

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

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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.

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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.

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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

care records. We calculated rates of maltreatment-related coding before (January 2010 to December 2011) and after (January 2012 to December 2012) implementation of the coding strategy in 11 English practices. The strategy was developed in collaboration with the audit leads in the 11 practices. These GPs were selected for expertise in child safeguarding or another relevant area.

The strategy centred on encouraging GPs to use, always and as a minimum, the Read Code 'Child is cause for concern' if they 'considered' maltreatment (as defined in NICE guidance²) had any safeguarding concerns. We also undertook a service evaluation of the strategy.

In the 25 106 children age 0–18 years registered with these practices we found increased recording of any maltreatment-related Code (rate ratio [RR] =1.4; 95% confidence interval [CI] = 1.1 to 1.6), child protection procedures (RR 1.4; 95% CI = 1.1 to 1.6), and cause for concern (RR 2.5; 95% CI = 1.8 to 3.4) after implementation of the coding strategy. Clinicians cited the simplicity of the coding strategy as the most important factor assisting implementation and time and competing priorities as the greatest barriers.

The coding strategy improved coding of maltreatment-related concerns in a small sample of practices with some 'buy-in'. Further research should investigate how coding relates to ongoing management of the family and can support the doctor-patient relationship.

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How can we communicate better with social services?

The article in the July issue by Brodie and Knight brings many questions. Are multidisciplinary team meetings not part of normal QOF-related primary care? Were the school nurses and health visitor funded from the Local Enhanced Service monies? There is no comment as to whether social services were invited and if so, attended. Safeguarding is indeed an important subject and huge amounts of time are spent on training and retraining. In our area though it is not lack of knowledge of the process or of those children who are or might be vulnerable, but the black hole of the 'system'.

Joined-up face-to-face meeting with the social services component of safeguarding might enhance the benefit and let us know as GP what 'they know' about the children and vulnerable adults in our shared care and what, if anything positive, can be done about them.

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DOI: 10.3399/bjgp14X680893

'Good diabetes care' and the NDA

The article from Pereira Gray and colleagues in the June edition of the *BJGP* questions whether the terms used to define 'good

diabetes care' are sensible and suggests there should be exemptions in the National Diabetes Audit (NDA).

The NDA collects information on all people with diabetes from practices that contribute (which was 88% of practices in England in the 2011–2012 audit). It does this to enable peer comparisons to be made to support quality improvement. Its purpose is developmental, not summative like QOF, which is focused on financial reward. Exemptions undermine valid inter-service comparison. There are justifiable clinical reasons for non-attainment of treatment targets but these are likely to be evenly distributed; and the NDA reports on the influence of factors such as age, type and duration of diabetes, ethnicity and socioeconomic status. Interestingly the NDA has shown no correlation with these 'usually quoted' reasons for non-achievement of treatment targets. We believe it is best and fairest to use everyone with diabetes as the denominator.

The twofold difference in care bundle achievement between practices operating in similar, geographical areas suggests that the NDA is identifying important differences in care delivery, and that this should drive diabetes quality improvement. Evidence-based treatment targets offer treatment goals to be negotiated with individual people with diabetes. No one suggests that they would or should be achieved in everyone, but the NDA, by reporting on everyone with diabetes shows that patients of similar practices have widely different chances of reaching them.

Standard setting is a separate process to data collection and we would agree that a strong general practice voice is needed at the standard setting table.

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DOI: 10.3399/bjgp14X680905