Berkshire, Buckinghamshire & Oxfordshire LMCs

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Report for HOSC: Demand, Capacity & Activity in General Practice in BBO. The BBOLMC SitRep

Methodology

The BBOLMC collects data from participating practices across several different measures, including:

- The **number of medical record entries** made by the practice each week within EMIS (the medical records system) and which type of staff member made those entries.
- The **number of in-coming telephone calls** each week. Practices are asked to also include into this total count the number of e-consults (online form submissions) and other contact points (such as walk-ins).
- The **number of GPs** they have in the practice each week.
- How much protected (ring-fenced) **admin time** a GP is given per week, outside of direct patient care.

This local data is used for two purposes:

1. To provide a Situation Report ("SitRep") on measures of demand, capacity, and activity in General Practice
2. To generate an *Operational Pressures Escalation Level* ("OPEL") score for each practice. OPEL scores are mathematically derived, based on the data submitted by the organisation. They have been used by hospital trusts for many years as a method of declaring operating pressures. The BBOLMC OPEL system was the first of its kind for General Practice. Below, we provide an OPEL score in two domains: demand-vs-capacity, and admin workload.

A methodology paper is available on request which gives greater detail about data collection, derived conclusions, and the many assumptions that potentially confound the data below.

Participation

Participating is voluntary for practices. It is a manual process which takes approximately 5-10 minutes of practice time each week. Uptake is limited. Out of approximately 200 practices in Berkshire, Buckinghamshire and Oxfordshire (BBO), Approximately 20-30 submit data on a weekly basis, which covers a (non-contiguous) population footprint of c.325,000 patients. Approximately 15 of the submitting practices are from Oxfordshire, which covers a footprint of c.195,000 patients.

We do not audit practice submissions for data quality. Practice contributions are not necessarily consistently done on a weekly basis. There was also a significant increase in the number of participating practices from April 2023 (prior to that, it was only c.13 practices across BBO). Thus, interpretation of the data should be done with caution.

BBOLMC is the data controller. Practices participate under a confidentiality agreement which specifies that BBOLMC will never release granular practice-level data without the practice's express prior consent.

