A New Model of Urgent Care within Primary Care

December 2017 Audit Full Report
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Executive Summary

Brookside Group Practice is an innovative three-site teaching practice in West Berkshire. The Practice seeks to continually improve and enhance the services offered to their 27,000 patient population.

Following increasing pressure on all appointments and an unsatisfactory urgent care system/process, a new model of urgent care was fully introduced in July 2017 which aimed to provide a robust service model to appropriately treat patients requiring same-day appointments. This new model eliminated the GP telephone triage system, and instead utilises the skills of the multi-disciplinary team, with support and overview from a supervising GP. A one-month audit was undertaken in December 2017 in order to measure and understand the impact and efficiency of the new model.

The results from the audit demonstrated that of the patients seen by non-GP staff, nearly half (47%) were seen and treated without the involvement of the supervising GP. The main reasons for the involvement of the supervising GP were for complex patients (51%) and prescriptions (44%).

Further analysis of the complex patients found that 41% of these patients were 16 years and under, and just under 40% of the presenting complaints of all complex patients fell under the category of respiratory illness and fever. The second most common presenting complaint of complex patients was related to skin/nail and rash issues (15.3%).

The results of this audit have helped to identify areas where additional training could increase the efficiency of the clinic, enabling a greater number of patients to be managed without input from the supervising GP. For example, developing additional staff to have prescribing rights and enhanced paediatric skills would enable staff to manage a number of complex patients who would otherwise require input from the supervising GP.

Alongside the new clinic model, the Practice introduced an enhanced website in July 2017. This gives patients much greater flexibility in how they interact with the Practice and provides the ability for patients to seek advice via the website instead of telephoning or attending the Practice in person. Results from an audit undertaken in April 2018 demonstrated that over a 9-month period, over 2000 telephone calls were avoided, over 1102 visits in person were avoided and nearly 300 appointments avoided.

Whilst it is not possible to make direct correlations between the new clinic model, website changes and acute hospital activity, it is interesting to note that during working hours non-elective admissions and emergency department attendances from the Brookside Group Practice population decreased by 26% and 6% respectively, when comparing December 2015 (previous model was operating) and December 2017 (new clinic was in place). Yet the same comparison, looking across all GP Practices within the Berkshire West CCG region, showed an increase of 11% in non-elective admissions and an increase of 8.7% in emergency department attendances.
The Practice’s activity data has shown a significant increase in the overall number of patients seen each month, with an additional 1650 patients seen following the introduction of the new clinic. Whilst many other factors (new website, increased staffing, etc) will have influenced this, the impact of the new clinic model cannot be underestimated. The new clinic will have contributed to the increase in activity, particularly as the new urgent care clinic now sees, on average, over 100 additional patients per month, while the surgery has a decreased waiting time of 5 days for routine appointments.

The staffing arrangement within the clinic varies, which means that the cost of running the clinic is similarly variable. However, the cost of running the new model of urgent care has been shown to be between 4% and 38% lower when compared with normal general practice. This does not take into account the additional work the supervising GP will undertake, such as writing letters/referrals, reviewing test results, urgent telephone calls, which further adds to the efficiency of the clinic.

The new model of urgent care has been shown to be an efficient and effective way of using the skills of the multi-disciplinary team to see urgent patients within primary care, while also providing regular training opportunities for clinicians. The audit has highlighted some areas for potential improvement in efficiency through the development of clinicians’ skill sets. Further efficiencies could also be generated with the implementation of point of care tests and Healthpods.
Overview of Brookside Group Practice

Brookside Group Practice is a well-established and progressive three-site teaching practice in West Berkshire that has been in operation since 1977. The Practice rapidly expanded during the 1970s and 1980s but now has a relatively static population size of approximately 27,000 patients.

The Practice employs around 130 staff across several disciplines, including doctors, practice nurses, healthcare assistants, patient services and support staff, smoking cessation advisors, paramedics and pharmacists.

The overarching aim of the Practice is to provide a high standard of healthcare by making appropriate and innovative use of limited NHS resources. The Practice continually strives to improve services, for example by adapting models of care or introducing point of care testing such as Kardia AliveCor for detecting atrial fibrillation.
Changing the Model of Primary Care Urgent Care

Urgent care is an extremely important component of primary care which can be managed in a wide variety of ways. It is crucial this element of primary care keeps pace with other operational demands in the NHS, otherwise it can lead to increased pressure on Emergency Departments and hospital admissions, and a corresponding negative impact on both patients and primary care staff.

Due to increasing pressure on all clinic appointments and an unsatisfactory model of urgent care, the Practice, of their own volition, introduced a new clinic model for urgent care during 2017. The introduction of this new model coincided with the introduction of an enhanced Practice website, which gave patients the ability to ask queries and for advice online rather than telephoning or attending in person.

This report outlines the changes that have been made, and highlights the findings of an audit of the urgent care model and the impact this has had on patients and the Practice.

