general practice: demanding work

UNDERSTANDING PATTERNS OF WORK IN PRIMARY CARE

john waller | paul hodgkin

CRC Press
Taylor & Francis Group

General Practice: Demanding Work

Understanding patterns of work in primary care

John Waller
Health Information Analyst
Centre for Innovation in Primary Care, Sheffield

and

Paul Hodgkin
Previously Co-Director
Centre for Innovation in Primary Care, Sheffield

CRC Press
Taylor & Francis Group
Boca Raton London New York

CRC Press is an imprint of the
Taylor & Francis Group, an **informa** business

First published 2000 by Radcliffe Publishing

Published 2018 by CRC Press
Taylor & Francis Group
6000 Broken Sound Parkway NW, Suite 300
Boca Raton, FL 33487-2742

ISBN-13: 978-1-85775-447-6 (pbk)

British Library Cataloguing in Publication Data

A catalogue record for this book is available from the British Library.

Typeset by Joshua Associates Ltd, Oxford

Contents

Preface

Friday 7 pm

'There goes the last patient. Once again my hopes for an early finish scuppered by all those emergency extras that just had to be fitted it . . . the end to another demanding week. Our neighbouring practice on Myrtle Road never seems to be this harassed. Maybe they have easier patients? Maybe they restrict the demand by providing a lower quality service? Maybe they are better organised than us or have come up with some innovative appointment system? Maybe they are better at pretending to cope?'

'So how are you going to find out the answers to all these questions? Perhaps by a practice team visit, perhaps by arranging some shadowing exercises with Myrtle Road? Or how about doing some workload data comparison with them and all the others in the Primary Care Group?'

'Data comparison – you mean league tables, name and shame and all that?'

'No, it doesn't have to be done that way. We mean benchmarking, comparing data with your peers that nobody outside of the PCG need see. Discovering where you stand in relation to everybody else, finding out who does things differently, being prepared to learn from others. You might even discover that you are doing an excellent job in really difficult circumstances.'

It feels like a time of rapid change in the way general practice in Britain is organised. Yet on another level its core function – seeing one million patients every working day – remains very stable. This

book will help anybody with an interest in the present and future of general practice to better understand how it currently handles that core function, and how it might do it differently in the future. As such, it will be of interest to health service managers, researchers, public health physicians, and PCG/Trust board members. Our principal readership though will be those who work directly in general practice – GPs, nurses, practice managers and receptionists.

This book can be read from cover to cover like any other, but we also see it as a reference book, another in the long line of Radcliffe Medical Press publications that can be there on the practice library shelf ready to be consulted. For a practice team thinking about changing its appointment system, or struggling with a perceived problem with defaulters, we see this book as a place to turn to for some comparative data; some useful tips and some pointers as to who else (as of June 2000) had researched the issue.

The book, in large part, summarises the findings of six years of data comparison and analysis involving up to 33 practices in Sheffield. In most chapters we refer to earlier reports that we have been involved in producing that go into more detail on a particular issue. Individual copies of those reports can be obtained free from:

The Centre for Innovation in Primary Care, Walsh Court, 10 Bells Square, Sheffield S1 2FY. Tel: 0114 220 2000 Fax: 0114 220 2001 Email: cipc@innovate.org.uk

Some of the more recent reports, plus the database toolkit for analysing computer appointment data, can be downloaded from our website:

www.innovate.org.uk

We hope we have written something that helps practices to better understand their workload and thus provide an improved service for their patients. We also hope that it enables them to make the conditions under which they work a little less demanding.

John Waller
Paul Hodgkin
August 2000

Acknowledgements

Many others have contributed to the body of work over six years on which this book is based. In particular, the idea and impetus for the original Practice Data Comparison project came from Rosalind Eve and Jeanette McGorrigan. Special recognition should go to:

- **Rosalind Eve** – now the Director of the Centre for Innovation in Primary Care, and the person who designed and set up the Practice Data Comparison project and directed its work for five years
- **Pete Jenkins** – the original project worker who established the original database and, even more importantly, established the working relationships with the participating practices
- **Jeanette McGorrigan** – the GP whose own interest and work on practice data collection inspired the development of the project.