Results

Demand

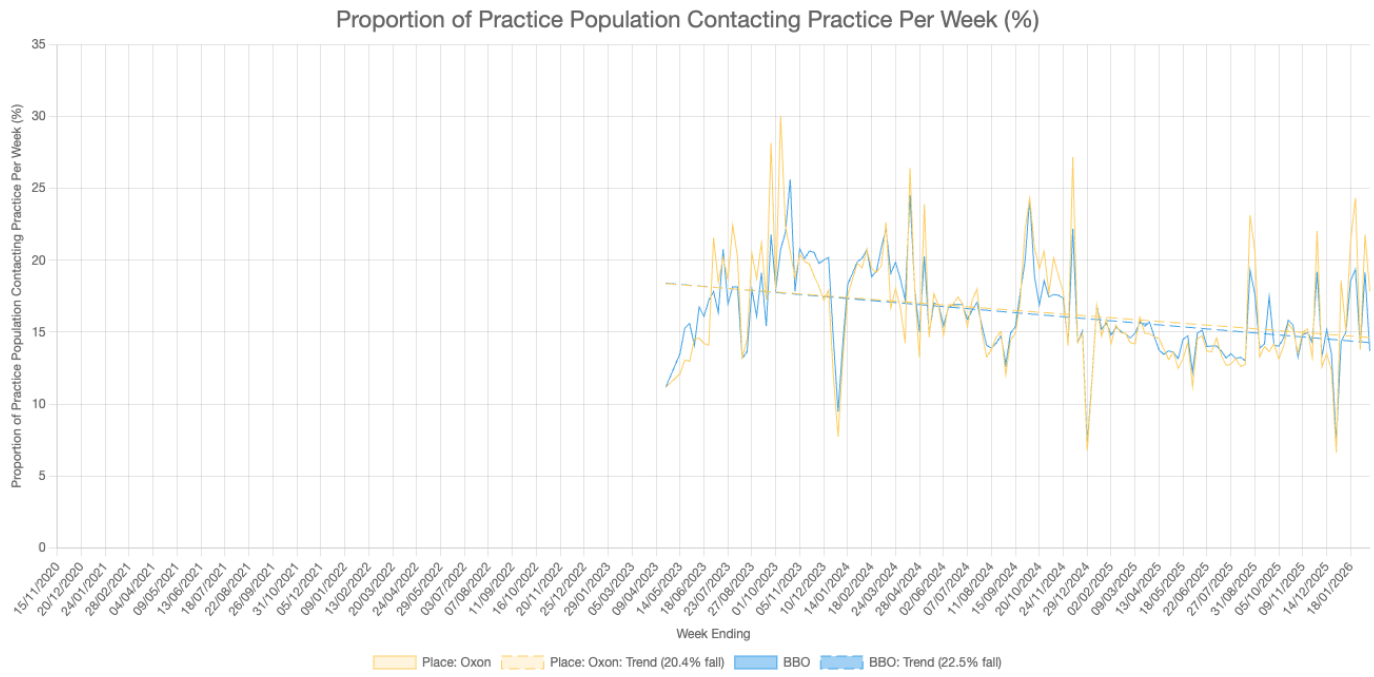

Chart 1: The proportion of Practice Population Contacting Practice Per Week (%). The blue line is all BBO; and the yellow line is for Oxfordshire practices specifically.

Data collection for incoming demand started in April 2023.

Chart 1 shows the proportion of Practice Population Contacting Practice Per Week (%). This summates gross income telephone call numbers + e-consults + walk-ins + any other contact points the practice is able to capture and report to us, per week. This total figure is divided into the practice population size to give us an estimate of the total % of the population calling weekly. As telephone lines are open 5 days per week, dividing the weekly figure by 5 will give an average daily demand figure.

The weekly average is c.15%. This means the equivalent of **1 in 7 of every person in the population contacts their practice each week**. The estimated daily average is 3% of the population. Of course, some patients will contact their practice many times, and some not at all (the figures are an average across the population).

Of note, the number of contacts into the practice has fallen steadily from April 2023 until now – a 20% decline for Oxfordshire. Reasons for this decline are not clear but may include:

- Patient health may theoretically be improving (we have no data to support this)
- Patients are giving up (chimes with anecdotal experience)
- It may be artefactual: From October 2024, GP contract changes triggered a shift away from telephone calls into the practice and towards online submissions to practices, and this *may* not be captured by the data submitted by practices which had priorly put a lot of emphasis on counting telephone contacts.

