Cambs LMC Black Alert Practice Action Tool

Technical Notes

These notes are intended as a guide to how to complete the Black Alert Practice Action Plan. Following the description of each field and how best to complete there is a commentary on the metrics fields giving an explanation of how those figures have been arrived at.

Only one response should be sent per practice.

For super-partnerships we request one response per main site.

We would value a response from every practice across our patch by **31 December 2019.**

Coversheet

The fields in this section should be reasonably self-explanatory. An active and regularly accessed e-mail address should be given so that LMC staff have a contact point in the event that any clarification is required.

A practice can dictate its level of data sharing. If you wish to share nothing at all then you are clearly free to use the tool and retain it purely for your own use.

Any data received will be kept in confidence by Cambs LMC. Our intention is to formulate a countywide assessment of resilience in each practice, to inform and tailor our support for practices, and early in 2020, to publish the main themes arising from the data in a document that can be shared with the wider system, stakeholders and commissioners of general practice. No individual practice data will be identifiable in this document. In the case of practices that are constituent parts of larger GP provider organisations of primary medical services, we ask that the return is broken down into site based units so as not to skew the data.

We hope that this reassurance of how your data will be used will give you the confidence to opt to share with us, as your statutory representative organisation.

Premises

You should answer the first question by selecting from the drop down menu. This will change the questions below that you will be asked, based on the specific context of your property arrangements.

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If you own your premises then you should enter the annual mortgage payments expressed as a positive number, annual notional/cost rent payments (expressed as a positive number, and any penalty cost (expressed as a positive number) for paying your mortgage off early. You should then enter (as positive numbers) the outstanding mortgage amount and the most recent valuation of your property.

If you rent then please enter your annual rental cost, followed by your notional rent reimbursements (both as positive numbers). Then enter as a positive number the cost to terminate your lease early. The next two fields are greyed out and should be left blank.

If you are operating as a superpartnership then please enter one set of data for each site.

The last 2 questions are yes/no answers chosen from the drop down menu. Answer them to the best of your ability. To a certain degree they are intended to ask for your opinion. For example, a prospective partner may have declined partnership for a number of reasons, but this question asks you for your opinion as to whether premises matters may have played a significant role in their decision.

Finances

This sheet asks for quite a bit of financial detail, most of which should be reasonably well known to you or which should be accessible from your latest accounts. Rough and estimated figures are acceptable where fine detail is difficult to access.

Enter the raw patient number in the first field followed by the number of whole- time equivalents (WTEs) you have as partners in the business, as defined by your practice agreement, profit shares or whatever internal calculation you apply. As a guide, it is now generally accepted that a WTE is 8 clinical sessions.

For the question about net current account holdings please give the sum total of the net value of the practice (not including building assets) as shown in your last set of accounts. For example, if Drs A, B and C have net end of year positions respectively of £5,000, £1,000 and -£3,000 the net worth will be these figures added together – i.e. £3,000.

In the next field please enter the outstanding estimated tax liability for the partners. If tax liabilities have been a part of the calculation in the field above then the answer to this question will be zero. From the above example if the estimated outstanding tax liabilities for Drs A, B and C are £6,000, £2,000 and £4,000 then this figure will be £12,000. Please express this figure as a negative number in this field. The next field asks you to enter the declared taxable profit for a full time partner. For example, if net profit per partner was £110,000 but MDO, GMC and other personal professional costs added up to £15,000 then you would put £95,000 in this field.

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Please do not include any income arising from property or assets here.

The next field asks you to enter the gross taxable salary of a full time salaried GP in your practice. If you do not employ a salaried doctor then leave this field as £1. If you employ one salaried doctor for 6 sessions a week and pay £48,000 then you will need to multiply this figure by 10/6 in order to show the full pro-rata cost. In this example the figure of £80,000 should be placed in the field.

In the taxable profit field you should enter the percentage by which the latest taxable profit figure (the £95,000 example given above) grew or contracted compared to the previous accounting year. In this example if the taxable profit the preceding year was £98,000 then the figure to be entered here would be – 3/98 x 100% = -3.06%. Please pay particular attention to entering this as a negative number if taxable profit has fallen.

In the next field enter the amount of income you would stand to lose through any final PMS review or atypical population review process over the next 3 years (enter losses as a negative figure). Then enter the sum total of all other known financial losses in income over the next three years. For example, if you make a net dispensing profit of £50,000 per year and know that you will lose your dispensing rights then enter this as -£50,000.

