While locuming on Saturdays I have often supplied chloramphenicol eye drops to parents because of nursery policies that allow infants to attend nursery if they are being 'treated'.[1] I do this knowing that the underlying cause of the infection is likely to be viral, which I feel uneasy about as it goes against my pledge to good antibiotic stewardship.

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Prevention of hospital-acquired thrombosis

Perhaps the *BJGP* should have a moratorium on papers which state that, 'GPs are ideally placed to …'? Yes, I'm sure you can find someone to say we're great at everything in medicine and beyond. But that doesn't mean it's our job or that we are actually the best people for it.

I'm pleased to report that in our area there is no uncertainty on this issue: hospital staff, who are actually ideally placed to assess and treat hospital-acquired thrombosis, do it.[1] Surprisingly, it has never crossed my mind that we may want to take this work off them, as they have detailed knowledge of the surgery or other factors that have occurred during admission, rather than the brief highlights on a discharge letter, and they have pre-surgical assessment clinics for elective admissions already in place where this can be addressed without any need for GPs to take on yet more workload. I imagine that they also have detailed knowledge of the guidelines, as they use them every day. Sure, I'll highlight any particular risks if I refer someone, but given that I may not see them again from referral for an outpatient consultation (at which point surgery is not definite in most cases) until they come out of hospital months later at the end of an 18-week routine wait, I'm not sure that discussion of DVT risk for an op that may not happen at that point is necessary.

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Improving access to primary care: can online communities contribute?

Roger Jones's editorial[1] described primary care in the context of accessibility, effectiveness, and care that is provided personally, and concluded that creative solutions are needed. More than 15 million people in England have a long-term condition or disability for which there is no cure, and these people account for at least 50% of all GP appointments.[2] Peer support is a self-management activity[3] with the potential to improve self-care while reducing demand for primary care appointments. Work on an online community of patients with stroke revealed that up to 95% of information and support requests were answered on an individual basis.[4] Responses received by peers were accurate and appropriate. At a time when GP surgeries are working at and beyond capacity, and patients are finding it difficult to obtain appointments, these online forums can provide a way for stroke survivors and their carers to receive helpful advice and support. As the NHS has been challenged to develop and benefit from digital health, primary care research should explore online patients' communities as potential self-management interventions. Such interventions could take up part of the service demand for information and indirectly improve access to primary care.

The use of online peer support within the NHS will be driven by providing research evidence that it is a cost-effective way of improving patient health and welfare. Outstanding questions to be answered include:

- How do effective online patients' communities form and maintain over time?
- What are suitable outcome measures for measuring effectiveness and cost-effectiveness of online peer-to-peer self-management?
- What part of healthcare demand can be safely dealt with by online patients' communities?
- How can online patients' communities be effectively policed to protect individuals from online risks?

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