Capacity

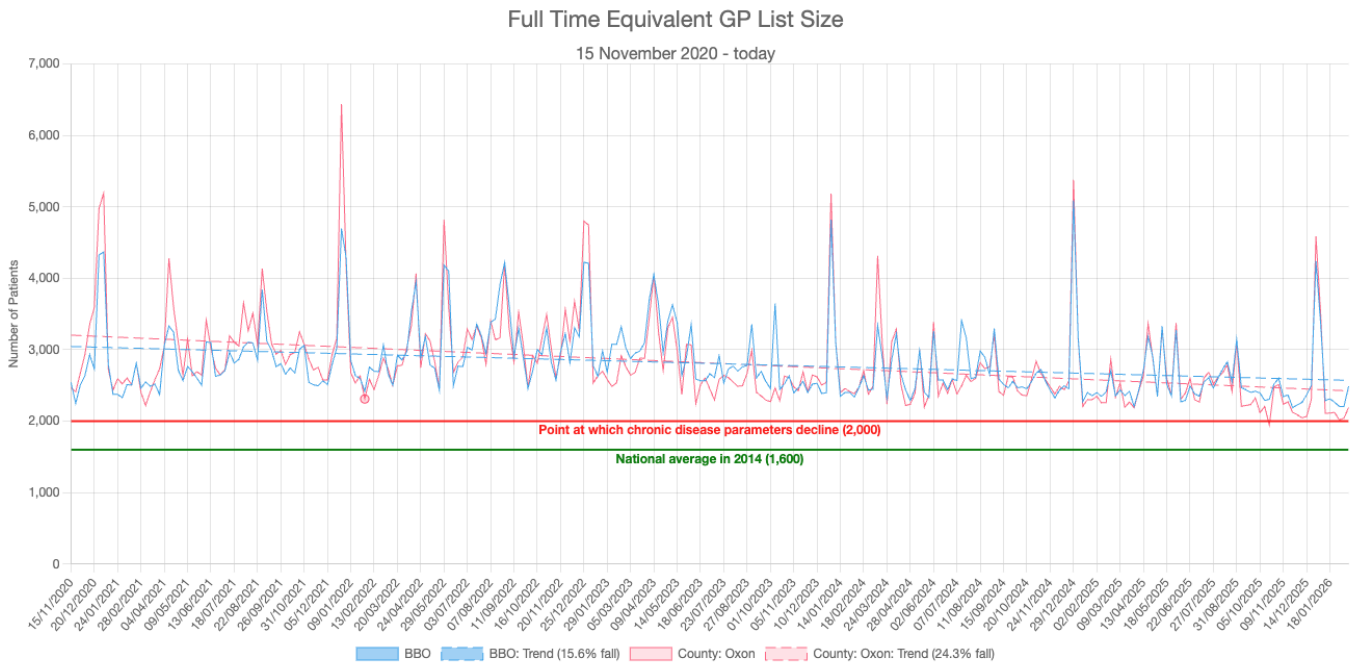

Chart 2: Full time equivalent GP list size over time in BBO (blue) and Oxon (pink).

Chart 2 shows Full time equivalent patient list size with two benchmarks:

1. comparison with national averages from 2014 [using national data sources] – the green horizontal line; and
2. the point at which international published research from developed healthcare systems shows that chronic disease parameters are known to decline (a full-time-equivalents GP list size of 2000[i]) – the red horizontal line.

The local FTE list size is calculated by taking the number of GP sessions available in the practice per week, and dividing that into the practice population (to give GP list size per session) and then multiplying that by 9 to arrive at a FTE (a full time GP is 9 sessions). "GP sessions" includes principals, salarieds, locums, and trainees (but not medical students). It also includes admin and business sessions - viz., all GP sessions contracted by the practice per week. It is a dynamic measure of GP “bums on seats” on a weekly basis. This data is not publicly available elsewhere at local and national level.

Across all data going back to November 2020, the FTE GP list size for BBO is c. **2,877**. For Oxfordshire specifically it is **2,724**. These figures are significantly above ‘safe’ levels associated with optimal management of chronic disease (the red line). (NB: this internationally specified ‘safe level’ of a list size of 2000 pts per full time GP was published prior to the diversification of the General Practice workforce as part of the PCN DES additional roles scheme).

The FTE GP list size has decreased steadily, indicating more GPs for the population. The reason for this may be:

- Changes in the GP contract in April 2024 which allowed specific ring-fenced PCN workforce funds to be allowed to employ newly qualified GPs.
- Artefactual: there was a significant increase in the number of participating practices from April 2023.

Activity

[i] Cited in Van Den Homberg & Campbell (2013). *Is ‘practice size’ the key to quality of care?* British Journal of General Practice, September 2013; 459-460

