Twenty four hour care in inner cities: two years' out of hours workload in east London general practice

Anna Eleri Livingstone, John Anthony Jewell, John Robson

Abstract

Two inner city general practices in east London jointly provide care outside normal working hours without using deputising services for about 14 000 patients. The statistics on workload were reviewed for 1987 and 1988. An overall rate of face to face consultations of 4.1 per patient per year was recorded, there being 115 965 consultations over two years for a mean list size of 14 174 patients. Four per cent (4737) of such consultations were outside normal working hours. The annual rate of visiting outside normal hours was 128.1 per 1000 patients in 1987 (1793 visits) and 131.5 per 1000 in 1988 (1888 visits). The rates of night visiting were 18.8 (262 visits) and 18.9 (271 visits) per 1000 patients in 1987 and 1988 respectively. Only 24% of all the requests for medical help out of hours (1483/6220) were dealt with by advice given on the telephone.

The high rates of consultation outside normal working hours with only a small proportion being dealt with on the telephone alone may be explained by indices of deprivation. Local rotas for out of hours work are a good compromise between meeting the needs of patients and doctors in deprived areas, but there are financial implications for inner cities.

Introduction

There is still a shortage of data on the workload of general practitioners working in deprived areas, although what data there are suggest that it is heavier and more taxing than in prosperous areas. This study not only is part of an ongoing audit by the practices concerned but also documents workload in inner east London as a contribution to the discussion of appropriate patterns of care, staffing, and remuneration in deprived areas.

Despite longstanding government recognition of the health problems of inner cities the "inverse care law" still applies,¹ and there has been little effective change in policy. The 1981 Acheson report on primary care in inner London made 115 recommendations.² Few have been acted on. Tower Hamlets lags 15 years behind England and Wales as a whole in the development of general practice when indicators such as growth of group practice, purpose built premises, and employment of ancillary staff are considered.³ The contraction of hospital services in the 1970s and 1980s has been pronounced in inner London.⁴ In Tower Hamlets five accident and emergency departments have closed in the past 15 years despite the strong tradition of patients using such departments for primary care in the district.

We present statistics for the workload outside normal working hours in two closely linked practices in the E14 district of Tower Hamlets over two years. We have not attempted to describe the nature or outcome of calls or to define what is an appropriate call to

general practitioners outside normal working hours. Doctors' and patients' views on what constitutes an appropriate out of hours call would differ somewhat, and detailed discussion of illness associated with social class and the non-medical factors leading to calls lie outside the remit of our audit.

Practices and methods

The patients served by our practices are among the most deprived in England and Wales. The figure shows the high deprivation indices for the wards in our practice according to Townsend and Jarman scores (see appendix).^{5,6} Housing is poor and mostly owned by the local authority, and rates of telephone and car ownership are low. We have a high proportion of young children and single parent families. It is a multiracial area, with over 40% of births in the district being to mothers of Bangladeshi origin. Our annual rates of patient turnover are up to a fifth.

Joint practice area showing Townsend Z scores (numbers on hatching) and Jarman underprivileged area indices* for each ward based on data from 1981 census. Townsend Z scores in greater London range from 8.42 to -11.01 (average 0) and Jarman underprivileged area indices in England from 72.95 to -62.52 (average 0)

Both practices grew in the early 'eighties from the merging of several traditional, mainly singlehanded east end practices, which used to delegate calls outside normal working hours (out of hours calls) to deputising services. They are now staffed by eight local vocationally trained principals (four men and four women), and the two health centres are open from 0830 to 1830 from Monday to Friday. All eight principals and the trainees cover out of hours calls on a rota. Out of hours calls are those received at weekends, on bank holidays, and between 1830 and 0830 on weekdays. The patient telephones a commercial medical answering service, which pages or telephones

Gill Street Health Centre,
London E14 8HQ
Anna Eleri Livingstone,
MRCGP, general practitioner

Chrisp Street Health
Centre, London E14 6PG
John Anthony Jewell,
MRCGP, general practitioner
John Robson, MRCGP,
general practitioner

Correspondence to:
Dr Livingstone.

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TABLE 1—Out of hours workload and overall consultation rates (per 1000 patients per year) in 1987 and 1988 based on family practitioner committee list*

	1987		1988	
	No	Rate	No	Rate
<i>All out of hours consultations</i>				
Total consultations	3 137	224.1	3 083	214.9
Emergency surgery	560	40.0	496	34.6
Visits	1 793	128.1	1 888	131.5
Telephone advice only	784	56.0	699	48.7
Total consultations in person	2 353	168.1	2 384	166.1
<i>Consultations from 2300 to 0700</i>				
Total consultations	445	31.8	453	31.8
Visits	262	18.8	271	18.9
Telephone advice only	183	13.1	182	12.7
<i>Consultations during normal working hours†</i>				
Total consultations in person	54 389	3 885.5	56 839	3 961.4
Attendances	50 445	3 603.6	53 028	3 695.8
Visits	3 944	281.8	3 811	265.6
<i>Consultations per 24 h†</i>				
Total consultations in person	56 742	4 054.6	59 223	4 127.6
Attendances	51 005	3 643.6	53 524	3 730.4
Visits	5 737	409.9	5 699	397.2

*Mean joint list size according to family practitioner list rose slowly from 13 864 to 14 483 over period of study. Annual figures are averages of quarterly figures with list sizes at start of quarter taken as denominator.

