

# GENERAL PRACTITIONER WORKLOAD

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## RCGP INFORMATION SHEET N°3



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## I. INTRODUCTION

There are many new and existing societal and professional forces affecting the size and complexity of workload in general practice. Advances in technology and clinical care, changes in the organisation of healthcare, policy initiatives, demographic change and increased patient expectations have resulted in changing patterns of demand in general practice. The information below is a statistical overview of some of the key workload indicators in primary care.

## II. TYPE OF CONTRACT

The majority of GPs in England and Wales (77.7%) are contracted to work full time within the NHS (see Table 1). However, there has been a 3% rise in the number of GPs on part-time contracts between 2001 and 2003 meaning that 22.3% of the workforce is now part-time. This reflects a steady long-term trend, with only 5.4% of GPs part-time in 1990. The trend for part-time work can be explained largely by the increasing proportion of female GPs in the workforce. Women constitute 38.3% of the workforce in 2003 (compared with 23.8% in 1990) and make up 74.1% of all part-time GPs at present.

**Table 1: Percentage of Unrestricted Principals by Type of Contract, England and Wales, 2001- 2003**

Type of Contract	%	
	2001	2003
Full Time	80.6	77.7
Three Quarter Time	9.2	10.7
Half Time	8.4	9.9
Job Share	1.9	1.7

Source: General and Personal Medical Services Statistics England and Wales September 2001, 2003.

**Table 2: Total Hours Worked (excluding on-call time): Percentage of GPs in Each Range, UK, 1997**

Hours Worked	%
Less than 15	4
15-25	9
25-30	8
30-35	11
35-40	19
40-45	20
45-50	14
50+	7
Don't know/not stated	9

Source: Review Body on Doctors' and Dentists' Remuneration, 27th Report 1998. London: The Stationery Office, 1998

Table 2 shows that while half of all doctors in 1998 worked between 30 and 45 hours per week (not including on-call time), one fifth worked at least 45 hours per week. Unfortunately current figures on total hours worked in general practice are not available. An Audit Commission report in 2002<sup>1</sup> reported that in 1998, when not on call, GPs spent an average 39.21 hours per week on

GMS duties\*. This is a slight increase on the 1992/93 figure of 38.84 hours per week, and on the 1989/90 figure of 37.01 hours per week, representing an upturn in working hours between 1989 and 1998 of 6%. The report also highlighted that the average number of GMS hours worked out of hours per week had fallen from 6.93 in 1993 to 5.52 in 1997. While the report stated that there was "little hard evidence" to back-up the general perception of a marked increase in general practice workload, it proposed that hard data does not reflect the real change in the complexity of GP caseload over time, and the "decision density" faced by the modern GP.

\* General Medical Services duties includes activities such as surgery, telephone consultations, home visiting, minor surgery, teaching, etc.

### III. LIST SIZE

There is no accurate figure for the percentage of the UK population who are registered with a GP. A popular estimate is about 98%, although no source has been found for this. Difficulties in reaching an accurate figure arise because some people may be registered with more than one GP. According to *Hansard*, 51,552,391 people in England were registered with a GP or a provider of PMS in September 2002, but the 2001 census statistics show the population of England in 2001 as just over 49 million people, with the overall trend suggesting that this is a relatively static figure.

From 1985 to 2003, the average list size of all (headcount) unrestricted principals and equivalents (UPEs) in the UK fell by 13.2% to 1,745 patients per principal (Table 3). When calculated purely by headcount UPE number, the year 2002-03 has seen the largest single year decline in UK list size since at least 1990 with the average list size falling by 31 patients. Most of this decline is due to the fall in list size by 36 patients per principal in England. The breakdown for England by contractual commitment in Table 4 helps to explain this fall. The highest rates of decline in list size over the whole period have been in Wales, Scotland and Northern Ireland which have seen a 15-17% fall in patients per unrestricted principal since 1985. The decline in average list size in Wales has been negligible since 1999, in virtue of a significant rise between 2001 and 2002.