The next field will self-populate. Then enter the percentage pay rise you awarded your staff last year. The final field asks you to estimate the redundancy costs of all employed staff. This is a rough estimate and is designed to assess the degree of exposure of the partners should the contract fail. Redundancy terms and payments are complex, but a reasonable illustrative figure for this sum can be achieved by taking last year's staff pay costs and multiplying by one third. Please remember to express this as a negative number.

Demand

The next sheet asks various questions to do with workload and delivery. The first field asks for the total number of all clinical contacts in the last year. Most IT systems will allow you to access this figure relatively easily. The next field asks you to say what percentage change this represents on the previous year. For example if you delivered 50,000 contacts last year and 47,000 contacts the year before the percentage increase would be 3/47 x 100% = 6.38%.

The total number of complaints for the whole practice should be entered in the next field. Then enter the number of weeks of total allowable leave (holiday and study) for a partner (based on WTE). Enter the same number for a salaried doctor (based on WTE).

The last two fields ask how many sessions are worked by partners and salaried doctors in a full week. The number that should be entered here is the number of acknowledged sessions

representing full time. For example, we know that partners often work 12 hour days but would call that 2 sessions rather than dividing 12 by a nominal 4 hour session to arrive at a figure of 3 sessions. In this case the figure 2 should be used for a normal full working day.

Do not forget to add in addition, any extended hours sessions that are now being provided in addition to the sessions, in light of the Primary Care Network DES commencing 01.07.2019.

Quality & Safety

The questions in this section are designed to look at the strain of demand on the service. Where safety may be in question, it is clear that this is as a result of increased demand and lack of availability of trained staff. This is not as a result of practice failure.

In the first field give the average number of hours worked by a partner in a full day. This should include management time, away days etc. If a partner averages 12 hours of clinical time each day over a four day working week but also does 6 hours a week of management work which might take place at home then the figure that should go in this field is 13.5 (12 plus 6/4).

Answer how many hours of paperwork on average a partner does in a normal working day. Then answer all the same questions again but for salaried doctors.

Relationships

Relationships are a very important aspect of resilience that are not traditionally quantified. This section asks you to make an accurate assessment of what you believe to be the situation. Please answer truthfully how you would honestly reply to these questions. To answer these questions click on each field and select an option form the drop down menu.

The answers will inevitably involve a degree of opinion, and that is to be welcomed. The options are colour coded to give an idea of whether the response scores positively or negatively. Please do not approach this as a competition to score as highly as you can, but rather answer honestly.

Regulation

The Regulation section is structured in the same way as the Relationship screen. Again, please answer the questions to the best of your ability from the drop down menu.

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Workforce

The workforce sheet attempts to look at your workforce structure and to scope any threats that may exist due to retirement or other losses. The first field asks you to record the total number of clinical hours provided by partners in your practice, while the next field asks how many of these may be at risk. For example, if Drs. A, B and C normally work 4 days a week each doing 12 hours clinical work a day (not just patient facing contacts), and they employ a nurse who does a 20 hour week then 164 hours a week is the total clinical delivery time of which 144 are partner delivered. If Dr A intends to retire in a couple of years then 48 of these hours are at risk. Note that these numbers are taken for a normal working week and should not be adjusted for leave.

Work down the page answering the same two questions for the different grades of workers (salaried, locums, nurse practitioners, nurses, HCAs and reception/admin). Then answer from the drop down lists the final two questions at the bottom of the page. Again, you are asked to a certain extent to give your honest opinion. We have deliberately excluded PCN related staff from this metric as a proportion of their cost is reimbursed and complex to ascertain at an individual practice level.

Metrics

The Metrics sheet is self-populating depending upon your answers to all other questions. This is where all of the information you have entered is pulled together. Inputs are used to calculate the projected profit in 3 years time and compares this with amber and red parameters. The Black Alert Practice Action Plan sets the amber alert if full time partner profit drops below £75k and red alert if it drops below £60k.

The Metrics sheet takes inputs to work out how much it would cost you to give your PMS/GMS contract back and close your business. This is mainly dictated by your practice's net current account position minus any building equity plus redundancy costs. This figure is divided by the number of WTE partners to give a personal financial liability. This figure clearly rises as the number of partners falls, reflecting the "last man standing" scenario. It is a measure of individual financial exposure, £20k and £40k being the thresholds chosen for amber and red alert.