†Excluding advice given on telephone.

the doctor on duty. When possible the doctor telephones the patient to give advice and determine whether a visit is necessary. There is a joint, open access, emergency surgery from 9 to 11 on Saturday mornings, which is staffed by the doctor on duty. Regular meetings are held of all doctors concerned to discuss the organisation and clinical management of work outside normal working hours.

The doctor on duty records all out of hours visits, advice given on the telephone, and attendances at Saturday's emergency surgery on a specially stamped card (FP8). These cards have to be delivered to the patient's own doctor by 0900 on the next working day. Receptionists record administrative details and the doctors transcribe clinical information on to the A4 medical record, where the card is retained.

Our practices keep statistics on attendances at surgeries and on home visits during normal working hours. The list size is taken to be that kept by the family practitioner committee. In areas of high patient turnover therefore the committee's list may overestimate the number of patients and hence underestimate consultation rates. Because ours are recently established practices we believe that our registered lists do not share the overall rate of list inflation of 19% reported to us by the City and East London Family Practitioner Committee, of which we are a part.

Our statistics cover the time from 1 January 1987 to 31 December 1988.

Results

In the two years of the study a mean population of 14 174 received 3681 visits after hours, 533 of which were requested and carried out between 2300 and 0700 (table I). Advice was given on the telephone alone in 1483 consultations, which was 24% of the total

6220 consultations outside normal working hours. Between 2300 and 0700, 365 calls entailed giving advice on the telephone alone, which was 41% of the total 898 consultations at this time. On average sleep was disturbed just over once a night when a doctor was on duty. There were also 1056 attendances at the emergency surgery, which was 17% of the total number of consultations outside normal working hours.

During the study there were 115 965 face to face consultations, 4737, or 4%, being outside normal working hours. Table I shows the numbers of patients consulting a general practitioner and the consultation rates per 1000 patients in 1987 and 1988.

Discussion

The high rates of consultations outside normal working hours that are characteristic of deprived areas are confirmed by our results. Table II shows the high rates of all out of hours consultations and those at night in practices in deprived urban areas, including ours, compared with other urban and rural settings. City and East London Family Practitioner Committee pays FP8 claims at the rate of 15.2 per 1000 patients (18.1 corrected for inflation). Most of these calls are dealt with by deputising services, which cannot usually give advice on the telephone.¹² The potential workload is greater still as it is well documented that patients attend accident and emergency departments in Tower Hamlets with problems more appropriately managed in general practice. Davison *et al* found that 86% of the subjects in their sample attended our local accident and emergency department without having previously consulted their general practitioner.¹³ They also considered 39% of the conditions to be neither accidents nor emergencies.

In our practices advice was given on the telephone alone in 24% of all calls (1483 out of 6220) and in 41% (365 out of 898) of night calls (from 2300 to 0700). In Cleveland Marsh *et al* gave advice on the telephone in 60% of the calls outside normal working hours,⁹ which suggests a lower threshold for responding to a call with a home visit in deprived areas. As Riddell said, "The young or lone parents were ill-equipped to cope even with advice."⁷ Low rates of telephone ownership and high rates of broken callboxes also decrease the extent to which advice can be given on the telephone. Our consultation rate per 24 hours is high at over four for each patient on the list a year, but crude rates do not adequately describe workload. They do not show the content and duration of the consultations, the difficulties encountered with patients with multiple problems and language problems, the difficulties of access in home visits, or the time spent in meetings, liaison, and administration.

The Acheson report criticised the inaccessibility of many inner London general practitioners and the problems incurred in the heavy use of deputising services.² We have not used deputising services in our practices in an attempt to improve the quality of care. In improving accessibility by day and night we have undoubtedly increased the workload of the practice. As a team we provide continuity of care, with prompt

TABLE II—Variation in call rates reported by practices (per 1000 patients per year) in relation to type of area

Location	Type of area	List size	Year	Out of hours calls (2300 to 0700)			Out of hours calls (total)			
				Telephone	Visit	Total	Telephone	Visit	Surgery	Total
Inverclyde	Industrial	63 249	1982-4		35.2		Not available			
East London	Inner city	14 174	1987-8	12.9	18.8	31.8	53.4	120.3	37.3	219.5
Glasgow	Housing estate and inner city	19 730	1977		16.8			83.3		
Stockton on Tees	Suburban	15 669	1984-5	9.8	13.6	23.4	76.1	47.5	6.3	129.9
Whitby ¹⁰	Coastal town and rural	15 274	1974		10.6		Not available			
Kent ¹¹	Rural	12 000	1979	8.3	7.7	16.0			Not included	122

handover and consistent policies of management. We are familiar with local hospital and community resources and staff, have access to medical notes, know the area, and are often known to the patients.

