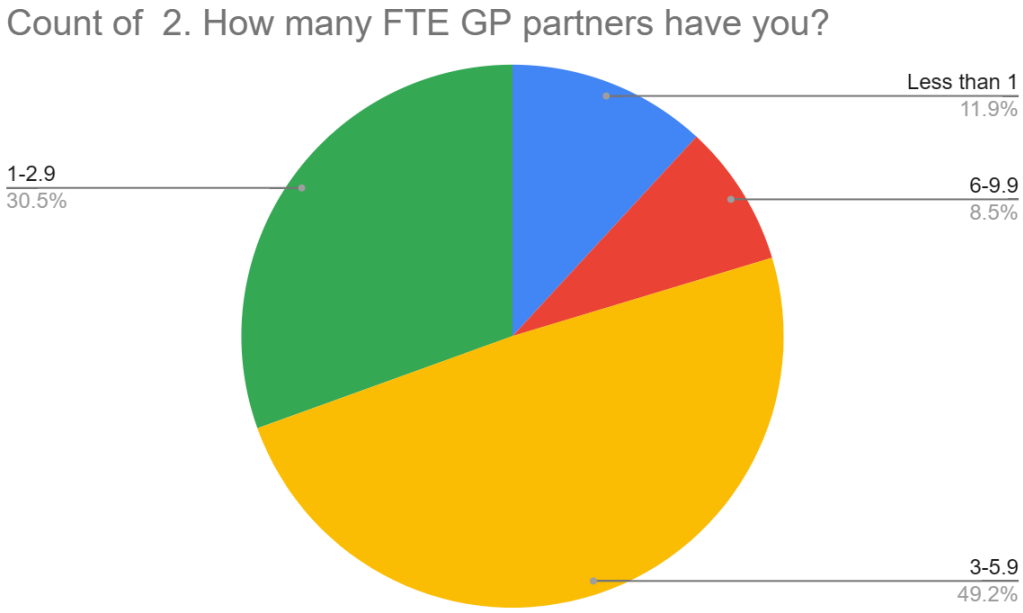
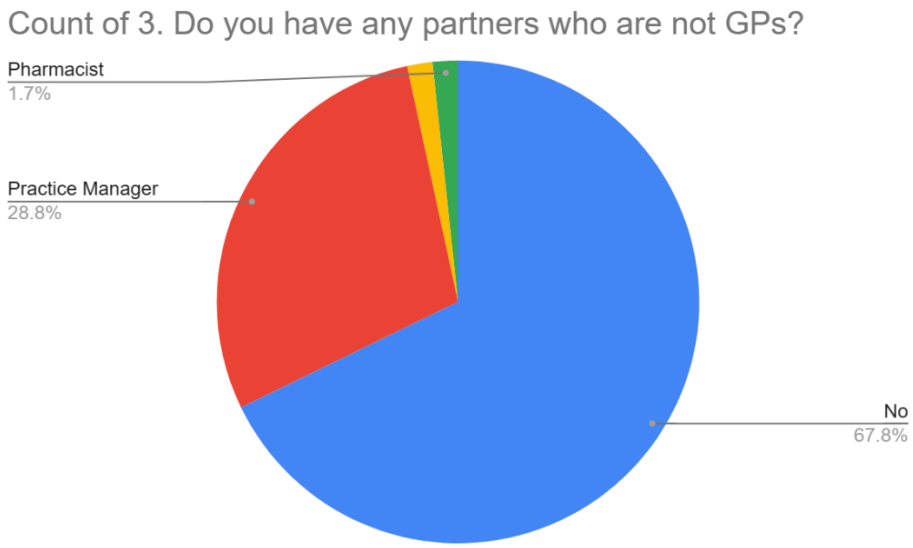
Leeds LMC Survey Results

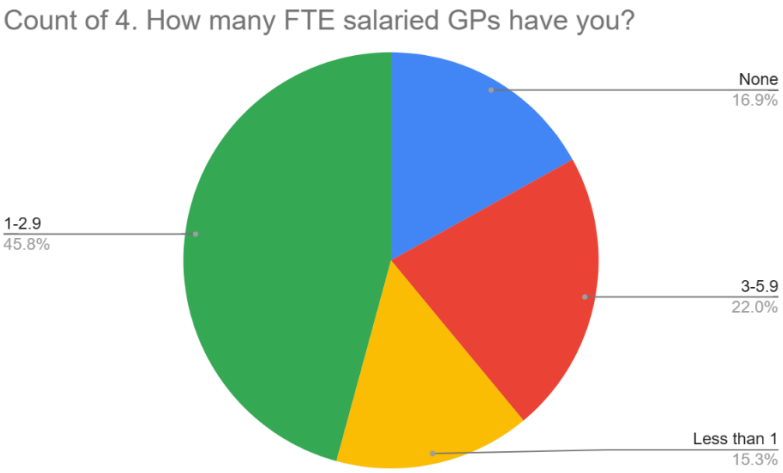
Leeds LMC carried out a workforce and work pattern survey in February 2022. The survey received responses from 59 practices.

