

'Immediate Post Consultation Reflection' (IPCR). To the best of my knowledge this was my invention. At the end of each consultation spend a few seconds and ask yourself: *Have I covered all the topics raised during the consultation? Have I applied my learning points? Have any intuitive ideas emerged and evaporated from my non-dominant hemisphere during the consultation?* I found that by employing this technique, fleeting (but often important ideas) came flooding back to me while the patient was still in the consulting room. IPCR will be perceived by the patient as a natural silence, or for what it is, a period of contemplative reflection. It is not the same as 'summing up', which is a recap of the important points covered in the doctor/patient dialogue. It takes only a few seconds and is time well spent. I retired from general practice some 3 years ago. Would anyone out there be interested in evaluating the efficacy of this potentially valuable consultation tool?

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## Improving telephone access to general practice reduces time to diagnose cancer

There has been much speculation about the use of telephone consultations over recent months and their effectiveness compared with face-to-face consultations.<sup>1</sup> There has also been public criticism of alleged delays within primary care related to the recognition and diagnosis of malignancy.<sup>2</sup>

Our practice, in north Worcestershire, has an average consultation rate of 10 per patient each year, a high proportion of elderly patients and a higher than national average disease prevalence. Three years ago we found a large proportion of our patients were choosing to wait several weeks to see a doctor of their choice rather than accessing another doctor within 48 hours. We therefore changed our appointment system to one where all patients requiring a consultation from a doctor have an initial telephone consultation as a first contact. On average three out of four patients are effectively

managed on the telephone and are satisfied with outcomes.

As expected, we experienced a reduction in our practice's A&E attendances, but in addition we decided to measure a marker of quality: the time between first patient contact with the surgery to referral into secondary care and time to a definite diagnosis of a malignancy.

Our data indicate that the average time of first contact in primary care to diagnosis was previously 53 days. This was reduced to 43 days in the first year and reduced further to 37 days in the second year, this being due a reduction in time between first contact with the surgery and a referral being made. This has fallen from 26 days to 10 days with 14 out of 17 patients within the past year being referred within the first week of their first contact. The average time from date of referral to a diagnosis being made in secondary care has remained the same.

We believe this supports the fact that GPs are skilled at recognising malignancy and how prompt access to GPs enables us to facilitate speedier diagnosis of malignancy in our communities. If the traditional systems of patients booking face-to-face appointments via reception or the internet are to be continued, this must be alongside securing adequate resources to allow GPs to provide both prompt access and quality of clinical care. If resources are not forthcoming, both the general population and healthcare providers need to be open minded about adapting to different models of healthcare delivery.

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## National Review of Asthma Deaths (NRAD)

While I agree with David Jewell that GPs are generalists, I don't agree with the way he has apparently written off the recommendations, and I would urge against complacency with regard to the findings of the National Review of Asthma Deaths (NRAD).<sup>1</sup> He suggests the report and recommendations emanated from specialists: this was clearly not the case. To clarify, the process of the NRAD involved collaboration of a multidisciplinary steering committee with representatives from the Royal Colleges, respiratory societies (primary and secondary care), respiratory and allergy charities, as well as patient representatives.

I was the Clinical Lead, and am a practising GP (with 37 years of experience, 15 years as a single-handed doctor). The 174 confidential inquiry panel members were primary and secondary care doctors and nurses; they made 1000 recommendations based on close scrutiny and discussion of the 276 sets of medical records of people who were certified as having died from asthma. Furthermore, the final report was a collaborative effort, with input from over 20 representative groups, including the Primary Care Respiratory Society who made 13 recommendations for change within a separate chapter in the report.

I understand clearly that we are working under extremely difficult, under-resourced conditions in the current economic climate. Nonetheless, the findings and recommendations applied to care provided by primary and secondary care. Preventable factors in over two-thirds of asthma deaths have been repeatedly identified in studies for over 50 years; and it is really time to take appropriate action and change the way care is being provided.

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