We would also like to mention and thank:

- **the Sheffield practices** who provided us with this data
- **Karen Kilner** – who worked on the project as a health information analyst for 18 months
- **Kay Noble** – who at various times assisted with the data input
- **Simon Dixon** – the health economist who gave us essential methodological advice for our work on costing consultations
- **Steve Maxwell** – who designed the database for the analysis of computer appointment data
- **Sheffield Health and Trent NHS Executive** for funding the work
- **Gordon Reid**, Director of Sheffield Health's Information Department and his staff for help and collaboration over many years.

And last but definitely not least:

- **the administrative staff** in those practices who for up to six years have been patiently filling in our monthly data sheets.

1 Introduction

In 1999 general practice directly cost the British taxpayer about £3 billion. Prescriptions for drugs cost about a further £4 billion and general practitioners (GPs) referred 11 million patients to hospital with considerable financial consequences for the National Health Service (NHS). In short, general practice is big business. Yet this key public service has hardly been managed in any direct way at all. Instead it is provided by some 30 000 practitioners working in nearly 10 000 practices. These small organisations have typically been under-managed and under-capitalised when compared both to hospital care and to other systems of primary care in the developed world.

For many decades general practitioners in Britain have resembled homesteaders, each tending their own little farm. Neither collaborating nor truly competing with their neighbours, each could do pretty much as they wished. This lack of interest in how colleagues did the job was especially marked in relation to work patterns. Just as farmers discuss the weather or the prices in the market, GPs discussed in an anecdotal way what the workload was like and how the business was going. Hard data was rare. Some practices added up the figures in their appointment books to measure their own workload, most did not, and nobody knew, beyond anecdote, what anybody else was experiencing. Data about individual patients was there in abundance, but buried in handwritten and typed pieces of paper in record envelopes dating from Lloyd George's era.

Imagine yourself as the new chief executive of General Practice plc in, say, 1990. One million people came through your doors

every day for a consultation, and your information systems for recording what was happening to them had barely entered the 20th century. General practice was like a black box. Staff, time and money went in, consultations, referrals and prescriptions came out, but very little was known about what was going on inside the box.

The 1990s saw some progress. A growing amount of the work of general practice is now recorded on computer, though using software that is often 10 years behind the times and from many competing companies whose systems rarely communicate with anybody else's. Practices also began to collaborate with each other – to share out-of-hours care in GP cooperatives, and to commission secondary care services in multi-funds, total purchasing pilots or locality commissioning groups.

Times change. The new primary care groups (PCGs) and trusts (PCTs) need to understand and influence the services their practices deliver, ensure that national service frameworks and clinical governance agendas are delivered, and manage resources efficiently and effectively. In short, the Government is out to ensure that patients receive efficient, transparent and consistent care and that general practice is finally brought into the managerial mainstream of the NHS.

The future requires new levels of information and understanding. Some of this will be about clinical effectiveness – what works, what does not, and what is in the enormous grey area where the art of being a GP still holds sway. But information about workload is also crucial. The bread and butter of general practice remains dealing with that million patients every day – those wanting advice or reassurance, wanting an explanation or diagnosis of what is happening to them, wanting a prescription, wanting a referral, wanting a sympathetic ear to listen to their story.

We have experienced that daily demand, one as a practice manager, one as a GP, in different practices, and we know the pressures involved in coping with it. It is indeed demanding work. For ten years, in changing roles, we have been involved in projects in Sheffield to work collaboratively, to share information, to

provide measures to benchmark how our practices were doing compared to others, and to use this information for the benefit of the service we provided. The aim has been to improve the quality of the service, and the quality of the working life of those who work within it. But if we are honest it has often been about finding pragmatic coping strategies for dealing with a heavy workload – maintaining the service and maintaining the morale of its workers.

For six years, through the Sheffield Practice Data Comparison (PDC) project, we have been collecting and analysing data on general practice activity rates in Sheffield. The results have been fed back to practices and other interested parties within Sheffield as individual reports. Since 1998 the project has been part of the Centre for Innovation in Primary Care, and some more recent reports have been circulated to every health authority and PCG. This book – *General Practice: Demanding Work* – presents the learning from the project in its totality to a national audience.

Results are presented so that those who work in general practice can compare their own data, if they have it, with our data. We do not claim that the results from 30 practices in one city are typical or represent a statistical average. But in a situation where comparative data is scarce they represent a useful benchmark, a step beyond the black box.

We have tried to make how we arrived at our results transparent, so that others can replicate the analysis on their own data if they wish, but without presenting excessive detail for other readers. For those who want to know more about our results and methodology, they are free to contact us for further information and copies of our reports, or to visit the Centre for Innovation in Primary Care's website (www.innovate.org.uk) and to download material from it.