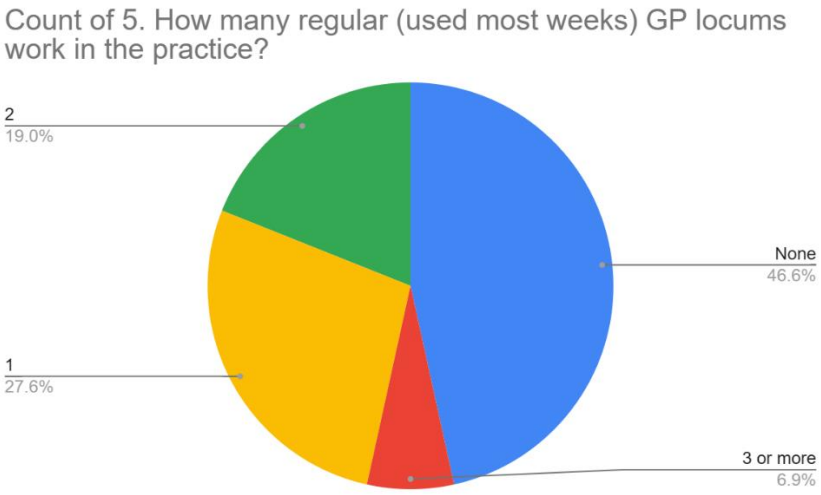
The survey illustrates the range of size of practices in Leeds, with over 90% having a partnership with less than 7 FTE partners, although the head count number will be higher. Over 30% of practices now have a practice manager as a partner with one practice having a pharmacist and another a nurse as a partner.