**Table 3: Average List Sizes of Unrestricted Principals (Headcount), 1985-2003, UK**

	1985	1988	1990	1992	1994	1997	1999	2001	2002	2003	% change 85-03
<b>England</b>	2,059	1,999	1,942	1,922	1,900	1,878	1,846	1,841	1,838	1,802	-12.5
<b>N. Ireland</b>	1,981	1,865	1,835	1,794	1,778	1,690	1,679	1,670	1,651	1,644	-17.0
<b>Scotland</b>	1,663	1,668	1,589	1,590	1,521	1,468	1,441	1,409	1,392	1,380	-17.0
<b>Wales</b>	2,013	1,914	1,849	1,819	1,739	1,706	1,694	1,685	1,704	1,695	-15.8
<b>UK</b>	2,011	1,938	1,893	1,875	1,847	1,818	1,788	1,785	1,776	1,745	-13.2

**Sources:**

DoH GMS Statistics for England and Wales October 1985;1988; 1990; 1992; 1994; 1997; 2001; 2002; 2003.

Scottish Health Service *Scottish Health Statistics 1998*; National Health Service in Scotland, personal communication 2001-2003

N.I. Health & Social Services *Statistical Report for Northern Ireland*. 1997, NIH&SS, personal communication 2001-2003.

OHE Compendium of Health Statistics 13<sup>th</sup> Ed 1999, 2002.

Table 4 (over) examines list size information for England at a more granulated level and gives a clearer picture of the actual, rather than the apparent, situation regarding list size. If total patients are divided by total (headcount) UPEs then a healthy reduction of 5.5% in list size is observed in the 1993-2003 period. However, although the total number of UPEs has increased by 2,279 (8.7%) from 1993-2003, the number of full time UPEs has actually fallen by about 10.6% (or more than 2,500 GPs). The increase in total UPEs is completely attributable to the disproportionate increase in part-time (half-time, three-quarter time and job share) UPEs. In 2003 they constitute 23.4% of the UPE workforce having only represented 5.7% in 1993. This is highly significant as the average list size of a part time GP is generally half that of a full-time UPE and heavily bias a mean average of list size. A fairer reflection of list size is that based on Whole Time Equivalent (WTE) UPEs which shows a negligible list size decrease of 0.4%. This highlights that the shortfall in full-time UPEs has barely been replaced (in workload terms) by the increase in total UPEs over the period.

WTE list size is also slightly unrepresentative of the average individual GP experience in England. Further analysis reveals that 90% of UPEs (full time, three quarter time, and job share) have experienced list size increase over the 1993-2003 period, with full time UPE average list size increasing by 1.8%.

A similar trend can be observed in Wales. Between 1993 and 2003 the average GP list size, based on headcount number of GMPs, fell from 1,736 to 1,695 (2%). However, list size based on WTE numbers increased from 1,808 to 1,841 (2%) due to the same factors outlined above\*. When calculated using WTE the average list size in Scotland in October 2003 was 1480.7\*\*, which is a full one hundred patients per principal higher than the 1,380 headcount-derived figure quoted in Table 5.

**Table 4: Unrestricted Principals and Equivalents (UPE), Average List Size by Contractual Commitment and % of all UPEs Represented by Contractual Commitment, England, 1993-2003**

	1993	1995	1997	1999	2001	2003
<b>Headcount UPEs</b>	<b>26,289</b>	<b>26,702</b>	<b>27,099</b>	<b>27,591</b>	<b>27,843</b>	<b>28,568</b>
<i>List size and % of UPE workforce (in brackets) by contractual commitment:</i>						
<b>All UPEs</b>	1902 (100)	1887 (100)	1878 (100)	1845 (100)	1841 (100)	1802 (100)
<b>Full Time</b>	1974 (94.3)	2005 (87.6)	2024 (85.0)	2007 (82.6)	2017 (80.6)	2009 (77.6)
<b>Job Share</b>	936 (2.0)	984 (2.4)	1002 (2.2)	997 (2.0)	992 (1.9)	1005 (1.7)
<b>Half-Time</b>	918 (2.9)	961 (4.3)	915 (5.8)	926 (7.2)	937 (8.4)	914 (9.9)
<b>Three Quarter Time</b>	1,110 (4.8)	1,149 (5.7)	1,183 (7.0)	1,221 (8.2)	1,290 (9.1)	1,253 (10.7)
<b>Ave List Size (WTE)</b>	<b>1,964</b>	<b>1,972</b>	<b>1,982</b>	<b>1,965</b>	<b>1,976</b>	<b>1,956</b>

**Source:** *Statistics for General Medical Practitioners in England: 1993-2003*. London: Department of Health; 2004.

<http://www.publications.doh.gov.uk/public/sb0403.htm>

\* *General Medical Practitioners in Wales*. Cardiff: National Assembly for Wales; 2004.