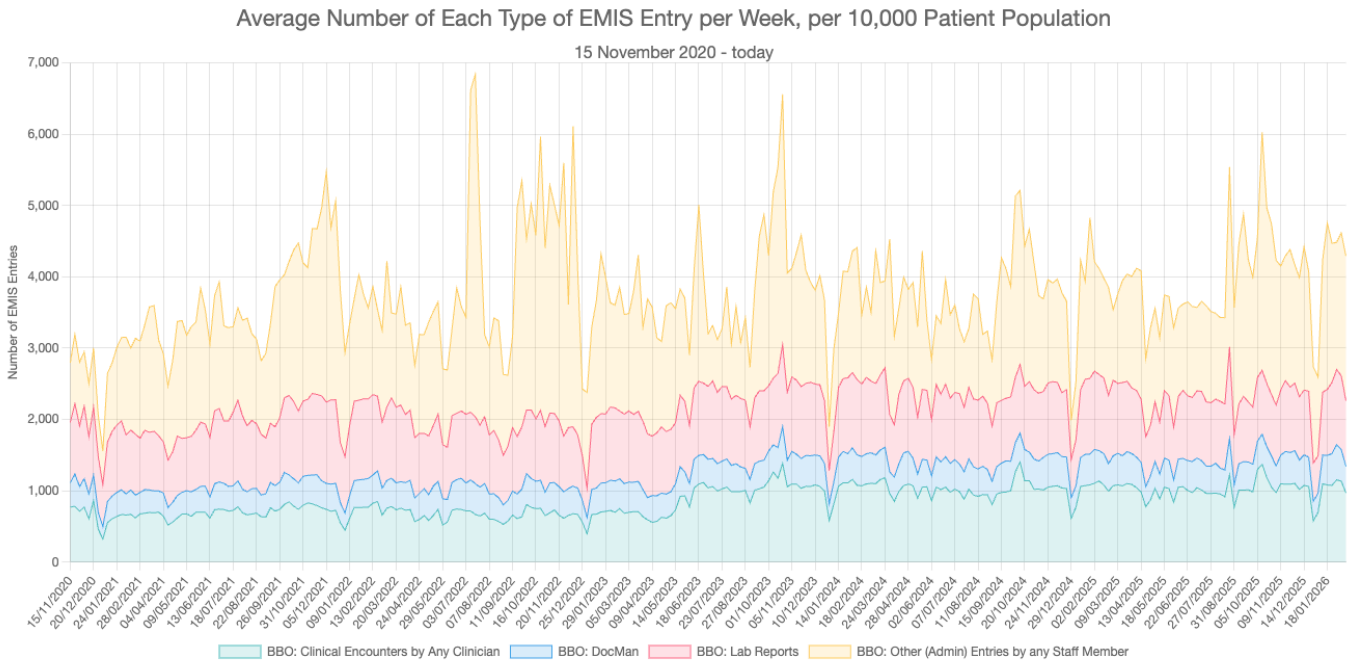

Chart 3: the average number of medical record entries made by a typical practice each week. Green is clinical entries (contacts with a patient). The remainder are admin-related.

Chart 3 shows the average number of medical record entries made by a typical practice each week. The types of medical records entries are subdivided into:

- **clinical encounters** (green: records of a consultation with a patient)
- **docman** (letters read by a practice member of staff and filled into the notes, such as hospital clinic letters)
- **lab reports** (red; results of tests received from the lab, read by the clinician, and filed into the notes)
- **All other** EMIS entries being created weekly within the practice

Data is shown using a denominator of a practice population of 10,000.

The medical record entry counts do NOT include medical record entries that are "externally generated" (such as OOH entries into EMIS, or Covid vaccination programme entries), or SMS/email messages between practice and patient. So, it only counts medical record entries generated manually, internally within the practice.

The data shows that only 25% or less of medical record entries are from consultations with patients. The remaining **75% of all medical record entries are admin-related**.