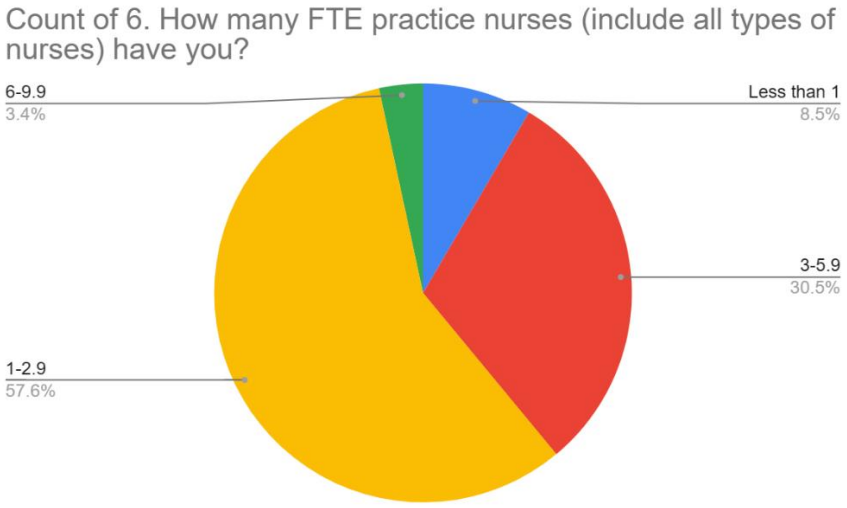


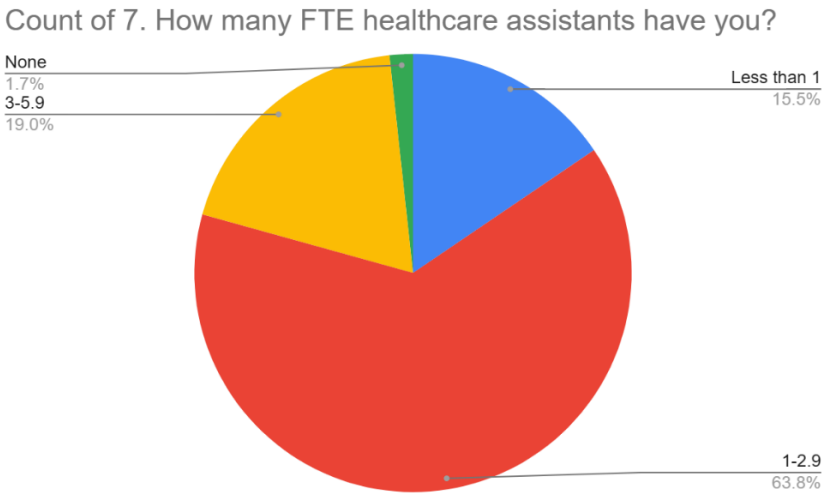
Despite the national trend of a fall in the number of partners and increased proportion of salaried GPs it is of note that 16.9% of practices in Leeds have no salaried GPs, although 22% of practices have between 5-6 FTE salaried GPs. Almost half of practices do not use regular locums, but 6.9% are dependent on 3 or more regular GP locums, a sign of recruitment issues.

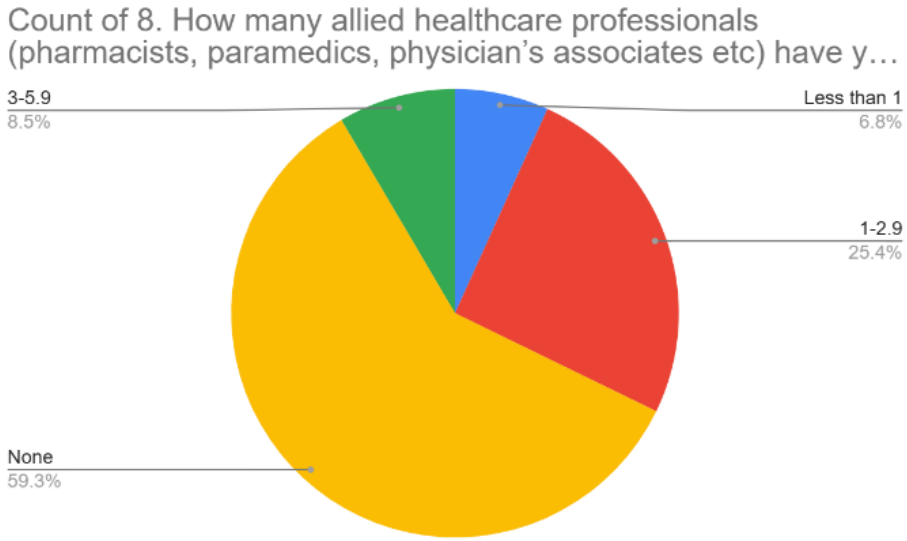




2/3rd of practices have fewer than three FTE nurses, but 84% have more than one FTE healthcare assistant and 40% now employ another allied healthcare professional, in addition to those who are employed by their Primary Care Network.