The net building value per partner is a measure of the average equity held in the building. It is appreciated that this may vary between partners, but is a useful measure of buildings exposure which has a significant impact on resilience.

Building profit per partner is a measure of whether the building acts as a break on other practice activities by being a financial drain. Amber is set at any annual loss generated by the building while the red threshold is set at £2,000 per partner.

The final metric in the premises and finance section needs careful explanation:

This parameter takes various inputs from different sheets and works out how many annualised hours a partner will work in total in 3 years' time and divides this into the projected taxable profit in 3 years. An analogous calculation is made for salaried doctors in your practice without taking into account demand inflation (as employed staff are not usually expected to work beyond contracted hours) to arrive at a projected level for gross pay per hour worked. One is divided into the other to give a ratio between partners and salaried doctors for the gross pay per hour in 3 years' time. The amber threshold is breached where salaried doctors achieve parity, and the red alert triggers where partners earn only 80% of the hourly rate for a salaried doctor. This parameter is important, not as a battleground between partners and salaried doctors, but as a marker of the disincentive for doctors to become partners.

The demand and quality section looks at partner annualised hours. Most normal employees on a 37.5 hour/week contract with 6 weeks paid holiday do 1,725 annualised hours. This parameter sets 2,000 as amber and 2,300 as red. Most GPs are already working in the red zone, even so called 'part time' GPs.

Projected contacts per patient in 3 years is a measure of demand growth. Parameters are set at 6.5 and 7.5 for amber and red. Complaints per 1,000 patients is used as a surrogate measure for system strain with 1.5 and 2.5 being used as the thresholds. The projected average partner decisions per day is an attempt to quantify the intensity of work rather than just the amount. The calculation is open to criticism but assumes on average 1 potentially fatal decision to be taken every minute of consulting, and 1 crucial decision made every 30 seconds of letters/results/prescription processing. The thresholds for safety have been arbitrarily set at 600 and 800.

We recognise that this methodology is rough and ready and is open to debate, but decision fatigue is an important invisible in the growing pressure in general practice.

The current partner time per registered patient index simply takes the number of partner delivered hours and divides by the number of patients x 100. It is a measure of how much clinical activity is delivered by partners in the business which we know is a marker for resilience.

The likelihood of replacing a partner is extrapolated from taking partner pay per decision index (a measure of reward versus work intensity). This should give a figure around 100 for an average practice. This is then modified by 20 points for each of the questions about your practice being located in a deprived area or your premises arrangements having deterred a partner from joining in the past (both of which are obvious brakes on recruitment) and a plus 20 modifier if your work environment is outstanding. If you are not in a deprived area

but have ordinary premises that have not deterred anyone in the past then the modifiers add to zero. If the total score is less than 80 then an amber alert is flagged for potential recruitment difficulties. Below 60 flags red.

The normalised risk of staff leaving takes the proportion of GP or nurse practitioner hours likely to be lost over 3 years multiplied by 4 plus the proportion of standard nurse hours to be lost times 2 plus proportion of other hours to be lost. The total is then divided by 7. This weights the loss of sharp end clinical time and gives a weighted proportion of staff likely to leave in the next 3 years. The amber alert is triggered at 15% weighted threat and red alert at 30%. The total risk index is generated by multiplying the weighted risk of losing staff by the likely difficulty of replacing them and normalizing the result (i.e. if all staff were to leave and the likelihood of replacing them was zero then the result would be unity).

In the relationships section scores of 2, 1 and 0 are allocated to answers of Strong, Fair and Poor with 1 and 0 allocated to Yes/No answers. These are summed according to whether the parameter measures an internal relationship dynamic or an external one. Your total score for external and internal relationships is calculated as a proportion of the maximum score possible. The same methodology is used for the section on regulation.

The results generated by the Metrics Page are then simply transferred in a more readable manner to the Reports page which is then headed with an appropriate notification about data sharing.

It is important to remember that all of these parameters are based on educated estimates and most are open to some debate. However, taken across the piece we believe that this tool will be useful to prompt practices to look at important areas of operation, to stimulate discussion and further analysis and to direct the support we are able to offer.

We are also cognisant of the current extreme pressures in our system and the need for a snapshot of practice viability and resilience at a time when many see PCNs as the solution to all the challenges facing our local NHS.

We foresee collation and publication of the themes emerging as forming a critical case for investment in our constituent practices, and thus we hope you will support us in achieving this ambition by completing this tool, and sharing your findings.