Discussion of the provision of out of hours care is a notable omission from the white paper on primary care¹⁴ and *Working for Patients*.¹⁵ These have been followed by the proposed new contract,¹⁶ which would give lower payments for deputised night visits but does not clarify support for local rotas such as ours.

Out of hours work is stressful as well as at times rewarding. This may contribute to the high use of deputising services by inner city general practitioners.¹⁷ Fatigue is known to impair judgment, and despite a rota we still have times when we are on duty continuously for 36 hours.¹⁸ Doctors visiting on their own may worry about increasing violence in inner city areas.¹⁹ Finally, general practitioners need to live near their practices, which in London often combines deprived surroundings with prohibitively expensive housing. Our practices have not achieved the review body's target net remuneration and confirm the findings of Bosanquet and Leese of a low gross income per partner in inner London.²⁰ A London weighting allowance for high expenses as well as a deprivation allowance for high workload would help us achieve average income.

Good quality out of hours care in general practice in deprived areas of London has financial implications. If the care is provided by local practices staffing has to be adequate and therefore list sizes have to be small enough to provide time off to recuperate without loss of earnings or placing an intolerable burden on partners. All out of hours work should be better recompensed as the long hours worked are both stressful and poorly paid. With a high patient workload list sizes need to be smaller to cope. Though other alternatives have been proposed,^{9,21} we believe that well financed local rotas for out of hours work provide the best compromise between meeting the needs of the patients in deprived areas and those of their doctors.

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Appendix

JARMAN AND TOWNSEND DEPRIVATION SCORES

Over the past decade several scores have been developed that aim at ranking areas in terms of deprivation or workload

for health services. The Townsend Z score aims at being an economic indicator and is a multiple deprivation index giving four variables from the census (unemployment, overcrowding, renting, and not owning a car) equal weight.¹ It specifically excludes variables such as age and ethnic group as not being in themselves directly representative of economic state.

The Jarman underprivileged area index, on the other hand, is an indicator of workload in general practice.⁶ It is a weighted score of eight variables from the census that are not amenable to intervention by the health services—that is, the numbers of elderly people living alone, children under 5, lone parents, and unskilled and unemployed workers; overcrowding; changing address; and belonging to an ethnic minority group. The eight variables were derived from a national survey of factors that general practitioners considered affected workload from among those mentioned by doctors in London to the Acheson committee. The score was developed as a way of locating areas where extra support might be given to general practice and has in fact been adopted as the basis for the weighted capitation fee in the government's new contract for general practitioners.¹⁶ It has, however, been criticised for giving low weighting to areas with, for example, high morbidity, mortality, and unemployment, but low proportions of elderly people or people from ethnic minority groups. It is a useful indicator of inner city workload but is not a direct measure of deprivation.

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MATERIA PARAMEDICA

The prick test

The prick test has been in steady use for many decades in the diagnosis of specific allergies in atopic subjects. A small drop of the suspected allergen in solution is placed on the skin. A pricker, preferably one specially designed for the purpose, enters the droplet and pierces the epidermis with a slight plucking motion. A positive response, indicating the presence of immunoglobulin E to the allergen, is manifested within minutes by the appearance of a weal surrounded by a hyperaemic zone, the flare.

Allergy to semen is fortunately exceedingly rare. It is, however, well documented. The response may be asthmatic or anaphylactic. A case of semen allergy was described some years ago at a meeting of the British Society for Allergy and Clinical Immunology. A married woman suffered severe and immediate symptoms after conjugal intercourse. A member of the audience asked if the patient had tried intercourse with an extramarital partner, and if so with what result. Yes, was the reply, she had, and

without ill effect. A wit in the audience exclaimed, "The prick test!"

The use of "prick" for "penis" is now vulgar slang, but it was not always so. *The Oxford English Dictionary* quotes: (1592) "The pissing Boye lift up his pricke." John Aubrey, in the latter half of the seventeenth century, wrote of the lawyer John Selden (1584-1654) that his advancement was achieved more by sexual favours than by professional ability:

He came to the Inner-Temple . . . and was Solicitor and Steward to the Earle of Kent, whose Countesse being an igeniose woman and loving men, would let him lye with her. . . . I remember my Sadler (who wrought many years to that Family) told me that Mr Selden had got more by his Prick then he had done by his practise. He was no eminent practiser at the Barre.¹

BERNARD J FREEDMAN

1 Dick OL. *Aubrey's brief lives*. Harmondsworth: Penguin, 1972:433-4.