Previous Model of Urgent Care

The Practice’s previous urgent care clinic was based on telephone triage and subsequent appointment if needed. Patients would contact the Practice and be placed on that day’s ‘urgent telephone triage’ list. Following a telephone consultation with the GP, patients would be given advice and a management plan, or be asked to attend the Practice for a face to face consultation that day.

GPs were spending a significant amount of time on the telephone rather than seeing patients. Furthermore, due to the demand for urgent appointments an evening clinic was scheduled each day from 17h30 – 18h30, to accommodate those patients who needed to be seen but could not be accommodated in the morning or afternoon sessions. However, the clinic regularly overran, on occasion as late as 20h00, which was very unsatisfactory for both patients and staff.

This model was not an efficient use of resources and was unsustainable. It did not adequately address the needs of patients and demands on the Practice, nor did it make appropriate use of the skills available within the multidisciplinary team.

New Model of Urgent Care

Following discussions within the Practice, a new model of urgent care was agreed. This was then introduced in two phases; the first in February 2017 and the second stage in July 2017. This model moved away from a single professional (GP) clinic towards utilisation of the skills and competencies of the multidisciplinary team.

During the first phase the urgent care clinic was run across two sites by the urgent care nursing staff and a GP. There was however no dedicated GP to supervise the clinic. This resulted in fewer patients being able to be booked into the clinic, as requests for GP review or advice would be to the GP in the urgent care clinic who had their own list of patients.
to see. The nursing staff also had criteria which determined the type of presenting complaint they could see. This restricted the number of patients that could be booked into the clinic. Furthermore, during this phase patients were not given an allocated appointment time, and instead attended the surgery at 11am to wait until they could be seen. This resulted in some patients not using the clinic as they did not want to ‘sit and wait’.

The second phase, and full implementation of the model, included the introduction of a supervising GP to the clinic, removal of patient criteria for non-medical staff, recruitment of a specialist paramedic, and the creation of a dedicated urgent care clinic area within Chalfont Surgery. The paragraphs below describe the service model in its current state.

Patients contact the Practice requesting an urgent appointment and will be given an appointment for either the morning or afternoon session. Each clinic has a finite number of slots which varies according to the number of clinicians available, and skill mix within the clinic. However, there are contingency slots available for any patients who have been advised via 111 they need to be seen urgently.

On average six clinicians, including the supervising GP, will work in the urgent clinic. The supervising GP oversees the clinic, but will not have patients booked to see them directly. The skill mix within the clinic will be a combination of practice nurses, GP Registrar, paramedics, prescribing nurses and GPs. The morning session runs from 11h00 – 13h00 and the afternoon session from 15h00 – 17h00. The Practice has taken on board patient feedback regarding the ‘sit and wait’ aspect of the clinic. Patients are now given a 30-minute slot in which to attend, i.e. at 11am, 11.30am. This has helped to spread attendance more evenly throughout the clinic and prevented very lengthy waits for patients.

A brief reason for the appointment is noted on the electronic patient record system which enables the specialist paramedic to review the list in advance of clinic start. Patients may be allocated to particular members of the team based on the reason for attendance, the skills of the clinicians, or if the patient is well-known to that member of the team.

During the clinic if a member of the team requires additional advice, or signing of a prescription, the supervising GP will be requested. The supervising GP will then review patients as required.
The Role of the Supervising GP

The role of the supervising GP is to oversee the running of the urgent care clinic and to provide supervision to the training grade medical staff and non-medical staff.

The supervising GP can be asked by clinic staff:
- To review patients
- For advice on appropriate management plans
- For a second opinion
- To sign prescriptions
- For referral to other services / investigations

This set up provides an excellent opportunity for continuous training and teaching of staff.

During the clinic the supervising GP will undertake other tasks in between providing advice and reviewing patients. This part of the audit has incomplete data and therefore has not been included in this report. The additional work that the supervising GP undertakes will include:
- Review of test results
- Review of case notes
- Electronic prescriptions
- Letters / referrals
- Urgent telephone calls
- Other telephone calls

This is an effective way of increasing the efficiency within the clinic, although it is difficult to quantify as demands on the supervising GP vary from clinic to clinic.
Understanding the Impact

The Oxford Academic Health Science Network (AHSN) and Brookside Group Practice have worked closely together to undertake an in-depth review of the new urgent care clinic model. This has enabled the impact and benefits to be openly assessed and clearly demonstrated, with a view to sharing this as a possible ‘best practice’ approach.

The Approach

An audit was undertaken in December 2017. This audit captured outcomes from the urgent care clinic that cannot be extrapolated from routinely collected activity and performance data, and the findings are included in this report. Following the audit, a review of patients requiring input from the supervising GP was undertaken through an analysis of the information on the Practice’s electronic record system.

Activity and performance data has been compared between the previous model and current model. Non-elective admissions and Emergency Department attendances from the Practice’s population have also been reviewed, and while differences in numbers cannot be directly attributed to the new clinic model, it is interesting to note the changes.