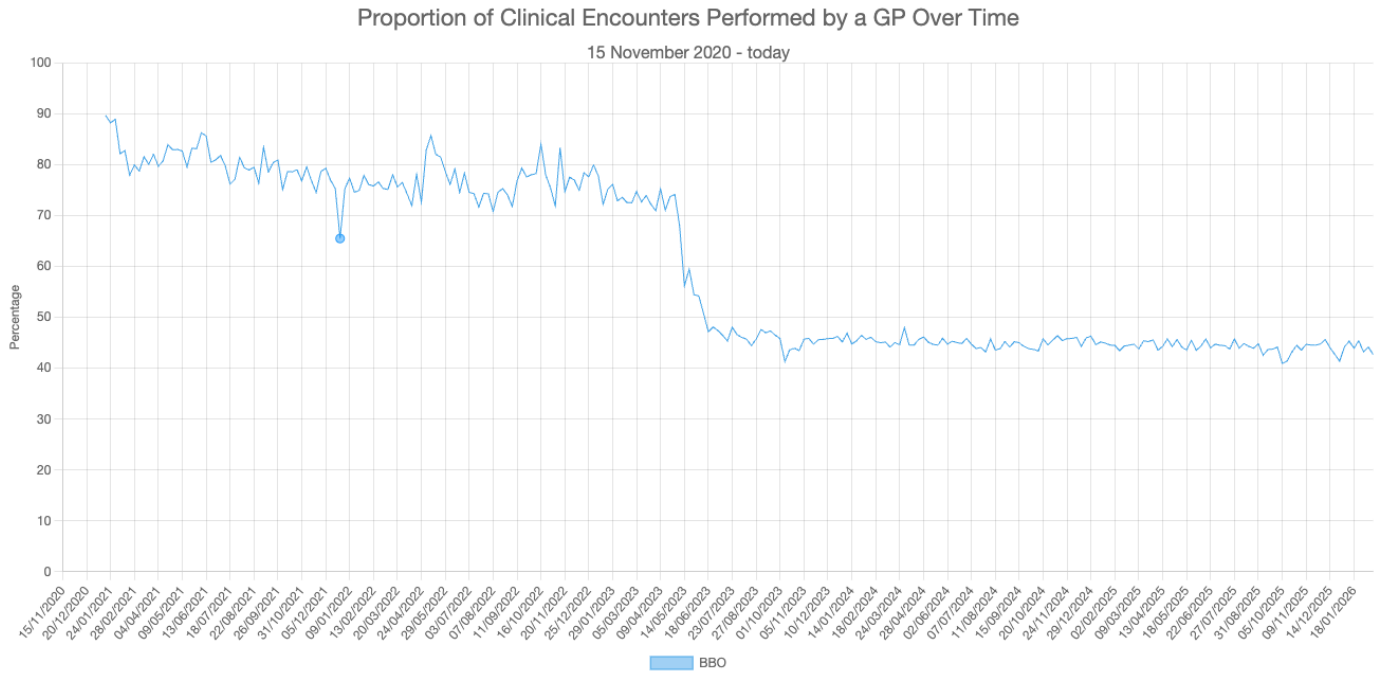

Chart 4: The proportion of clinical encounters that are conducted by a GP, as opposed to another patient-facing allied health professional.

Chart 4 shows the proportion of clinical encounters that are conducted by a GP, as opposed to another patient-facing allied health professional. Which AHPs are included depends on the practice's 'clinical user group' settings specified in EMIS but, as a general rule, it includes Nurses (any type), advanced nurse practitioners, paramedics, pharmacists, health visitors, physiotherapists, phlebotomists, physician assistants, and Midwives, but not healthcare assistants.

55% of all clinical consultations in the practice are now delivered by a non-GP.

The steep drop in April 2023 corresponds to the point at which the pilot phase ceased, and data collection was rolled out across all BBO so may be artefactual. However, the imposed GMS contract for the year 2023-24 showed continued significant real-time cuts to general practice and this drop may therefore have reflected practices cutting back their finances by employing AHPs (funded by the PCD DES additional roles reimbursement scheme) rather than GPs (funded from practice income).

Demand-Capacity Matching

In 2021 Oxfordshire Healthwatch performed a survey[ii] of patients contacting their practice in the previous month and asked them the reason for their contacting their practice. From this data we extrapolated that approximately 56% of all patient contacts to a practice ideally required a consultation with a GP *specifically* (rather than an allied health professional, or administrative staff).

If we apply this % figure to the total amount of contacts per week for a given practice, we can estimate how many GP appointments each participating practice needs per week. For example, if a practice receives 1000 contacts from a practice per week, 560 will ideally need a GP appointment.