<http://www.wales.gov.uk/keypubstatisticsforwales/content/publication/health/2004/sdr15-2004/sdr15-2004.pdf>

\*\* Figure derived from Table on ISD Scotland website:

<http://www.isdscotland.org/isd/files/Average%20List%20Size-03.xls>

Table 5 shows that, in England and Wales, despite a long term trend for the decline in average list size by headcount, there is still a significant problem with very large list sizes and that the average figures may be hiding this trend. Between 1999 and 2003 there has been an 8.3% rise in the numbers of GPs in England and Wales with a list size in excess of 3,000 patients. This is probably accounted for by the decline in the number of full time UPEs, as observed in Table 6. There are recent signs (2002-03) that this trend is beginning to be reversed. The year 2002-03 has also witnessed a dramatic increase in principals with list sizes of less than one thousand, with a single year growth of 12.7%. This can be explained by the rise in the proportion of half and three quarter time UPEs, who tend to have considerably smaller list sizes, and whose numbers have risen disproportionately since 2001 (see Table 4).

**Table 5: Number of Unrestricted Principals (Headcount) in England and Wales with List Size of:**

	<1,000	%	1,000-1,499	%	1,500-1,999	%	2,000-2,499	%	2,500-2,999	%	3000>	%
<b>1998</b>	4301	14.9	3706	12.9	7650	26.6	8121	28.2	3130	10.8	1872	6.5
<b>2001</b>	4354	14.7	4193	14.2	8413	28.4	7989	27.7	2845	9.6	1816	6.1
<b>2002</b>	4456	14.9	4193	14.0	8463	28.2	8000	26.7	2800	9.3	2091	7.0
<b>2003</b>	5021	16.5	4269	14.1	8517	28.1	7789	25.7	2727	9.0	2028	6.7

Percentages may not equal 100 due to rounding

**Source:** DoH *GMS Statistics England and Wales, October 1998; 2001; 2002; 2003*.

Table 6 (over) shows how anomalous the Scotland list size figures are in the overall picture of the UK. Over ninety-five percent of Scottish principals have list sizes of less than 2,000 patients compared with about sixty percent in Northern Ireland, England and Wales.

**Table 6: Number of Unrestricted Principals (Headcount) in Scotland/N. Ireland, 2003, with List Size of:**

		<1,500	1,500 -1,999	2,000 -2,499	2,500 -2,999	3,000>
<b>Scotland</b>	<b>No %</b>	2,572 66.4	1,160 29.9	116 3.0	23 0.6	5 0.1
<b>N. Ireland</b>	<b>No %</b>	416 38.3	239 22.0	242 22.3	114 10.5	76 7.0

Sources: N.I. Health and Social Services, and National Health Service in Scotland; personal communications

**Table 7: Number of Patients by Age Group per Unrestricted Principal, UK, 1952-2002**

	<5	<15	15-29	30-44	45-64	65-74	>75	>85	All ages
<b>1952</b>	201	562	509	549	598	183	91	12	2,491
<b>1962</b>	186	520	456	448	565	169	95	15	1,909
<b>1972</b>	180	549	485	397	544	197	108	20	2,280
<b>1982</b>	125	405	463	393	445	182	120	22	1,779
<b>1992</b>	122	350	400	382	397	160	126	29	1,770
<b>2002</b>	98	317	319	385	409	143	129	33	1,703

Source: Office of Health Economics. *Compendium of Health Statistics, 15th Edition 2003/04*. London: OHE, 2004.

Table 7 shows that the average number of over-75s on each unrestricted principals list has risen to 162 in 2002. This represents over 9.5% of all patients, compared with only 4.1% in 1952. This is significant in terms of demand in general practice, as this demographic group tends to consult their GP more than any other. Tables 8 and 9 show that over-75s visit their GP eight times a year compared with the general average of five visits and were responsible for 10.7% of all GP consultations in 2001. Elderly patients are more likely to experience co-morbidity which makes their cases far more complex than younger patients. Those aged over 75 years also account for 40% of all GP home visits.