A financial analysis has been undertaken to compare the previous and current clinic model. Due to the commercial sensitivity of this information, the details have not been included in this report, although a summary of the comparison has been provided.

This report details the findings and provides evidence to demonstrate the positive impact of the new model of urgent care clinic, including the potential for future training opportunities and further development opportunities that would enhance the clinic’s efficiency.
Audit Findings

The audit was carried out from Monday 4\textsuperscript{th} December – Friday 29\textsuperscript{th} December 2017. Clinics were held each weekday with the exception of Monday 25\textsuperscript{th} and Tuesday 26\textsuperscript{th} December, as these were Bank Holidays.

Every clinician working in the clinic had one audit form to complete per clinic (Appendix 1).

Overview

<table>
<thead>
<tr>
<th></th>
<th>Number of clinics</th>
<th>Number of forms submitted</th>
<th>Number of patients seen</th>
</tr>
</thead>
<tbody>
<tr>
<td>AM clinic Minimum</td>
<td>18</td>
<td>4 (28\textsuperscript{th})</td>
<td></td>
</tr>
<tr>
<td>AM clinic Maximum</td>
<td>36</td>
<td>8 (4\textsuperscript{th})</td>
<td></td>
</tr>
<tr>
<td>PM clinic Minimum</td>
<td>16</td>
<td>3 (13\textsuperscript{th})</td>
<td></td>
</tr>
<tr>
<td>PM clinic Maximum</td>
<td>39</td>
<td>8 (18\textsuperscript{th})</td>
<td></td>
</tr>
</tbody>
</table>

Number of Patients Per Clinic

There was no difference in the average number of patients seen in the morning and afternoon clinics – an average of 26 patients per clinic regardless of time of day.

There was a large difference in the maximum and minimum number of patients seen in one clinic. This, however, was accompanied by a corresponding difference in the number of clinicians in the clinic.

The graphs below clearly illustrate the relationship between the number of patients seen with the number of clinicians available in the clinic.
The graph below shows the same information, but for all dates on which the audit was conducted. Data from morning and afternoon clinics have been combined.

The close management of patient numbers and flexibility within the clinic model is crucial to ensure urgent patients are seen in a timely manner and that clinicians can safely and appropriately review and treat patients.

The graph below shows the average number of patients and the average number of clinicians by day of the week. The stacked bar chart also highlights the number of patients requiring GP input and those who do not. As can be seen, the resources available each day are consistent with the number of patients seen.
By reviewing and modelling the number of patients attending by day of the week, the Practice has a good understanding of the demand by day. This has enabled appropriate clinic staffing to be scheduled to meet the anticipated demand.

Patients asked to return for same issue
Only 4% of patients (38 patients) were asked to return for another appointment for the same issue (either to the urgent care clinic or a routine clinic). A number of such requests were ‘if the issue had not resolved in XX days/weeks’.

This demonstrates that the urgent care clinic staff feel equipped to provide appropriate and complete treatment and management plans for most patients. It would be interesting to look at the number of patients who subsequently attended the Practice for the same issue within 2 months of their initial urgent care clinic attendance. However, this data would be difficult and time-consuming to obtain as it would require a review of all 948 patients.

Inappropriate attendances
9.8%, or 93 patients, were deemed to be inappropriate attendances at the urgent care clinic. A number of such patients had the presenting issue for a long-time and as such would have been appropriate to attend the routine clinic (for which the waiting time is approximately 5 days); other patients could have been dealt with by a telephone call.

Did Not Attends (DNAs)
Unfortunately, there are some patients who fail to attend for their urgent appointment. The table below highlights the total number of DNAs during the audit, including a split by morning and afternoon clinic. While there is a slight increase in the number of DNAs in afternoon clinics, the average is less than one per clinic.

<table>
<thead>
<tr>
<th></th>
<th>Number of DNAs</th>
<th>Average per Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Clinics</td>
<td>28</td>
<td>0.8</td>
</tr>
<tr>
<td>AM Clinics</td>
<td>11</td>
<td>0.6</td>
</tr>
<tr>
<td>PM Clinics</td>
<td>17</td>
<td>0.9</td>
</tr>
</tbody>
</table>

Multidisciplinary team – Exclusion of Clinic GPs
As well as there being a supervising GP in each clinic, there is often a GP working within the urgent care clinic. Clinic GPs do not require the input or supervision from the supervising GP. Therefore, to understand the impact of the other clinicians and to avoid skewing the outcomes, it is important to remove the clinic GP from the data.

