

Perhaps inadvertently, the article provides an interesting case study on some of the difficulties in developing diagnostic instruments for low prevalence target disorders. Generating an adequate sample size for the target disorder (breast cancer) is difficult when, per thousand women, there are so few cases seen in general practice.

To circumvent this problem, the authors used data from a specialist-clinic setting to extract the relevant variables for their logistic regression model. In such a setting, it is not just the prevalence of breast cancer that is likely to be much higher than in general practice. Patients attending specialist clinics have already undergone some diagnostic filtering by GPs. The effect of filtering is that only those patients that are considered to have potentially serious conditions get referred on to the clinics. Thus not only is the prevalence of disease

increased in the clinic setting, but also the severity of disease is increased. This may affect the significance of some of the explanatory variables in the model.

Nonetheless, using data from specialist clinics is understandable given the difficulty of deriving data from an unselected general practice population. Furthermore, it is not necessarily a concern if the resulting prediction rule proves valid in the intended population, that is, general practice. Unfortunately, in this instance, validating the tool proved difficult owing to the sample size in the validation cohort being underpowered.

Currently, the prediction tool represents a step in the right direction but needs much larger validation studies in unselected general practice populations before its uptake in general practice may be recommended.

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Authors' response

We thank Dr Willis for his comments on our paper. We agree that our findings should be seen as a first step in developing a decision tool for women with breast symptoms in terms of prioritising and enhancing the appropriateness of referral to breast care clinics. We have submitted a large collaborative proposal, led by colleagues at the University of Southampton via the NIHR School of Primary Care Research, so that the issues that Dr Willis raises of prior prevalence, possible spectrum bias, and precision of clinical predictors can be assessed. This proposal, the CANcer Diagnosis Decision rules (CANDID) project, will also encompass patients presenting with symptoms suggestive of colorectal cancer and will provide a working template for similar large-scale studies in cancer in the primary care setting.

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Correction

In the article 'Patients' views of antidepressants: from first experiences to becoming expert' *Br J Gen Pract* 2011; DOI: 10.3399/bjgp11X567045 [abridged text, in print: *Br J Gen Pract* 2011; 61: 252–253], the author Ayesha Waqas, BA Research Assistant at the University of Manchester, was omitted. The author order should have been: Peter Schofield, Ann Crosland, Waqas Waheed, Ayesha Waqas, Saadia Aseem, Linda Gask, Annie Wallace, April Dickens, and André Tylee. The correct version of this article is available online. DOI: 10.3399/bjgp11X578386

Correction

In the article 'How frequently do young people with potential cancer symptoms present in primary care' *Br J Gen Pract* 2011; DOI: 10.3399/bjgp11X572418 [abridged text, in print *Br J Gen Pract* 2011, **61**: 331–322] the order of the authors was incorrect. This should have been: Lorna A Fern, Christine Campbell, Tim OB Eden, Robert Grant, Ian Lewis, Una Macleod, David Weller, and Jeremy Whelan. The correct version of this article is available online.

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