An Audit Commission report of 2004<sup>2</sup> found that the average number of patients per WTE practice nurse in England ranged from 3,885 to 5,202 with a wide range within PCTs.

#### IV. CONSULTATION NUMBER AND SITE

Table 8 estimates that GPs in the United Kingdom carried out about 261 million consultations in 2001. This is equivalent to about 740,000 people (approximately 1.3% of the population) consulting a GP every day. Women tend to consult GPs more often than men. There were 155 million consultations by women and 106 million by men.

**Table 8: Estimated Number of NHS GP Consultations by Gender and Age Group, UK 2001 (in millions)**

	0-4	5-15	16-44	45-64	65-74	Over 75	All Ages
<b>Male</b>	11	8	36	28	12	11	106
<b>Female</b>	10	11	61	43	13	17	155
<b>All</b>	21	19	97	71	25	28	261

Source: Office of Health Economics. *Compendium of Health Statistics, 15th Edition 2003/04*. London: OHE, 2004.

Table 9 shows that each person saw their GP an average of 5 times during 2002. This represents an increase from the National Household Survey of 2001 which showed an average of 4 GP consultations per person per year. Females are, however, significantly more likely to consult than males (6 and 4 respectively) and the increase in female GP consultations accounts largely for the overall rise in consultation averages from 2001. In 2002, an analysis was undertaken of consultation rates in 226 UK general practices contributing to the General Practice Research Database<sup>3</sup>. Over the period 1992-1998 the mean age-standardised consultation rate per person year at risk was 3.85 (3.01 for males and 4.71 for females).

**Table 9: Average Number of GP Consultations\* per Person per Year, by Sex and Age, Great Britain 2002**

	0-4	5-15	16-44	45-64	65-74	75+	All ages
<b>Males</b>	7	3	3	5	5	7	4
<b>Females</b>	4	2	6	5	7	9	6
<b>All</b>	<b>5</b>	<b>2</b>	<b>4</b>	<b>5</b>	<b>7</b>	<b>8</b>	<b>5</b>

\*In the 14 days before interview

Source: Office of Health Economics. *Compendium of Health Statistics, 15th Edition 2003/04*. London: OHE, 2004.

Table 10 estimates that, since 1985, the number of consultations per unrestricted principal has fallen by just under 500 to 7,566 per annum in 2001. As this is based on headcount figures for unrestricted principals rather than Whole Time Equivalent it is difficult to take at face value. The replacement of full time with part time GPs (see section on list size) means that headcount-based mean averages are misleading. Hard consultation data is not necessarily an accurate indicator of workload due to problems of data interpretation, and also because greater caseload complexity and the increasing need to liaise with a range of external bodies, such as PCTs and social services, is not reflected in official data. The diversification of GP workload is demonstrated by the shifting workload from hospitals to primary care (9 out of 10 contacts with the NHS occur in general practice), patients' growing health and social care needs, including more complex drug regimens (see prescription data in further table) and exacting national clinical standards involving greater professional scrutiny.

**Table 10: Estimated Number of NHS Consultations per Unrestricted Principal, UK, 1985-2001**

Age Range	1985		1991		1995		2001	
	M	F	M	F	M	F	M	F
<b>0-4</b>	436	415	437	419	415	395	310	295
<b>5-15</b>	377	358	347	331	347	444	227	324
<b>16-44</b>	839	2,060	1,188	1,969	1,101	2,216	1,052	1,784
<b>45-64</b>	823	1,068	774	991	795	1,013	805	1,236
<b>65-74</b>	366	469	359	530	354	595	335	383
<b>Over 75</b>	243	572	301	500	341	564	329	488
<b>Total M/F</b>	<b>3,083</b>	<b>4,943</b>	<b>3,406</b>	<b>4,739</b>	<b>3,352</b>	<b>5,227</b>	<b>3,057</b>	<b>4,509</b>
<b>Overall Total</b>	<b>8,026</b>		<b>8,145</b>		<b>8,578</b>		<b>7,566</b>	

Source: Office of Health Economics. *Compendium of Health Statistics, 15th Edition 2003/04*. London: OHE, 2004.