The figures below relate to patients seen by:

- Practice nurse
- GP Registrar
- Specialist Paramedic
- Physician Assistant
- Prescribing nurse
- Returning GP (i.e. returning to practice)
- Paramedic
Overview

<table>
<thead>
<tr>
<th>Number of patients seen (excluding those seen by Clinic GP)</th>
<th>698</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of patients seen without supervising GP input</td>
<td>331</td>
</tr>
<tr>
<td>% patients seen without supervising GP input</td>
<td>47.4%</td>
</tr>
<tr>
<td>Average number patients per clinic seen without supervising GP input</td>
<td>9</td>
</tr>
</tbody>
</table>

Almost half of patients were treated without involvement from the supervising GP.

Breakdown of Reasons for Supervising GP Input
367 patients (52.6%) required input from the supervising GP

The audit gave four options for GP input:

- Prescription
- Complex issue
- Referral for other service or test
- Patient requested GP input

<table>
<thead>
<tr>
<th>Reason for GP Input</th>
<th>Patient Numbers</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescription</td>
<td>161</td>
<td>43.9%</td>
</tr>
<tr>
<td>Complex issue</td>
<td>187</td>
<td>51.0%</td>
</tr>
<tr>
<td>Referral for other service or test</td>
<td>17</td>
<td>4.6%</td>
</tr>
<tr>
<td>Patient requested GP input</td>
<td>2</td>
<td>0.5%</td>
</tr>
</tbody>
</table>

The significant majority of requests for input from the supervising GP was due to the patient presenting with a complex issue (51%) or a prescription being required (43.9%).
## Breakdown by role

<table>
<thead>
<tr>
<th>Role</th>
<th>Total pts seen</th>
<th>Av pt / clinic</th>
<th>% seen without GP input</th>
<th>For those requiring supervising GP input: % breakdown of reasons</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Prescription</td>
</tr>
<tr>
<td>Clinic GP</td>
<td>250</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practice nurse</td>
<td>277</td>
<td>5</td>
<td>29.2%</td>
<td>48%</td>
</tr>
<tr>
<td>Reg / returning GP</td>
<td>150</td>
<td>4</td>
<td>84.7%</td>
<td>0%</td>
</tr>
<tr>
<td>Specialist paramedic</td>
<td>149</td>
<td>5</td>
<td>37.6%</td>
<td>69.9%</td>
</tr>
<tr>
<td>Paramedic</td>
<td>17</td>
<td>3</td>
<td>35.3%</td>
<td>18.2%</td>
</tr>
<tr>
<td>Prescribing nurse</td>
<td>101</td>
<td>5</td>
<td>60.4%</td>
<td>0%</td>
</tr>
<tr>
<td>Physician Assistant</td>
<td>4</td>
<td>2</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

By looking at individual roles and the reasons for GP input, it offers the opportunity to consider increasing the competencies of clinicians. For example, 70% of the requests for GP input from the specialist paramedic is for prescriptions.
Prescribing nurses
Prescribing nurses saw a total of 101 patients. Of these, the nursing staff dealt with 61 patients without input from the supervising GP (60.4%). A total of 51.5%, or 52 patients, were given prescriptions by the nursing staff and as such did not require input from the supervising GP.

The chart below provides a breakdown of outcomes for patients seen by the prescribing nurses, including the reasons for supervising GP input.

![Chart showing breakdown of outcomes](chart.png)
Comparison of Prescribing Nurses and Non-Prescribing Clinicians

<table>
<thead>
<tr>
<th>Role</th>
<th>Total pts seen</th>
<th>Av pt / clinic</th>
<th>% seen without GP input</th>
<th>% breakdown of reasons</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Prescription</td>
</tr>
<tr>
<td>Prescribing nurses</td>
<td>101</td>
<td>5</td>
<td>60.4%</td>
<td>0%</td>
</tr>
<tr>
<td>Non-prescribing</td>
<td>447</td>
<td>5</td>
<td>32%</td>
<td>53%</td>
</tr>
<tr>
<td>clinicians*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*practice nurses; specialist paramedic; paramedic; physician assistant

There is no difference in the average number of patients seen in clinic, with prescribing nurses and those in non-prescribing roles each seeing an average of 5 patients.

There is however, a difference in the number of patients who do not require input from the supervising GP – 60.4% for prescribing nurses and 32% for those in non-prescribing roles. The main reason for this is due to prescriptions. Over half (53%) of the patients seen by non-prescribers and who require input from the supervising GP, require prescriptions.

If the assumption is made that all prescription requests from non-prescribers can be dealt with by the clinicians themselves, the percentage of patients who do not require GP input would increase to 68%. Consideration should therefore be given to increasing the number of prescribers within the clinic, which would further reduce the demand for supervising GP input.
Further Analysis of ‘Complex Patients’

Following the audit, it was agreed a more in-depth look at the patients requiring supervising GP input for ‘complex’ reasons would be beneficial. As the audit forms did not request patient details to be recorded, a review of each clinic from the audit period was undertaken on the Practice’s electronic patient record system.