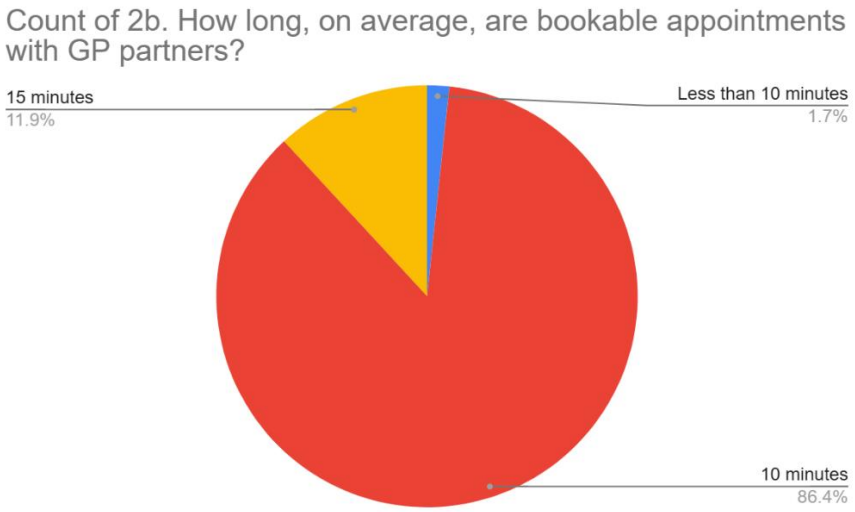


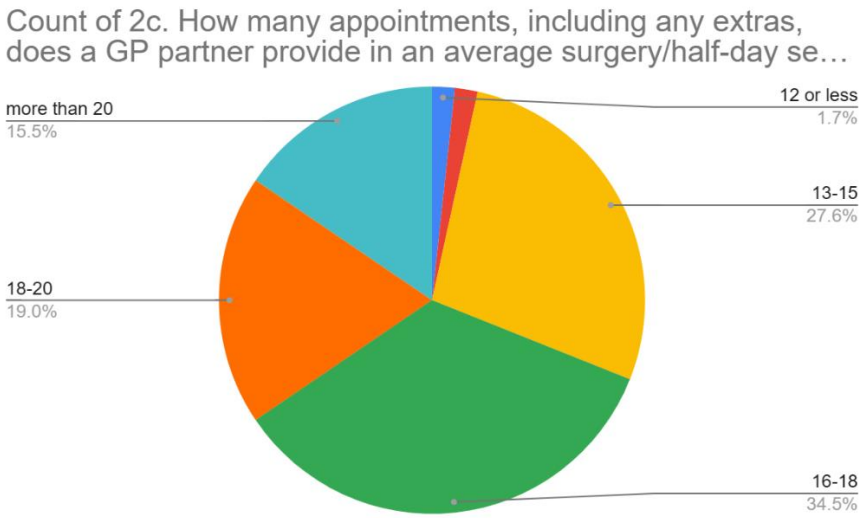




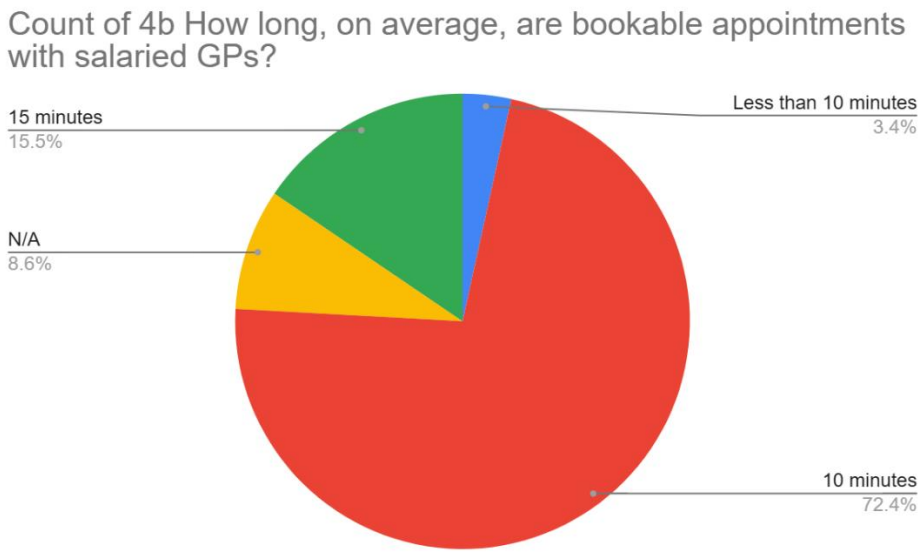
Appointment data

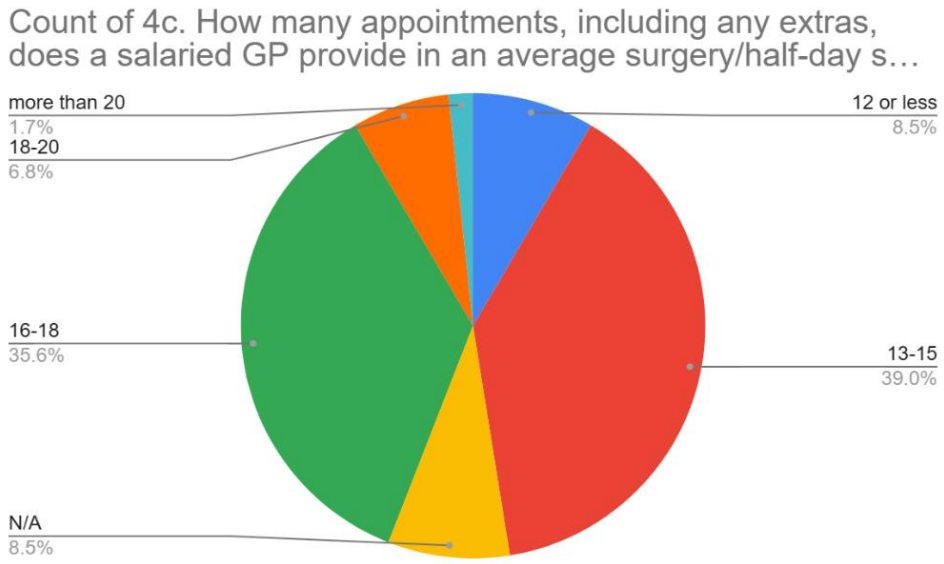
The vast majority of GP partners continue to have 10 minute appointments, with only 7 practices (11.9%) having an average of 15 minutes for bookable appointments. No practices were routinely offering 20 minute bookable appointments with partners. 42% of GP partners will deliver between 13-18 appointments in a half-day session, with the commonest arrangement being for between 16-18 appointments per surgery session. Typically this would mean 26-36 appointments per day. However, 1/3rd (34.5%) of GP partners are delivering 18 or more appointments per session, or 36 or more each day.