Trend data from 1971 (Table 11) shows that there has been an overall reduction in the number of NHS GP consultations taking place at home (excluding out-of-hours work) and an increase in surgery and telephone consultations. The proportion of consultations taking place in respondents' homes has fallen from 22% in 1971 to only 5% in 2002. In 1971 73% of consultations took place in the surgery, but by 2002 this figure had increased to 86%. In 1971 4% of NHS GP consultations took place over the telephone and has since fallen to 9% in 2002.

**Table 11: Percentage of Patient Consultations per Week by Site, Great Britain, 1971 & 2002.**

	1971	2002
<b>Surgery</b>	73	86
<b>Home visiting</b>	22	5
<b>Telephone</b>	4	9

Source: ONS. *Living in Britain: Results from the 2002 General Household Survey*. London: ONS, 2004.

An Audit Commission report of 2004 (Ref. 2), which collected data from 200 practices in nine PCTs, stated that GPs saw an average of 117 patients per week while practice nurses saw 105. The 2002 General Household Survey found that, on average, there were two consultations with a practice

nurse per person, per year, with this figure doubling for those aged 65 and over. Overall, females were more likely than males to report consulting a practice nurse during the fortnight before interview (7% compared with 5%). This may be partly due to women visiting practice nurses for reasons associated with family planning and pregnancy. The proportion of respondents to the survey aged 75 and over who had consulted a practice nurse increased from 9% in 2000 to 12% in 2002.

## V. CONSULTATION LENGTH

A comparison of surgery and consultation times has shown that although the average number of surgery sessions per week fell slightly, between 1990 and 1997, the length of each session increased, as has the average length of consultation (see Table 12). On average in 1997, one third of all GPs carried out nine surgery sessions per week, with nearly three-quarters of all GPs carrying out between 7 and 10 sessions per week.

In 1990 the average length of GP surgery consultations was 8.33 minutes which had risen to 9.36 minutes by 1997. An international comparative study in 2002<sup>4</sup> found that, of the six European countries examined, Belgium and Switzerland had the longest GP consultation times, Germany and Spain had the shortest consultation times, and consultation times for the Netherlands and the United Kingdom (9.4 minutes) were in between. The Audit Commission report of 2004 (Ref. 2), which is perhaps the most authoritative and current source for consultation length, found that the median consultation length for GPs was 13.3 minutes and 19.6 minutes for practice nurses. It noted that there was a wide variation between practices and PCTs and that in a small number of practices GP consultation length exceeded 20 minutes. Planned consultation intervals of ten minutes were common although actual consultation times were consistently longer. On average 30% fewer patients than anticipated were seen, with non-attendance only responsible for 5% of this figure. The report suggests that realistic assessments need to be made of the number of patients that can be seen in a session, or session length adjusted to reflect the time that patient consultations actually take.

Despite fears that Government plans to offer a choice of hospital appointment at the point of GP referral would significantly increase consultation length, an early evaluation of pilot schemes<sup>5</sup> has found a statistically insignificant increase. Implementing patient choice of time and venue for hospital appointment extended mean consultation length in consultations involving a referral by 36 seconds.

**Table 12: Comparisons of Surgery and Consultation Lengths, UK, 1990-2003**

Activity	1990	1997	2003
Average Number of Surgery Sessions per Week	8.47	8.38	N/A
Average Length of Surgery Sessions	2h 22 mins	2h 44 mins	N/A
Average Length of Consultations in Surgery	8.33 mins	9.36 mins	13.3 mins*

### Sources:

*Review Body on Doctors' and Dentists' Remuneration, 27th Report 1998.* London: The Stationery Office, 1998.

\* *Transforming Primary Care: the Role of PCTs in Shaping and Supporting General Practice.* London: Audit Commission, 2004.

## VI. APPOINTMENT AVAILABILITY

Responding to targets set by the NHS Plan, significant progress has been made towards ensuring that everyone has fast access during opening hours to GPs and other health care professionals. As Table 13 shows, 97% of patients in early 2004 could see a GP within two working days – an increase from 75% in March 2002 – and 98% saw a primary care health professional within one working day. The National Primary Care Development Team (NPDT) using a technique called advanced access and working with around 5,000 practices in England has reduced the average waiting time to see a GP by 72% and the average waiting time to see a practice nurse by over 50%.