It was possible to identify all the patients who had been reviewed by the supervising GP and exclude some who only needed the supervising GP for a prescription. However, it was not possible to identify only those patients who fell under the ‘complex’ category. As such more patients (236) have been included in this further analysis, rather than the 187 ‘complex’ patients indicated in the audit.

Summary of Patients

The table below shows the split between male and female patients, with a fairly even split.

<table>
<thead>
<tr>
<th>Gender</th>
<th>Number of Patients Seen</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>131</td>
</tr>
<tr>
<td>Male</td>
<td>105</td>
</tr>
<tr>
<td>Total</td>
<td>236</td>
</tr>
</tbody>
</table>

The graph below provides a breakdown of the patients seen by age, with the largest age group requiring supervising GP input being the 1 – 5-year olds.
Patients who were 16-years old and under accounted for 40.7% of complex patients. There could therefore be an opportunity to develop paediatric skills across the multidisciplinary team to potentially reduce the number of patients requiring supervising GP input.

The graph below shows the same information including a split by gender.

Apart from 1-5 years and 71–80 years, females account for 50% or over of the complex patients in each age group.
Breakdown of Complex Patient by Presenting Complaint

The presenting complaint for the complex patients have been grouped for ease of analysis. The table below provides an overall summary of these reasons. The top three presenting complaints that required supervising GP input were:

1. Respiratory illness and fever (39.4%)
2. Skin/nail issue, rash (15.3%)
3. Eye/ear/facial pain (7.6%)

<table>
<thead>
<tr>
<th>Reasons</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal/flank pain</td>
<td>3</td>
<td>10</td>
<td>13</td>
<td>5.5%</td>
</tr>
<tr>
<td>Back, shoulder, joint pain</td>
<td>8</td>
<td>4</td>
<td>12</td>
<td>5.1%</td>
</tr>
<tr>
<td>Blood in stool</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0.4%</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>9</td>
<td>6</td>
<td>15</td>
<td>6.4%</td>
</tr>
<tr>
<td>Cardiac</td>
<td>2</td>
<td>3</td>
<td>5</td>
<td>2.1%</td>
</tr>
<tr>
<td>Respiratory illness and fever</td>
<td>47</td>
<td>46</td>
<td>93</td>
<td>39.4%</td>
</tr>
<tr>
<td>Eye/ear/facial pain</td>
<td>9</td>
<td>9</td>
<td>18</td>
<td>7.6%</td>
</tr>
<tr>
<td>Fall</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>0.8%</td>
</tr>
<tr>
<td>Fever with rash</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>0.8%</td>
</tr>
<tr>
<td>Gynae/genital issue</td>
<td>3</td>
<td>4</td>
<td>7</td>
<td>3.0%</td>
</tr>
<tr>
<td>Headache, dizziness, vomiting</td>
<td>3</td>
<td>3</td>
<td>6</td>
<td>2.5%</td>
</tr>
<tr>
<td>Mastodynia</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0.4%</td>
</tr>
<tr>
<td>Medication issue/side effects</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>1.3%</td>
</tr>
<tr>
<td>Skin/nail issue, rash</td>
<td>12</td>
<td>24</td>
<td>36</td>
<td>15.3%</td>
</tr>
<tr>
<td>Unwell post-surgery</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>0.8%</td>
</tr>
<tr>
<td>Urinary symptoms, UTI</td>
<td>2</td>
<td>13</td>
<td>15</td>
<td>6.4%</td>
</tr>
<tr>
<td>Other*</td>
<td>3</td>
<td>2</td>
<td>5</td>
<td>2.1%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>105</td>
<td>131</td>
<td>236</td>
<td>100%</td>
</tr>
</tbody>
</table>

* domestic violence                   | 0    | 1      | 1     |
* plaster cast feels tight            | 1    | 0      | 1     |
* pain in arm                         | 0    | 1      | 1     |
* generally unwell                    | 1    | 0      | 1     |
* needs time off work                 | 1    | 0      | 1     |
For complex patients aged 0 – 5 years, 50% of the presenting complaints were due to respiratory illness and fever. The graph below provides a breakdown of the presenting reasons for this age group.

The graph below provides the breakdown of presenting complaints for complex patients aged 0 – 16 years.
A review of the breakdown of complex patients and their presenting complaint by age group shows that for nine out of the ten age groups (the exception being 81 years and over) the most common presenting complaint was respiratory illness and fever. The audit was undertaken in December, which could account for such a high proportion of patients presenting with these issues.

For six of the ten age groups, skin/nail issue and rash was the second most common presenting complaint requiring GP input.

Whilst the grouping of reasons used does not provide the detail as to why the supervising GP was required, this data could be used to prioritise training for the Practice’s clinical staff.
Comparison of Activity and Performance Data

This section shows the activity and performance data taken from a period in which the previous urgent care clinic was operating and from a period in which the current model has been operating. The time period has been specified where relevant.

