Letters

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Impact of Advanced Access

Last year we conducted a qualitative study entitled 'The impact of Advanced Access', as part of an Intercalated BSc degree, at a practice involved in the National Primary Care Collaborative who were implementing Advanced Access in January 2003. We interviewed patients and staff to investigate whether their opinions of appointment systems, job satisfaction and workload had changed.

Advanced Access ensured patients had better access to their own GP and many enjoyed not having to wait 3 weeks for an appointment, especially those employed full time. However this was at the expense of elderly, more chronically ill patients, who were unable to successfully navigate the telephone system and tended to forget to make their follow-up appointments. We were unsure as to whether access to care was still in equilibrium with continuity of care.

Advanced Access has the motto 'doing today's work today'.[1] According to the GPs, this meant that you were dealing with an unlimited demand, especially because patients presented earlier in their illness. This demand probably exceeded the primary care capacity, hence the need for the nurse practitioner to be deployed to doctor-type duties to increase the number of available appointments, and thus changing her role.

Advanced Access was seen to reduce job satisfaction, especially among the receptionists, as they had lost their, in the broadest terms, 'gate-keeping' role.[2] They used to decide who should reach the doctor or the nurse, but now they just gave out appointments.

Finally, it seemed that Advanced Access may even affect the recruitment and retention of GPs. It no longer allowed GPs to control their availability and work around family and childcare commitments, as they would have to work with an open-ended commitment when demand was high. Meanwhile, training seemed problematic, with registrars seeing more minor illness and less clinical variety, as when patients could see the GP of their choice, they rarely offered to see the registrar.

GPs may welcome the new initiatives to improve patient access to primary care,[3] but perhaps in reality this is in the form of a mixed system of same-day and bookable appointments.[4,5] This way, patients are satisfied by access to care that is in equilibrium with continuity of care, and GPs are still in control of their workload, with no changes to the roles of staff.

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Failings in primary care collaborative

One major problem with the National Primary Care Collaborative project was the inadequacy of the data collection. As Dr Mark Pickin points out, it is easy to manipulate the third available appointment time downwards simply by severely restricting the advanced booking of appointments.[1] I am not sure I see this as an advance. There was also no attempt to measure consultation rates in participating practices, which surely is a key measure when looking at changing appointment patterns.

It is interesting to note in Dr Pickin's paper that 47% of the participating practices were either not sure or thought they did not have a problem with access prior to joining the collaborative.[1] It looks, therefore, as though the project was not accessed by those most in need.

My own experience was that debate was stifled in collaborative project meetings. There was little, if any, critical appraisal of project interventions. The decision that the collaborative was a success appeared to have been made almost before the project began and it seemed to be more a vehicle of career advancement than an instrument of health improvement.

I am of the generation that was taught that critical reading skills and evidence-based medicine are important. It is therefore disappointing to see a health service willing to commit large sums of money to a project whose evidence base appears so shaky.

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CSM thioridazine advice

I was interested to read Dr Wright's paper on the impact of the Committee on Safety of Medicine (CSM) advice on thioridazine prescribing in general practice in Leeds in the May edition of the *BJGP*.[1]

Working in a general practice of 5500 patients in Sheffield, we have an above average number of patients in either sheltered or supported accommodation, of whom 11 were well controlled on thioridazine at the time of the CSM advice. Owing to the forceful nature of the advice we did not feel we were able to continue prescribing thioridazine and the local advice in Sheffield was to convert patients onto promazine (in retrospect, bad advice). The effect on these patients was marked; of the 11, only one remained controlled on thioridazine, the number of consultations and hospital appointments increased and there was marked distress to the patients, their families, and their carers.

I would agree with Dr Wright's suggestions for how the CSM relates urgent advice regarding medication when there is emerging evidence of poor safety profile, but I would also add that there should then be clear guidance as to what the appropriate alternatives are, with the appropriate evidence.

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1. Wright NMJ, Roberts AJ, Allgar VL, *et al*. Impact of the CSM advice on thioridazine on general practitioner prescribing behaviour in Leeds; time series analysis. *Br J Gen Pract* 2004; **54:** 370-373.

Wright and colleagues report on the impact on GP prescribing of thioridazine as a result of advice issued in December 2000 by the Committee on Safety of Medicines.[1] They conducted a time series analysis and showed a significant reduction in the monthly number and cost of thioridazine prescriptions. Their paper is accompanied by a commentary on this type of before-and-after study, which does not really help the non-statistician to understand the method of analysis used. Although not subject to the same robust, high scientific standards as their paper, I prefer the interocular test (when data hit you in between your eyes).[2] This test, if applied to data for GP prescribing in Cornwall and Isles of Scilly (Figure 1), tells us all we need to know about how GPs acted following this CSM urgent cascade fax. The prescribing of thioridazine dropped dramatically from over 4000 items per quarter down to less than 1000 in the space of two quarters.

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Author's response

We welcome the letter by Paul Driscoll and were disappointed, yet not surprised to read of the increased number of consultations, hospital appointments and increased distress to patients, families and carers as a result of urgent facsimile advice to change prescribing practice. We would encourage both the primary care profession and the prescribing regulatory authorities to learn from this episode, and agree with Driscoll that clear guidance should suggest appropriate alternatives with the appropriate supporting evidence.

Regarding the letter by Wilcock, we always suspected that although only claiming generalisability of our findings to the Leeds area, that the picture we described would be representative of the national picture. Despite the obvious attractions of the interocular test, which are obviously in the eye of the beholder (excuse the pun), we felt it important to apply scientific and research methodological rigour to our study. Whereas Wilcock has given us some excellent descriptive data (and we do hope that the *BJGP* affords him space of a whole figure for a small letter) we do prefer to use comparative statistics wherever possible. Such statistics in the form of a time series analysis can account for any natural seasonal variation which can be missed by the interocular method. Comparative statistics are also both more sensitive and specific to detect small yet significant changes. Such changes can be missed by the naked eye. However, on this topic we feel that the most important point is that there is no evidence that thioridazine is more cardiotoxic than any other antipsychotic medication. The current evidence base would suggest that *all* antipsychotic medication should be prescribed with caution to the elderly

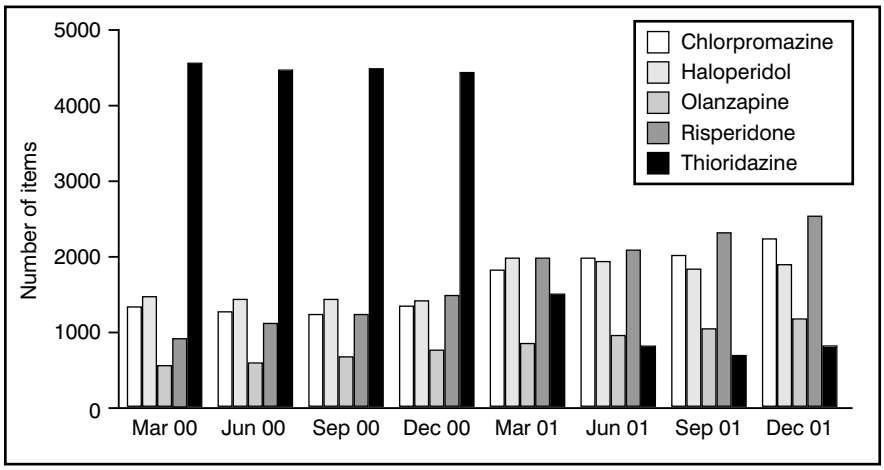

Figure 1. Number of items prescribed by GPs per quarter.