primary care capacity and capability, as we have done in Central Manchester.

Ivan John Benett,

Clinical Director and GP, NHS Central Manchester CCG.
E-mail: ivan.benett@nhs.net

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DOI: 10.3399/bjgp14X680845

Access to general practice and A&E attendance

Cowling *et al* have added a useful piece of work to the increasing understanding of acute care and the interface between general practice and accident and emergency (A&E) in England.[1] In the absence of good quality data from A&E departments this was a creative use of primary care data to estimate impact of patient access to healthcare services.

However, focus on availability of GP appointments only addresses a sub-section of patients who attend A&E departments. While patients often cite poor availability of GP appointments as a reason for attending A&E, a significant proportion have already seen a GP or not tried to get an appointment. One recent survey of patients with minor ailments found that 32% of A&E attenders had not tried to make a GP appointment and a further 10% came for a second opinion following GP consultation.[2]

While the increasing strain on general practice will inevitably force more patients into emergency departments we need to recognise that many patients choose A&E in the first instance. Perhaps it is time to accept that patients with minor ailments are as likely to attend an A&E department as see their own GP. Planning resources and standardising training in management of minor ailments across general practice and emergency medicine may do more than the political drive to open GP practices for a few extra hours a day.

Paul A Lord,

NIHR Academic Clinical Fellow / GP Trainee (ST3). Leeds Institute of Health Sciences, University of Leeds.
E-mail: p.lord@leeds.ac.uk

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DOI: 10.3399/bjgp14X680857

Patients are often unaware of how to access medical help out of hours

Out of hours' (OOH) care is currently under close scrutiny. In order to understand patients' perspectives on OOH care I conducted a survey of 186 sequential patients (87 men and 99 women aged 17–93 years) in a rural practice in central Cornwall with a patient population of 5011. Those <16 years, temporary residents, and those with significant cognitive impairment were excluded. Patients were asked 'Do you know how to reach medical advice out of hours?'. If the answer was 'no' they were invited to make a guess to see if they would reach the right conclusion.

Almost half (44%) knew how to obtain medical advice out of hours and a further 17% guessed correctly, but 33% made an incorrect guess or no guess at all, and the remainder made an alternative suggestion which was likely to be successful. Dialling 999 was suggested by 9%. The incorrect attempts at 111 were surprisingly varied and included 101, 118, 121, 212, 911, and 991. Small numbers of responders would ask a relative or go to accident and emergency.

The study is small but hints at a significant problem, because one–third of the sample was unaware of how to access appropriate OOH care. This group represents patients who are either making demands on the ambulance service instead, or are missing the opportunity to access suitable OOH care.

Better awareness could be achieved by an information push within practices and commissioning groups, and possibly the use of patient participation groups. Making the future NHS work on budget will need collaboration between medical professions and the public; improved systems and communication should be a cornerstone of this work.

Christopher George Tiley,

GP, Mevagissey Surgery, Mevagissey, Cornwall.
E-mail: Christopher.tiley@mevagissey.cornwall.nhs.uk

DOI: 10.3399/bjgp14X680869

A simple clinical coding strategy to improve recording of child maltreatment concerns: an audit study

Recording concerns about child maltreatment, including minor concerns, is recommended by the General Medical Council (GMC)[1] and National Institute for health and Care Excellence (NICE)[2] but there is evidence of substantial under-recording.[3,4] GPs are apprehensive about how recording is perceived by parents and the impact of this on the patient–doctor relationship.[4] However, careful clinical coding, even of minor concerns, is essential for building a cumulative picture of concerns and making children 'findable' on the system.

We determined whether a simple coding strategy (www.clininf.eu/maltreatment) improved recording of maltreatment-related concerns in electronic primary