<table>
<thead>
<tr>
<th></th>
<th>Previous Model</th>
<th>Current Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Average monthly routine clinic attendances</td>
<td>2720 (Jan-16 – Dec-16)</td>
</tr>
<tr>
<td>2.</td>
<td>Average monthly urgent clinic attendances</td>
<td>1430 (Jan-16 – Dec-16)</td>
</tr>
<tr>
<td>3.</td>
<td>Average waiting time for routine appointment</td>
<td>10 days</td>
</tr>
<tr>
<td>4.</td>
<td>DNA rate per urgent clinic</td>
<td>2.2 (Dec-16)</td>
</tr>
<tr>
<td>5.</td>
<td>Average urgent care consultation time</td>
<td>14.8 minutes (Jan-16)</td>
</tr>
<tr>
<td>6.</td>
<td>Annual consultation rate across all staff groups (average number of consultations per patient per annum)</td>
<td>6.02 (2015)</td>
</tr>
</tbody>
</table>
Other Changes Within the Practice

Website
The Practice introduced an enhanced website in July 2017, coinciding with the full implementation of the urgent care clinic. The website gives patients much greater flexibility to engage with the Practice online rather than in person or by telephone, and in doing so has improved the efficiency of the Practice.

![Website Screenshot]

Patients can undertake the following via the website:

<table>
<thead>
<tr>
<th>Ask the doctor a question</th>
<th>Ask the nurse a question</th>
<th>Ask the practice a question</th>
<th>Ask the reception a question</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma review</td>
<td>Blood pressure review</td>
<td>Cancel appointment</td>
<td>Change name and address</td>
</tr>
<tr>
<td>Epilepsy review</td>
<td>Give feedback</td>
<td>Medical report request</td>
<td>New patient registration</td>
</tr>
<tr>
<td>Patient health questionnaire (PHQ-9)</td>
<td>Patient reference group registration</td>
<td>Prescription query</td>
<td>Private referral request</td>
</tr>
<tr>
<td>Register a carer</td>
<td>Register for online services</td>
<td>Register for Electronic Prescription Service</td>
<td>Repeat prescription request</td>
</tr>
<tr>
<td>Request E-referral password</td>
<td>Sick note request</td>
<td>Smoking review</td>
<td>Temporary patient registration</td>
</tr>
<tr>
<td>Test results request</td>
<td>Track a referral</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The average number of visits to the website per month is over 5200, with over 18,200 visits to individual pages, equating to almost 20% of the Practice’s population. Since going live in July 2017, there has been a steady increase in use of the website.
A survey of 2466 patients in April 2018 asked patients ‘if you were not able to make this request online what would you have done?’. The results are shown in the graph below.

Over a 9-month period this equates to:
- 2049 phone calls avoided
- 1102 visits in person avoided
- 283 appointments avoided

**Pharmacists**
The Practice employs three pharmacists, totally 1wte, who undertake several tasks that would normally fall within the daily workload of GPs. The pharmacists do not work within the urgent care clinic, but instead focus on the Electronic Prescription Service, medication reviews and telephone consultations. This has helped to release GPs to be able to supervise the urgent care clinic.

**Paramedics**
Three paramedics are employed by the Practice, equating to 1.7wte, with a further paramedic very recently appointed. The 1wte specialist paramedic started in post in April 2017 with the specific remit of managing the urgent care clinic, including the operational, staffing and training requirements of the service.

Two paramedics provide a combined total of 0.7wte. As well as working within the urgent care clinic, these paramedics cover home visits throughout the week. This has enabled GPs to be available for the urgent care clinic until 13h00, and has taken the pressure off late home visits which can be requested late in the afternoon. In close liaison with the GPs, the paramedics review care plans and commence treatment, and can also refer into community services are required. The newly appointed paramedic will further add to the flexibility of covering home visits and the urgent care clinic, enabling a greater number of patients to be seen.

Both staffing groups receive training and upskilling to continually enhance their role. The development of these roles has further enabled the efficiency of the Practice and responsiveness to patients.
Non-Elective Admissions and Emergency Department Attendances

Changes in the number of non-elective (NEL) admissions and Emergency Department (ED) attendances from a GP practice population are the result of many factors, and therefore such changes cannot be attributed to one change in working practice. However, at a Practice level it is interesting to understand any changes and consider any potential implications of service redesign work.

A snapshot of the NEL admissions and ED attendances from the Brookside Group Practice population has been reviewed, with data from December 2015 and December 2017 compared. Only data from weekdays 08h00 – 18h00 has been included to reflect normal GP working hours. This analysis provides a snapshot only; a more detailed review of data would need to be undertaken to understand trends in NEL admissions and ED attendances.

Non-Elective Admissions

The chart below compares NEL admissions from the Practice between December 2015 and December 2017.

![Non-elective admissions chart](chart.png)

Compared to December 2015, there was a 26% reduction in NEL admissions in December 2017 from the Brookside Group Practice population.

A review of the NEL data from all GP practices within the Berkshire West CCG region, comparing the same two months, revealed an 11% increase in NEL admissions in December 2017.