There is a little more variation in appointment length for salaried GPs, although 72.4% offer 10 minute booked appointments, with only 9 practices (15.5%). Salaried GPs typically have fewer booked appointments in a half-day session than GP partners, with almost half (47.5%) having 15 appointments or less per surgery session.



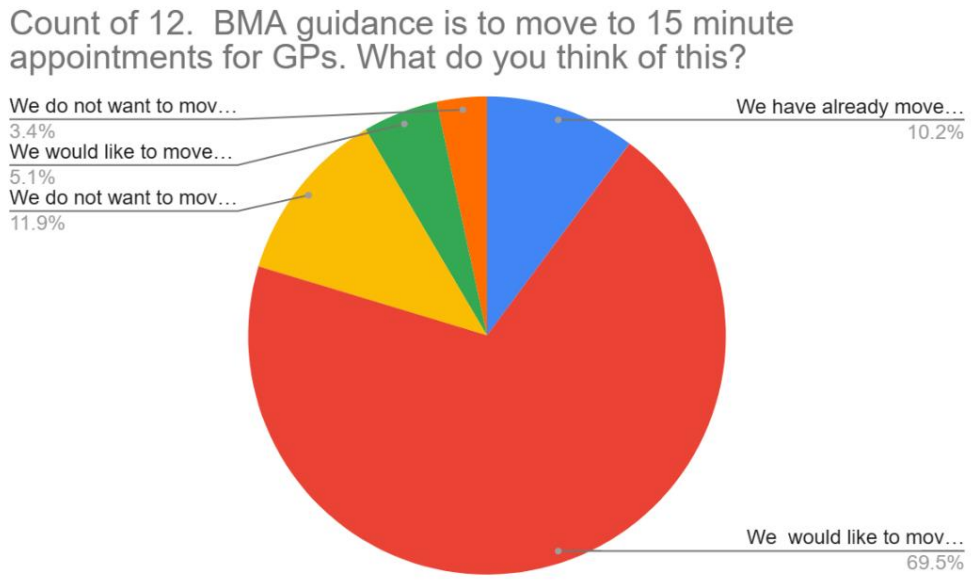


Practices adjust the length of appointments based on the characteristics of patients and their specific needs.

	Number of practices
Yes, for those who need translation services	49
Yes, for those with specific healthcare needs	46
Yes, for specific procedures	44
Yes, for specific named patients	24
No	4

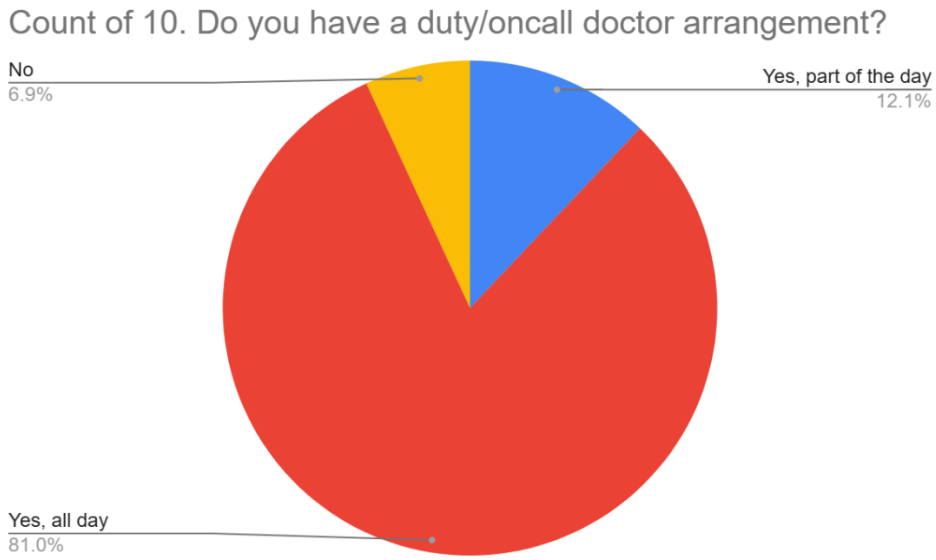
41 responding practices (69.5%) would like to move to 15 minute appointments but do not think it is practical as the number of appointments would reduce and it would increase