Participating practices tell us how many GP 'bums on seats' they have per week (reported as how many 'GP sessions – or clinics - available per week. A clinic is assumed to be half a day). We can use this figure to answer the following question: *with the number of GPs a practice has available per week, how many patients would each GP need to see per clinic to meet the incoming demand*? For example, using the above worked example,

[ii] https://healthwatchoxfordshire.co.uk/wp-content/uploads/2022/05/20220504_GP-report_final.pdf

if there were 560 patient requests for a GP in a week, and 10 GP sessions/clinics available that week in the practice, each GP would need to see 56 patients per clinic to meet that demand.

We can then apply "BMA safe-working limits" to this activity. The BMA, in collaboration with the European GP Committee of the EU, has published safe working limits for the number of patient contacts a GP can safely manage in one day[iii]. The further a GP goes above this limit, the more unsafe their working. The limits are as follows:

- **Safe**: 12 patient contacts per session (25 per day). For the purpose of assigning an OPEL level to the practice, we classify this as working at **OPEL 1**.
- **Pressured Working**: 13-17 patient contacts per session (26-34 per day). We classify this as working at **OPEL 2**.
- **Unsafe working**: 18 – 21 patient contacts per session (36 – 42 contacts per day). We classify this as working at **OPEL 3**.
- **Off the scale**: >21 contacts per session (>42 contact per day). We classify this as working at **OPEL 4**.

Chart 5, below, displays the data in graph form for Oxfordshire specifically. The Y-axis is the number of contacts per GP session. The **blue line** is the number of contacts per session each GP in the practice is *actually* delivering per session. The **red line** is the number of contacts each GP would *need* to deliver per session if the practice were to meet all the demand for a GP coming in that week. The coloured background bands are the BMA safe working bands (OPEL 1 – OPEL 4):