The chart below highlights the number of NEL admissions from the Brookside Group Practice population by time of admission. This demonstrates in December 2017 there was a much more even spread of admissions across the working day, unlike December 2015 which had a peak in the afternoon.
The chart below shows the same data from all GP Practices within the Berkshire West CCG region. This demonstrates that while a greater number of patients were admitted in the morning in December 2017 compared to December 2015, there was no decline in admission numbers in the afternoon.
Emergency Department Attendances
The chart below compares ED attendances from the Practice between December 2015 and December 2017.

Compared to December 2015, there was a 6% reduction in ED attendances in December 2017. A review of the ED attendance data from all GP practices within Berkshire West CCG region, comparing the same two months, revealed an 8.7% increase in ED attendances.

The graph below highlights the number of ED attendances by time of admission. In December 2017, there was a slight decrease in the number of ED attendances around 11h00 and 14h00, but overall the time of attendances is roughly comparable to those in December 2015.
The same data for all GP Practices within the Berkshire West CCG region shows a very similar pattern in terms of time of ED attendance between December 2015 and December 2017. The greater number of attendances in December 2017 reflects the 8.7% increase in activity.
NEL and ED Figures Against Urgent Care Clinician Numbers

The chart below shows the NEL admissions and ED attendances against the average number of clinicians in the urgent care clinic.

It is not possible to demonstrate a correlation between the number of clinicians in the urgent care clinic and NEL and ED activity figures. While there are points of interest (for example, Mondays have the lowest number of NEL admissions and ED attendances but the greatest number of clinicians in the urgent care clinic) much more detailed information would be required to draw definitive conclusions from this.
Summary of Financial Analysis
Due to commercial sensitivity it is not possible to share details of the financial breakdown of the clinic staffing. However, this has been reviewed by the Oxford AHSN and the summary below is based on these findings.

The cost of the new model of urgent care clinic was compared with normal general practice.

The urgent care clinic runs for 2 hours, and sees an average of 26 patients. In normal practice a GP will see 5 patients per hour, meaning that three GPs would be needed to see the equivalent number of patients.

The average number of clinicians in the clinic, including the supervising GP, is six. Apart from the supervising GP, the staffing composition of the urgent care clinic is not fixed and so the remaining five clinicians can be a combination of the following:

- Clinic GP
- GP Registrar
- Specialist paramedic
- Practice Nurse
- Paramedic
- Prescribing nurse

The staffing cost of clinic can therefore vary. A review of different possible staffing combinations has shown that the new model of urgent care clinic is cost-effective compared to normal general practice costs. The new clinic model costs between 4% and 38% less than normal general practice, depending on the skills mix of clinicians working in the urgent care clinic.

This figure does not take account of the work the supervising GP can undertake during the clinic (reviewing test results, urgent and routine telephone calls, electronic prescriptions, letters and referrals reviewing case notes). It is not possible to quantify this work as it will vary greatly between clinics depending on the patient needs. However, the capacity to undertake additional duties further increases the efficiency of the urgent care clinic.
Lessons Learned

The first phase of the new model of care provided an opportunity for the Practice to review the organisation and set up of the clinic. This enabled the necessary components of the clinic to be fully understood so that it would be as efficient as possible for both patients and staff. The key elements that were changed/implemented in the second phase included:

- supervising GP: this role is crucial to improving the efficiency of the clinic and ensuring ongoing training opportunities for staff
- removal of selection criteria for non-GP staff
- patients asked to attend within 30-minute slots rather than having to ‘sit and wait’: patients are still seen within order of clinical priority but this arrangement means the wait is rarely longer than 40 minutes
- dedicated urgent care clinic area: building work at Chalfont Surgery has created a dedicated urgent care clinic area. This has generated greater efficiencies in the clinic as the clinicians are situated closely together, and the clinic does not interrupt other clinics running in the surgery. The clinic runs at this site on four days a week, with one day at Brookside Surgery, without the benefit of a dedicated clinic area.

Due to the large geographical area the Practice serves, a review of the patients attending the urgent care clinic revealed a number of patients were travelling to the urgent care clinic from the Winnersh area. As a result of this the Practice established a small urgent care clinic at the Winnersh Surgery on a Monday.

When introducing any change in service delivery, clear and continual communication with patients and staff is crucial for success. The Practice delivered a lot of training in advance of introducing the new clinic to ensure all clinicians and support staff were fully briefed on the new service model, including the aims and benefits for patients and staff. The Practice ensured the new clinic was advertised on the website and in the practice sites with newsletters, slides on the waiting room screens and fliers on waiting room chairs. Feedback from patients demonstrated they felt engaged with the changes to the clinic.

Feedback is continually sought from patients and staff, enabling the Practice to adapt and evolve in response to the needs of patients and staff.
Patient and Staff Feedback

Patient feedback is routinely collected through the Friends and Family Test and through comments posted on NHS Choices.