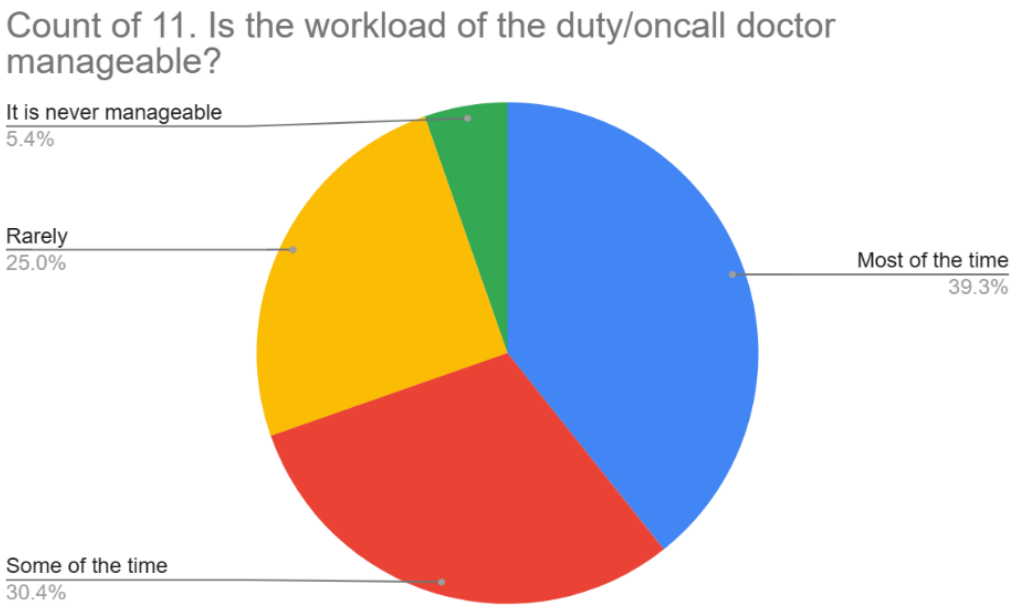
pressure elsewhere in the practice. A further 3 would like to but don't think it's practical because it would increase the length of a typical surgery. Nine practices (15.3%) do not want to move to 15 minute appointments as most offered a flexible range of appointment times currently. 6 practices already offer 15 minute appointments routinely and



Workload

Most practices have a duty doctor arrangement with only 4 respondents not having this. For 39.3% the workload for the duty doctor is manageable most of the time, and for another 30.4% the workload is manageable some of the time. However a seriously concern is that for a quarter of practices the workload is rarely manageable and in 3 practices (5.4%) the workload was never manageable.





Practices offered a range of suggestions on what works well for them in helping the practice to manage demand. These included:

Good signposting, clever use of embargo slots, GP flexibility

e-consultations

On-call GP is set up to react throughout the day to urgent calls

Total Triage and use of eConsult to manage and prioritise patient demand

Providing additional appointments on the day depending on demands

Almost all appointments are book on the day - either bookable online or by contacting the practice

Reception signposting; message on the answering machine to say we are at safe capacity (urgent only)

Care Navigation by the Patient Support Team

Constant re-evaluation of appointments that have been booked for signposting/ appropriateness

More GPs working on Monday managing already booked appointments and a triage list that is extended to allow for demand on Mondays

Requesting all clinicians help / support on-call GP with admin tasks due to workload

Care navigation by receptionists to the Pharmacy scheme, FCP physio and Healthy Minds.