**Table 13: GP and Primary Care Professional Appointment Availability March 2002-03**

Availability	March 2002	March 2003	February 2004
GP Within Two Working Days	75%	88%	97%
Primary Care Professional Within One Working Day	59%	91%	98%

Source: *A Responsive and High-Quality Local NHS: Primary Care Progress Report 2004*. London: Department of Health, 2004.

## VII. REASONS FOR PATIENT CONSULTATIONS

**Table 14 Estimated Number of Patients Consulting a GP by Selected Disease/Condition, UK, 2002**

Disease/Condition	Patients (000s)
Infectious and Parasitic Diseases	5,496
Neoplasms	1,500
Blood and Blood Forming Organs	651
Endocrine, Nutritional and Metabolic Diseases	3,986
Mental and Behavioural Disorders	5,270
Nervous System	3,012
Eye and Adnexa	4,025
Ear and Mastoid Process	4,007
Circulatory System	8,047
Respiratory System	13,876
Digestive System	6,476
Skin and Subcutaneous Tissue	9,775
Musculo-skeletal system and connective tissue	9,937
Genito-urinary System	6,738
Pregnancy, Childbirth and the Puerperium	348
Conditions of the Perinatal Period	59
Congenital Anomalies	309
Injury and Poisoning	5,832

Sources: Office of Health Economics. *Compendium of Health Statistics, 15th Edition 2003/04*.

## VIII. PRESCRIBING AND DISPENSING

Another possible indicator of increased workload in general practice is the amount of items prescribed. Between 1996 and 2002 the number of items prescribed increased by 24.6%, while the increase in GPs in the same period was 7.1% (Table 15). The rise in items prescribed was more pronounced between 2000 and 2002, due to a range of factors including national policy; new drugs becoming available and pressure from patients and the pharmaceutical industry. The National Service Framework (NSF) for Coronary Heart Disease was published in March 2000 and there is good evidence to suggest that GPs have embraced this approach through the prescribing data for statins, beta blockers and ace inhibitors. Spending in the NHS on life-saving statins is expected to rise to £694.7 million for the year 2003/04, an annual increase of 30%.<sup>6</sup>

A similar pattern of increasing workload can be seen in Table 16 which relates to dispensing doctors. Between 1992 and 2002 there was a 2.1% increase in the number of dispensing doctors while the number of items they dispensed increased by 55.8%.

The introduction of extended prescribing by nurses and pharmacists, as well as the spread of repeat dispensing schemes and the electronic transfer of prescriptions will make any future increase in prescribing and dispensing less onerous in terms of GP workload. By February 2004 over 1,400 nurses and nearly 100 pharmacists had been trained as supplementary prescribers and can prescribe any medication prescribable by GPs on the NHS (except controlled drugs or unlicensed medicines) in partnership with a doctor and within the limits of a Clinical Management Plan for the patient.

**Table 15: Number of Items Prescribed and Number of Practitioners, England, 1996-2002**

	1996	1997	1998	1999	2000	2001	2002	% Increase
<b>Number of Items Prescribed (millions)</b>	468	480	498	509	527	553	583	24.6
<b>Practitioners (excluding retainers)*</b>	29,116	29,389	29,697	29,987	30,252	30,685	31,182	7.1

Sources:

Prescription Pricing Authority, 2002.

\* *Statistics for General Medical Practitioners in England: 1993 – 2003*. London: Department of Health, 2004.

**Table 16 Number Items Dispensed by Dispensing Doctors and Number of Dispensing Doctors, England, 1992-2002**

	1992	1994	1996	1998	2000	2002
<b>Number of Dispensing Doctors</b>	4,396	4,577	4,783	4,783	4,959	4,489
<b>Items Dispensed by Dispensing Doctors (millions)</b>	32.1	35.5	37.6	40.6	44.3	50.0

Source:

Office of Health Economics. *Compendium of Health Statistics, 15th Edition 2003/04*. London: OHE, 2004.

## IX. ALTERNATIVE PRIMARY CARE PROVIDERS

One of the key changes in primary care activity has been the development of new services offering convenient health care alternatives, such as NHS Walk-in Centres and NHS Direct. NHS Direct currently handles over half a million telephone calls and half a million online transactions each month whereas the average number of visits by patients per day to Walk-in Centres has risen from 55 in December 2000 to 97 by December 2003 (Ref. 5).