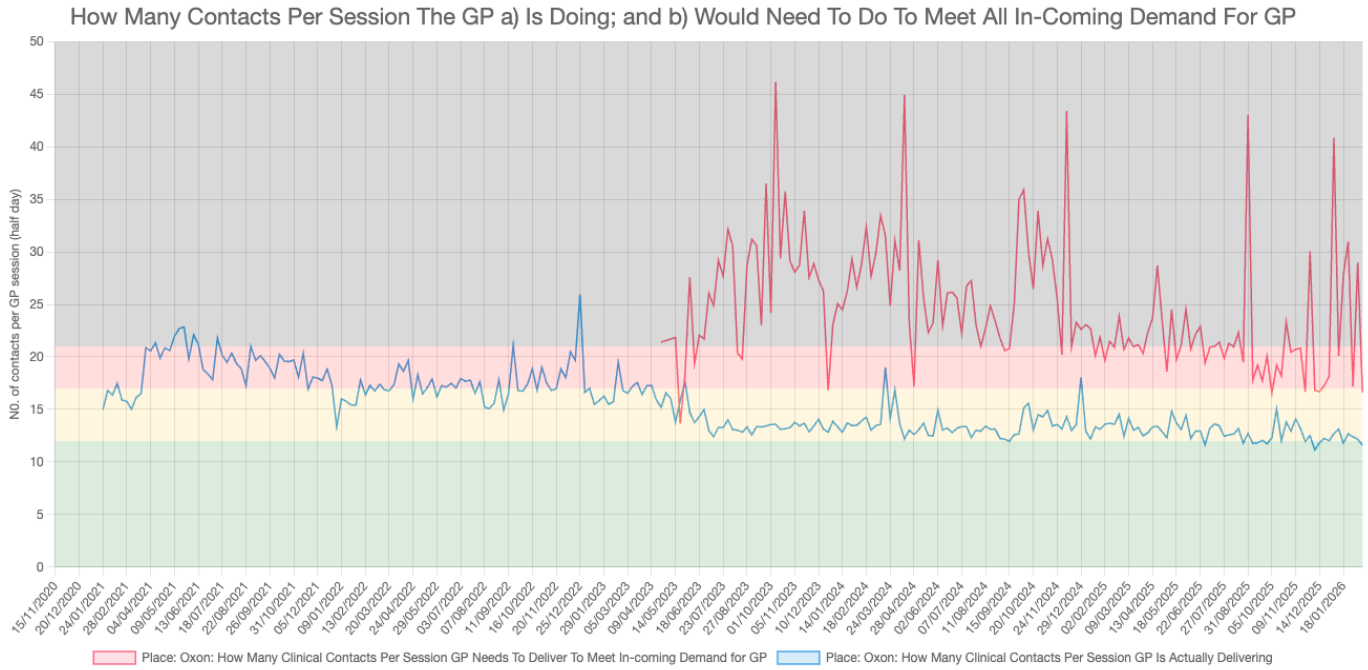

Chart 5: How many contacts a GP delivers per session (blue line), and how many contacts they would need to deliver to meet all the estimated demand for a GP (red line).

The **blue line** on this chart shows that in 2020-2021, GPs in Oxon were seeing approximately 18-20 patients per clinic (that is, 36-40 patients per day). This put them at 'unsafe levels' of working. Over the time, the number of contacts has reduced towards safer levels. This reduction likely reflects a combination of:

- Successful BMA-coordinated 'collective action' which empowered GPs to limit their contacts to what is safe.

[iii] https://www.bma.org.uk/media/1145/workload-control-general-practice-mar2018-1.pdf and https://www.bma.org.uk/advice-and-support/gp-practices/managing-workload/safe-working-in-general-practice

- An increasing number of "simple" presentations being consulted by allied health professionals (chart 4) means that only the more complex presentations are left for GPs to see. This necessarily takes more time, necessitating a drop in the total number a GP can see per session.

The **red line** in the chart is the number of contacts per session each GP would need to see if it were to meet all the demand for a GP coming into the practice. This would put GP working predominantly into OPEL 4 – unacceptable working conditions for GPs and their patients.

The difference between the blue line and the red line is the mismatch between demand for GPs and GP capacity. In reality, this mismatch is managed by directing patients to allied health professionals, or other services in an attempt to meet their needs as best as can be done.

It is of note that the drive to have more patients seen by allied health professionals rather than their GP is a central tenet of both the *PCN DES* and the *NHS 10 Year Plan*. It is an attempt to increase the availability of a diversified – and often cheaper – workforce. It does, however, pose an existential challenge to the *raison d'etre* of a GP. Many GPs in practices went into the profession wishing to 'follow the patient and not the disease' – viz., to provide continuity of care for the patient, which means seeing the 'simple' things as well as the complex. The current direction of travel in our workforce, however, is to restrict what the GP sees to only the most complex. This reduces continuity of care and is likely to have adverse outcomes for patients in the long run. It also has the potential to reduce GP morale and work satisfaction.

Admin Burden

How little admin time is too little? The BMA safe working publications previously estimated that one GP clinical session of three hours was associated with one hour of required admin time. If we assume a BMA session to be 12 patient contacts, then then this equates to 5 minutes of admin time required per patient seen.

Because we know from our data collection the number of patient contacts a GP has per session on average, we can work out how much admin time they need: *5 mins x number of patients seen*. Practices tell us how much protected admin time each GP has per week on average. We can therefore compare how much GPs get on average with how much they need. The greater the disparity between the two, the greater the admin burden. To quantify this, we revert to the same BMA thresholds as above (chart 5) and create *admin OPEL levels* for each practice:

OPEL 1: Receiving BMA "safe" amount of time (5 mins per clinical encounter)

OPEL 2: Receiving up to 60% of BMA "safe" amount of time (3 mins per clinical encounter)

OPEL 3: Receiving up to 20% BMA "safe" amount of time (1 min per clinical encounter)

OPEL 4: Receiving less than 20% of BMA "safe" amount of time (<1 min per clinical encounter)

Chart 6 below reports the proportion of practices at each admin OPEL level in Oxfordshire.