Opel reporting & support from extended access, bookable hub and extended access appointments evenings and weekend, team working between the GP team to support the on-call doctor

We have a shorter afternoon surgery for the on-call doctor to allow them to deal with urgent triage calls and queries. Allocated time for the on-call doctor to deal with urgent medication queries/tasks

Restricting the number of e-consult requests and requests for telephone calls once all appointments full

We have freed up the duty doctor from routine work and split the day in to two halves. The duty doctor also has support from a second GP.

Care navigation, e-consults, sick notes by text, pharmacist to deal with prescribing issues, time in day to sort through e-consults, reducing the hours e-consults are open

Realistic expectations from patients

Very few bookable appts for duty doc so that we have time/flexibility to manage the queries, triage urgent extras, meds management. Clear messaging and training for reception about signposting and alternatives if we have reached safe capacity

Practices were asked to choose the top three actions that would make the biggest difference to reduce workload and improve the practice workforce wellbeing. The top three responses were to increase the practice workforce, something currently prevented by the underinvestment for many years in core contract funding, a reduction or removal in national targets, something that has only be partially delivered through the most recent contract imposition, and a reduction in work transferred from secondary care, which has seen a big increase during and since the COVID-19 pandemic. However the government and NHS England's agenda has been to promote an expansion of the PCN workforce and greater use of community pharmacy, and yet neither of these two proposals are seen as significant solutions to reducing practice workload and the pressures this causes.

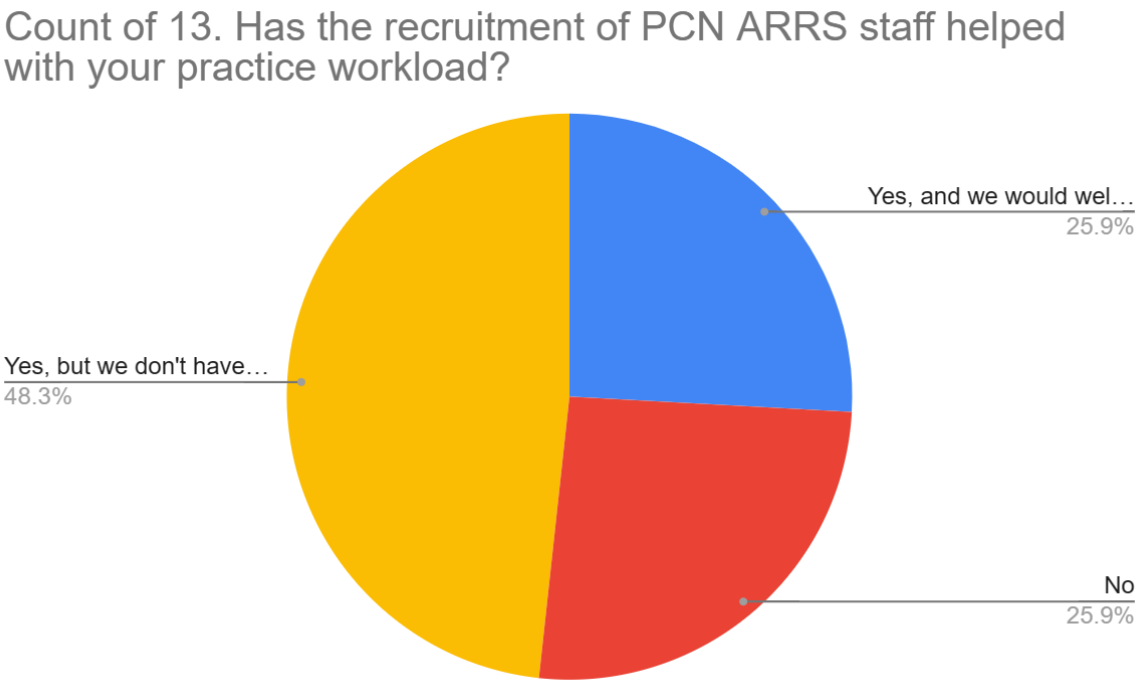
What would make the biggest difference to reduce practice workload and improve wellbeing?	**No of practices**	**Percentage of practices (%)**
Increase the workforce in the practice	40	68
Reduce/remove national targets (such as QOF, IIF)	39	66
Reduce work transferred from secondary care	36	61
Reduce/remove local targets (such as QIS)	29	49
Transfer more work to extended access, same day access services	13	22
Increase the workforce in the community team	12	20

Increase the workforce in the PCN	10	17
Reduce attendance at external meetings	8	14
Transfer more work to community pharmacists	7	12
Other (please specify)	4	7