**Table 17 Patients Using NHS Walk-in, Telephone and Online Services 1999-2003**

	1999/2000	2002/2003
<b>Patient Visits to NHS Walk-in Centres</b>	0	1,373,000
<b>Calls to NHS Direct</b>	1,650,000	6,319,000
<b>On-line Visits to NHS Direct</b>	1,500,000	3,972,487

Source:

*A Responsive and High-Quality Local NHS: Primary Care Progress Report 2004*. London: Department of Health, 2004.

It is not yet clear what impact these services have or will have on demand in general practice. A report in 2002 by the National Audit Office<sup>7</sup> suggested that NHS Direct has not yet had a visible effect on demand for NHS services but could reduce demand for services provided outside normal working hours by GPs. Since the report was written PCTs as part of the new contract provisions can commission out-of-hours services from NHS Direct which confuses this picture slightly. The 2004 *Primary Care Progress Report* (Ref. 6) suggests that: "NHS Walk-in Centres improve access for patients and can reduce pressure on other local primary care services and A&E departments through their extended opening hours – early until late seven days a week." However, the report provides no evidence to validate this assertion.

Another aspect to consider in regard to GP workload is the increasing skill mix in practice. Skill mix change in British primary care is largely focused on the transfer of tasks from GPs to less highly qualified professionals, such as task delegation from GPs to practice nurses. Although service efficiency and cost-effectiveness are paramount to this concept, it has also been suggested that the workload pressure on GPs could be reduced by allowing GPs to concentrate on the more complex cases. The NHS Workforce Development Confederation has estimated that 15% of all GPs work could be transferred to practice nurses and plans to transfer 10% of this workload by 2008.<sup>8</sup> A recent Dutch study<sup>9</sup> found that adding nurse practitioners to general practice teams did not reduce the workload of GPs, at least in the short term, implying that nurse practitioners are used as supplements, rather than substitutes, for care given by general practitioners.



## X. CONCLUSION

It is difficult to form a consistent overall impression of general practitioner workload, and it would be simplistic to use quantitative consultation based data as the sole measure of GP workload. Evidence-based practice, quality assurance and data collection mean that administrative workload outside of the consultation is becoming more complex. Additionally, the pressure on GP consultations is increasing through a combination of demographic and social changes. These particularly include: more elderly patients; patients for whom English is a second language; greater prevalence of chronic and multiple problems; better awareness of psychological and social aspects of suffering; a widening range of possible medical interventions; a greatly increased preventive health agenda; a shift of responsibility for chronic disease management from secondary to primary care; and, a reduced continuity in general practice.

The trend of shifting responsibility for chronic disease management from secondary to primary care and also locating the preventive health agenda in primary care is set to continue. The recently published second Wanless report<sup>10</sup> envisages greater costs associated with increased life expectancies and increased health seeking behaviour, such as people presenting themselves more frequently to GPs. Coupled with this will be the ability to keep people out of expensive acute services, for instance, through improved chronic care management and the integration of health and social care. Further evidence of the shift in workload from secondary to primary care is the dramatic increase in the amount of specialist services available in family practices. In 2003 more than 700,000 minor surgical procedures were carried out in local practices that were, until recently, only available in hospital. This is an increase of 100,000 on the previous year (Ref 6).

## WEBSITES OF INTEREST

Statistics for General Medical Practitioners in England: 1993 – 2003.

<http://www.publications.doh.gov.uk/public/sb0403.htm>

Living in Britain. Results from the 2002 General Household Survey.

[http://www.statistics.gov.uk/downloads/theme\\_compendia/lib2002.pdf](http://www.statistics.gov.uk/downloads/theme_compendia/lib2002.pdf)

ISD Scotland. General Practice Datasets for Scotland.

[http://www.isdscotland.org/isd/info3.jsp?pContentID=1044&p\\_applic=CCC&p\\_service=Content.show&](http://www.isdscotland.org/isd/info3.jsp?pContentID=1044&p_applic=CCC&p_service=Content.show&)

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<http://www.dh.gov.uk/assetRoot/04/07/93/97/04079397.pdf>

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[http://www.wdc.nhs.uk/bulletins/bulletin\\_77.php](http://www.wdc.nhs.uk/bulletins/bulletin_77.php)

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<http://bmj.bmjjournals.com/cgi/content/full/328/7445/927>

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