Practice activity analysis 6. Visiting profiles

FROM THE BIRMINGHAM RESEARCH UNIT OF THE ROYAL COLLEGE OF GENERAL PRACTITIONERS

THIS report is based on the first 110 proformas received and analysed, which concerned 37,679 consultations. These took place in late November or early December, 1977. Recorders were self selected and are not necessarily representative of general practitioners nationally.

Results

The consolidated results are presented in Grid C as in the retained analysis slip of the original proforma. A total of 5,925 visits was undertaken which approximates to one visit for each five consultations in the practice centre. Visits are either requested by the patient (P) or initiated as a follow-up by the doctor (Dr). Variation among the recorders is detailed in Table 1. The 110 recorders are divided into five groups each containing 22 recorders. The maximum and minimum rates of visiting, together with those rates which separate the groups, are presented.

Small increases were found in the visiting rates of doctors with relatively few consultations (less than 250) compared with those reporting large numbers (more than 350). This is probably a reflection of the fact that scattered and rural practices tend to be smaller than those in urban areas.

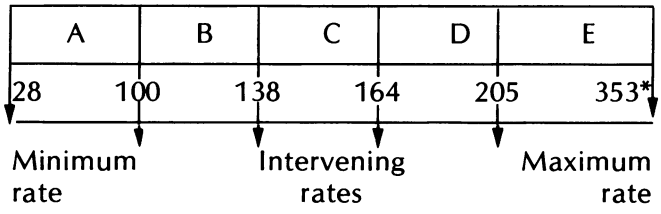
Every doctor made at least one visit, though two made no follow-up visits at all (Table 2).

Table 2 may be used in conjunction with Grid C to make two points:

Grid C. Visits by age group (number and rates per 1,000).

Age		P	Dr	Total
Less than 12 months	Number	138	33	171
	Rate	3.7	0.9	4.5
1-14 years	Number	580	65	645
	Rate	15.4	1.7	17.1
15-64 years	Number	1,257	743	2,000
	Rate	33.4	19.7	53.1
65 + years	Number	1,326	1,783	3,109
	Rate	35.2	47.3	82.5
Total	Number	3,301	2,624	5,925
	Rate	87.6	70.0	157.3

Table 1. Total visiting rates (per 1,000 consultations) in each of five groups of 22 recorders.



*Excludes one recorder whose visiting rate was 720 per 1,000.

Table 2. Number of recorders making no visits by specified category of visit and age group.

Age group	P	Dr	Total
Under 12 months	50	94	47
1-14 years	8	73	8
15-64 years	1	10	0
65 + years	0	5	0
Total	0	2	0

1. As might be expected, visiting is maximal in the 65-plus age group. More than half the visits made were to elderly people (3,109 out of 5,975). This was the only group in which doctor initiated follow-up visiting exceeded those visits requested by patients. There was a wide variation among doctors, ranging from the five who made no follow-up visits in this age group to one who made 68. The problems surrounding practices in scattered communities lead to increased visiting, but this is less important than the behavioural variation among doctors because there is greater variation in the results for follow-up visits than for new visits.

2. Eight hundred and sixteen visits were made to the youngest two age groups (i.e. less than 15 years), and 718 of these were in response to patient requests, leaving only 98 doctor initiated follow-up visits. Follow-up visiting among children was not undertaken to any great extent. Only six of the recorders made a follow-up visit to a baby (under 12 months) in the study fortnight, and 17 to a child (1 to 14 years).

Acknowledgements

The Birmingham Research Unit in association with the Department of Engineering Production of Birmingham University thank recorders for sending in their returns, and Messrs Reckitt and Colman, Pharmaceutical Division, who sponsored the series.

National Conference of Postgraduate Advisers in General Practice

THE thirteenth meeting of the National Conference of Postgraduate Advisers in General Practice of the UK was held at the College on 1 December 1977. Dr Alistair Donald took over as Chairman from Dr John Hasler. Dr Hasler was warmly thanked for the authority and distinction he had brought to the task of Chairman of the Conference.

The Conference continues to perform a useful function in providing a medium for exchanging ideas about the different ways of resolving the problems which beset all advisers. For example, there is concern about the future of training for women doctors who want to enter general practice but cannot work for more than half the usual time. The NHS (Vocational Training) Act (1976) requires that provision should be made for such trainees and the present regulations already allow for this. Implementation, however, depends on the availability of funds for training posts in hospitals. It is rarely possible for two women to cover one established post, though this has occasionally been achieved. It also depends on the willingness of trainers to accept them. The amount of time and reorganization of the practice required for part-time traineeships is similar to that for full-timers, yet at present the trainers' grant is spread over two years, which means that there is little incentive.

The advisers are also concerned about the present regulations covering the appointment and reappointment of trainers. There are several aspects of Paragraph 38 of the Statement of Fees and Allowances (NHS General Medical Services, 1972-8) which are regarded as unsatisfactory. The General Medical Services Committee is, of course, represented by an observer at the Conference, and several advisers are also members of that Committee, which gives them the opportunity to put forward the advisers' views to those negotiating on the profession's behalf.

Another problem aired at the Conference was that of overlap of trainees in teaching practices. Many of those involved in organizing vocational training schemes consider that a splitting of the 12 months' traineeship into two, not necessarily equal, parts is educationally desirable. This may involve one trainer having two trainees for a few weeks, one completing his training and the other beginning. Furthermore, with the absence of women trainees on maternity leave or any trainee on sick leave, rotations can sometimes get out of phase. Women may return to join their traineeships after having their babies later than originally planned and this again can give rise to clashes. At present the Department of Health and Social Security allows only three weeks' overlap but the advisers are of the opinion that the length of overlap should be entirely dependent on educational considerations and that such decisions should be left to regional postgraduate committees and their general-practice advisory committees.

Visits by teams from the Joint Committee on Postgraduate Training for General Practice again formed a major subject for discussion, and for this the Conference was joined by members of the Joint Committee and visitors who were not themselves regional advisers. Some advisers are concerned about the time taken in preparing for, and reacting to, these visits. They advocate that, at the most, they should occur at two-yearly intervals, or possibly even three. They have also been critical of the relatively minor impact of the Joint Committee on the content of hospital posts. In view of the imminent tabling of regulations for implementation of the Vocational Training Act, it is vital that the posts used for training