PCN workforce

The PCN employed workforce has significantly increased in Leeds since the development of primary care networks in 2019, and 74% of practices would like to welcome more. Most practices now have the support of pharmacists which is improving the quality of prescribing, paramedics are doing many home visits as well as practice based clinics, social prescribers are supporting vulnerable people across the city, physiotherapists have been able to offer much earlier reviews than the existing physiotherapy service which had very long waiting times, physician associates and occupational therapists are reviewing patients with long-term conditions and multimorbidity and wellbeing coaches are promoting healthier lifestyles. Increasingly other healthcare professionals are joining the PCN teams, but one of the biggest challenges is the lack of space in many practice premises to enable these new members of the general practice team to consult with patients, with 48.3% responding that they would welcome more PCN employed staff but don't have the space for them.

However, as highlighted above, although most practices would welcome more staff they do not see them as a significant solution to workload pressures, as in many cases staff have focused on other targets previously unmet need.



Practices were asked to share their views on PCN recruitment and they said:

PCN recruitment is great but generally has managed areas that don't directly impact on practice workload and in some cases can increase practice workload

More spaces needed to accommodate more staff

We are in a proactive PCN so relatively happy although sharing between member practices prorate, so overall appointments offered are very few

Need more flexibility around funds and roles so can tailor needs to practice demands

First contact physios have helped with MSK issues but unsure that other roles are helpful

So helpful to us but estates is a real problem.

They are great but they have their own workload so no real workload saving to the practice.

Some excellent staff, but often shared too thinly and no space to offer any of the PCN staff a place to work from.

Don't seem to make an appreciable difference to workload except physio. Funding would be better spent by practice. (Non- clinical) oversight of staff seems not as strong as it could be.

The staff recruited are not the staff needed, practices should have the money to employ what they need. PCN social prescribers and wellbeing coaches were supposed to complete our SMI patient and patients with high BP - this wasn't achieved and came back to practices who are already snowed under with all other elements of contractual requirements.

We don't have space at the surgery but find that remote working is very welcome and patients don't seem to mind it.

I think the workload has increased, therefore we don't see the benefit of PCN staff

They take time to train and have much longer appointment times so see less patients and can increase GP workload of patient coming back to see GP

Care coordinator to support care homes has been helpful

The PCN salaries should be the same as practices as surgeries are losing staff as they are being offered more money to do the same job for the PCN, often working from home. This does not help with the recruitment difficulties or retention of staff.

Useful but not huge impact on workload

Difficulty recruiting PCN staff

PCN staff have a DES to achieve which is unachievable

Estates is a major problem for our PCN, as we are pressured to employ more, with no regard to where they will work from. Assistance with funding to extend existing estates is complicated and doesn't appear to be on the NHS radar

Has been helpful but not a complete solution as patients still want to see a doctor

Our size is so small we are often forgotten - we have no space to put staff into and no computer for them to use, ARRS is almost worthless even after 4 years.

The ANP who helped with visits x2 days per week was withdrawn 2 years ago and not replaced

Unfortunately recruitment and retention has been challenging re pharmacists.

Because it takes a lot of training, support and the majority of the work they do does not take away from the GP's but it does improve quality which may over time help

PCN ARRS staff have picked up workload but this just opens GPs to the unmeasured unmet demand

No estates to put them, hard to integrate ARRS staff when working across multiple practices

Not the full solution- really we need more GPs

We struggle with PCN recruitment, there are too many PCNs looking for the same staff

Conclusions

The LMC survey clearly demonstrates that practices in Leeds have become growing multidisciplinary teams but remain under significant workload pressures. GP partnerships are increasingly being joined by practice managers and other healthcare professionals. Practices in Leeds are using a variety of ways to manage same day and urgent demand and whilst many would like to be able to offer longer appointments the large majority do not think this is practical. We have largely welcomed the new PCN workforce but there are major concerns about the lack of space available in practice premises and this will inhibit their ability to consult with patients and become fully active members of the practice team. Further work and training is needed to enable the new workforce to make a noticeable contribution to practice workload reduction. However what practices really want is investment in to core practice funding to enable them to recruit GPs, nurses and others, as well as national action to reduce unnecessary targets and bureaucracy, as well as local action to tackle unfunded workload shift from secondary to primary care which often inconveniences patients as well as adding unnecessarily to practice pressures – something the new Integrated Care Board show see a priority.