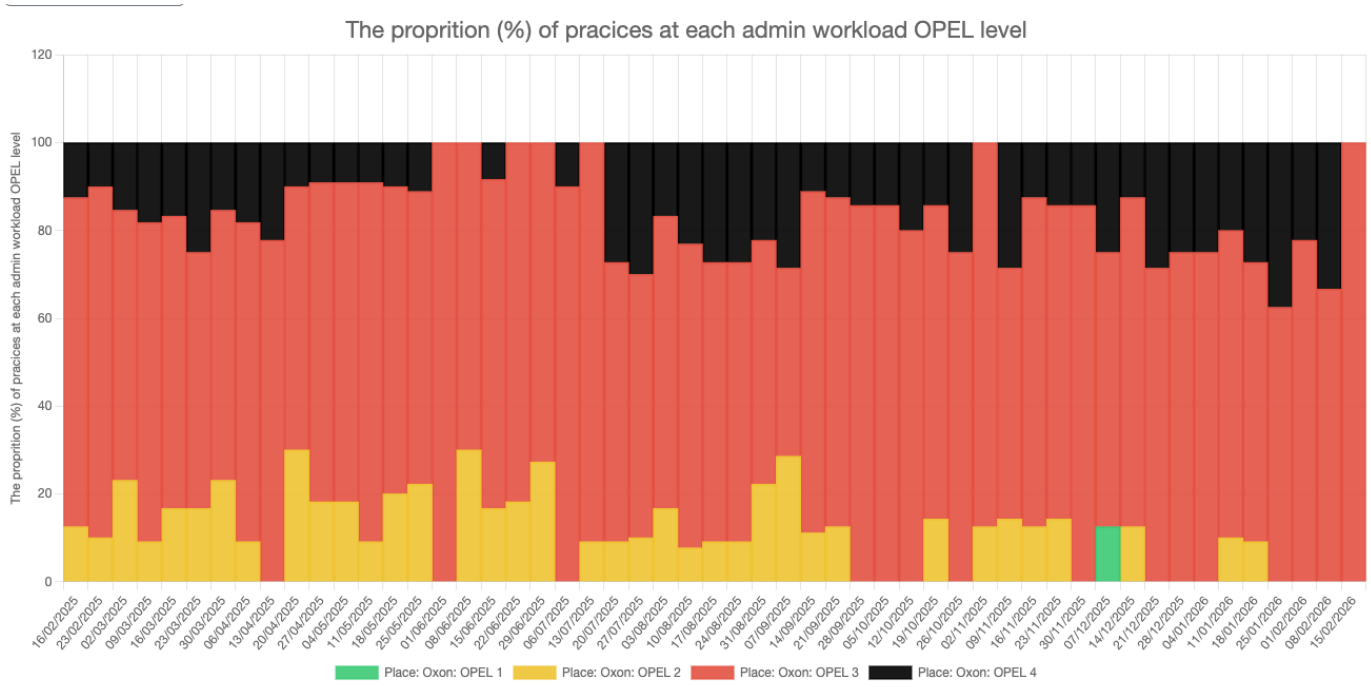

Chart 6: Admin burden: The proportion of practices at each admin OPEL.

Chart 6 shows that the majority of practices (>80%) can only ring-fence 20% or less of the admin time required for GPs (**OPEL 3**). Safe levels of adequate admin time (**OPEL 1**) are a rare event.

Conclusions

- The equivalent of 1 in 7 of every person in the population contacts their practice each week.
- the FTE GP list size for BBO is c.2,877. For Oxfordshire specifically it is 2,724. These figures are significantly above 'safe' levels associated with optimal management of chronic disease
- 75% of all medical record entries are admin-related.
- 55% of all clinical consultations in the practice are now delivered by a non-GP.
- Most practices are now delivering safe levels of patient contacts per session (12 contacts per clinic). Where they to meet all the demand for a GP coming into the practice, they would need to operate at dangerous levels of activity.
- Most practices (c.85%) receive only 20% or less of the admin time they need.

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