Benchmarking alone is useful. For a practice to know, for instance, that its default rate on appointments is high, low or average can lead to that practice taking appropriate action. At points in the book, however, we go beyond presenting results to make suggestions about what practices might do to improve their service. We *do not* claim to be the experts in how to run a general

practice, if such people exist we have yet to meet them. We *do* think that the work we have done provides a rich source of evidence-based learning on what is really happening in general practice and how it might be done better.

We are, of course, not alone in analysing consultation patterns in general practice. National surveys have been undertaken, and pieces of research have occurred based on data from one or more practices. In most chapters we present a brief section on what others have found, providing information and references for those who want to follow up the issue in more depth.

This is a time of great change for general practice – so much so that there are questions about the future role of the general practitioner itself. Can the self-employed GP principle be flexible enough to survive long into the 21st century? Will a salaried service or nurses replace the general practitioner? To give the title of this book an alternative meaning, do GPs have the right to *demand work*, to demand a job? The data about consultations contained in this book sheds some light on these questions, particularly the relationship between the work that practice nurses do and that of GPs. Questions about the role of the GP itself are addressed, more polemically, in Chapter 20.

GPs and practice nurses spend their days dealing with, and thinking about, unique individual patients. Our focus is on aggregate behaviour – not the one patient in a 100 that stood out, but the 99 who did not. All too often bright ideas for change founder because they are rooted in myths about what is actually happening on the ground. If we enable readers to better understand the daily reality of general practice, perhaps dispelling a few myths along the way, then this book will have been worth writing.

2 Studying consultation patterns

Studying consultation patterns involves a trade-off between:

- *representativeness* – collecting data from a sample that allows generalisations to be drawn about all practices
- *completeness* – covering all aspects of practice work
- *workload* – keeping the work involved to a minimum.

This trade-off has produced two broad approaches.

In the first, enthusiasts design and collect their own data drawn from one or a small number of practices. Much of the literature is of this type and we will be reporting many of its conclusions throughout this book. The drawbacks of this method include non-standardised definitions and dependence on enthusiasts. These make the results less useable to everyday practices or PCGs who wish to understand their patterns of work and make changes.

The second approach is to collect standardised data from large groups of practices or populations of patients. This method is more likely to generate representative results since the sample is both larger and can be recruited in ways that increase representativeness. To the extent that this method can be adapted to use the routine data generated by many computerised systems, it can also form the basis of internal benchmarking for practices and organisations outside the original participants. The Sheffield data used throughout this book falls into this category.

Since such studies form the backdrop for this book, the next section summarises the main national surveys that are useful when studying workload.

The National Morbidity Surveys of England and Wales

The most extensive source of information on general practice workload comes from the decennial National Morbidity Surveys (NMS) of England and Wales, of which there have been four, with the last in 1991/2.

The 1991/2 survey involved 60 volunteer practices in England and Wales who, for a full year, recorded every face-to-face contact with patients who were on the practices' age–sex registers – over 500 000 patients in all. Socio-economic data was also recorded by questionnaire for 83% of the patients. Comparison with the 1991 census showed that the patients were representative of the general population. The practices were geographically diverse, but tended to be larger than average with younger GPs and more ancillary staff. They also had to be amongst the 34% of general practices that at that time had the necessary computer system to record details of every consultation.

The principal purpose of the survey was to provide epidemiological data on *morbidity*. The reason(s) for every face-to-face contact with a doctor or practice nurse, either in the surgery or the patient's home, was recorded, thus providing a wealth of data on the prevalence and incidence of disease. However, as a by-product the survey also provided an extensive record of *workload* and the determinants of it.

We present in Appendix 1 four key graphs on contact rates from the survey. These are reproduced by kind permission of the authors. The full report is:

> McCormick A, Fleming D and Charlton J (1995) *Morbidity Statistics from General Practice: fourth national study 1991–1992.* A study carried out by the Royal College of General Practitioners, the Office of Population Censuses and Surveys, and the Department of Health. HMSO, London.

Amongst the key workload, conclusions of the survey were:

- broadly 'J'-shaped curves for age-specific contact rates with doctors and nurses in surgery, with high rates in children under five, lowest in the 5–15 age range and then rising steadily with age to a second peak at about 70–74
- surgery contact rates for females were much higher than for males in the 16–64 age range
- rates for home visit contact for both doctors and nurses were extremely skewed towards patients over 70
- higher contact rates for men aged 16–64 in the north of England compared to the rest of the country; higher rates for people in the more deprived social classes IV and V compared to classes I and II; and higher rates for patients from the Indian subcontinent than white people.

The survey catalogued its own strengths and weaknesses. From the perspective of workload data, the key strengths were:

- a very large sample – 1% of England and Wales
- a wide geographical spread
- varied practices in terms of characteristics, though with the advantage of largely being experienced data recorders
- a full year's data and high reportage rates (96%) for doctor contacts
- direct linkage between each contact and its morbidity cause(s)
- combined with socio-economic data for 83% of patients.

The acknowledged weaknesses included:

- not a random sample of practices, relying instead on volunteers
- poor data recording by some practices for nurse contacts, with an average reportage of only 64%.

To this we would add:

- it is an expensive exercise and therefore is only done every ten years, which means the data becomes progressively out of date.

This is a serious issue at a time of rapid change in general practice

- it cannot detect local factors, for instance only one Sheffield practice participated
- since it is practices who choose to participate rather than patients, the self-selection could arguably lead to high-workload practices being under-represented because they could not face the extra demands of participating in the survey
- since it does not use data that is routinely generated by the everyday workings of the practice, it is hard for practices to use NMS data as a direct standard for benchmarking their own work.

The General Household Survey

The annual General Household Survey is a sample of about 25 000 individuals in 10 000 households in Great Britain which, amongst many other questions, asks them about their visits to the doctor over the last two weeks. Whilst this data set avoids the issue of GP bias by going direct to patients, there are problems in extrapolating from two weeks to 52 weeks. A greater concern is the reliability of peoples' memory recall over the two-week reference period. However, it has been shown to produce similar results to the National Morbidity Surveys.

The National Survey of NHS Patients

During October to December 1998 the first annual National Survey of NHS Patients in England was conducted. It was a self-completed questionnaire sent by post to a random sample of 100 000 adults from the electoral registers. Over 61 000 questionnaires were returned. The survey focused on patients' experience of general

practice. Some of its questions were of relevance to studying consultation patterns – including details about contact with a GP or practice nurse, and waiting times to see a GP. As with the General Household Survey, it relies on peoples' memory recall. Reference to its findings are made at various points in this book.

Department of Health's General Practice Research Database (GPRD)

This routinely collects data from 288 practices who use the VAMP clinical computer system and have been deemed reliable and comprehensive in their clinical data collection. Whilst it is a potential source of information on GP activity, its use for research purposes has entirely focused on morbidity or pharmacology

A local approach?

In the last ten years, quite a number of projects have been set up to systematically collect data from many general practices in one area. Almost all of these projects have focused on the collection of morbidity data, and there now exists a national body that guides their work – the Collection of Health Data from General Practice (CHDGP) project. Rarely though has the focus been on workload. Our work in Sheffield has been an exception.

The Sheffield Practice Data Comparison (PDC) project

In 1989, eight geographically dispersed practices initiated the Towards Coordinated Practice (TCP) project, whose aim was to explore ways in which collaboration between practices could

usefully assist the development of primary care. One of the ideas that emerged was the routine sharing and comparison of standardised practice-held data. The Practice Data Comparison project began in 1994 and was funded by Sheffield Health. Project workers were accountable to an independent management group and the project was clearly identified as of, and for, general practice. Data has been collected on activity rates, finances and morbidity, but the principal focus, decided by the general practices involved, has been on activity and workload issues. The results of the data comparison have been used to:

1 inform resource management decisions within practices
2 make accurate, anonymised data available to Sheffield Health about a broad patient base to inform the commissioning process
3 improve the appropriateness, accessibility, costs and quality of care given to patients.

Over time the project has expanded the number of participating practices so that we have at least one year's worth of data for 33 practices. The project is now a part of the Sheffield-based Centre for Innovation in Primary Care, which is a charity independent of NHS structures and commercial interests.

The initial reports presented the participating practices with comparative bar charts of annual data and commentaries, with the practices openly identified. These reports generated intra-practice discussion and sometimes were supplemented by multi-disciplinary meetings of all the practices where participants sought to understand the reasons for variation and learn from each other.

The next step was a series of reports entitled *Your Questions Answered.* Each of these short reports started from a practical question from somebody in a practice, e.g. 'how many days do our patients have to wait for an appointment?', and answered it within a comparative framework. A number of the chapters in this book grew out of such questions.