Brookside Group Practice strives to maintain good communication with their patient population and kept them fully informed as to the changes planned for the urgent care clinic. Patients were engaged with these changes and feedback has been extremely positive. Below is sample of comments:

- ‘Excellent service and saved us a visit to A&E’
- ‘Best way to be seen on the same day and if necessary follow up appointment with your own GP’
- ‘I cannot speak highly enough of the nurse assessing my condition (which was pretty bad at the time), double checked the treatment plan with the specialist asthma nurse and prescribed the necessary medication’

Due to the nature of the urgent care clinic and despite being allocated a 30-minute attendance window, patients do sometimes need to wait to be seen, as reflected in the comment below:

- ‘Sometimes it is too much of a wait, I prefer appointment rather than sit and wait’

The Practice has taken on board such comments, and patients are reminded when they book an urgent appointment that they may have a short wait to be seen.

Staff feedback on the new model has also been extremely positive. There has been a particularly positive impact on teamworking, as staff in the clinic work together to manage patients based on the skills and knowledge available, rather than clinicians managing their own lists. Furthermore, the impact on learning and development of skills has been recognised, as non-GP staff have regular opportunities for support from GPs.

- ‘I love the variety of patients and the level of support we receive from the supervising doctor’ (Paramedic)
- ‘The patients are really lucky to have this service and I wish my surgery had it. The main reason I work here is to work in urgent care’ (Practice Nurse)
- ‘I have a love-hate relationship with urgent care. Some days it can be hard work and I wonder why I do it, but on those days the patients have normally come with something chronic and not acute. On the majority of the days it is really good and the level of support and learning we get is fantastic’ (Practice Nurse)
- ‘The urgent care clinic allows us to make the best use of the wide variety of skills from GPs and Allied Health Professionals. It has enhanced supervising and teaching skills for GPs, is quite dynamic and as a partnership helped give us a sustainable blueprint for the future. It has also meant GPs can focus more on the chronic, complex patients that need their care the most.’ (GP)
Future Plans
Brookside Group Practice is continually looking for ways to innovate, improve services and increase efficiency.

Point of Care Testing
The Practice is keen to explore point of care (POC) testing as it has the potential to change and improve practice by providing additional information to inform clinical decisions. Atrial fibrillation (AF) POC detection devices are being rolled out across the country as part of the national AF programme. The Practice has recently introduced the Kardia AliveCor AF POC test, which has been easily and positively incorporated into daily clinical practice.

The POC tests the Practice is considering include:
1. Lactate: blood lactate is a useful biomarker in identifying patients at increased risk of mortality from sepsis. This POC test will help guide the initiation of early treatment.
2. C-Reactive Protein (CRP): CRP is released into the blood in response to various infectious and inflammatory triggers. The POC test quantifies the CRP in blood and is used to guide the prescribing of antibiotics for patients with lower respiratory tract infections.
3. D-Dimer: is used in patients with suspected DVT (deep vein thrombosis). These POC tests can improve the cost-effectiveness of the diagnostic process and avoid the need for labour intensive laboratory testing. It is effective within primary care by contributing important information to guide patient management, including the exclusion of DVT.

Healthpods
This development would allow patient observations, such as weight and blood pressure, to be taken prior to being seen in clinic with the results captured in the patient record. This would greatly speed up and improve the efficiency of the urgent care clinic, and could enable a greater number of patients to be seen.

Links with Other Services
A pilot is due to start imminently with the IAPT (Improving Access to Psychological Therapies) service which will enable frequent attenders at the urgent care clinic to be reviewed by the IAPT team.

A redesign of the MSK services across Berkshire West CCG region has the potential to enable direct access to physiotherapy appointments. This would allow the Practice to direct patients to the appropriate MSK service rather than to the urgent care clinic.

Interest from Other GP Practices
The Practice has been approached by other GP practices who are interested in developing a similar urgent care model, with several visits undertaken to see the clinic in operation. Pending appropriate resourcing, the Practice is willing to work with and help others to develop urgent care plans, and to learn from the setup and evolution of the urgent care clinic at Brookside Group Practice.
Contacts
For further information please contact:

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Alison Gowdy, Clinical Innovation Adoption Manager, Oxford AHSN
alison.gowdy@oxfordahsn.org
Appendix 1

Audit Form

**Urgent Care Clinic – Audit**

Brookside Group Practice is working with the Oxford AHSN to measure the impact and benefits of the urgent clinic model that was introduced in July 2017. As well as a review of data captured routinely, a prospective audit is required to measure certain aspects of the clinic and service model that are not monitored through regular data recording.

Please complete one form for each clinic

<table>
<thead>
<tr>
<th>Date and time of clinic</th>
<th>Date:</th>
<th>AM</th>
<th>PM</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Your role in clinic</th>
<th>Supervising GP</th>
<th>Clinic GP</th>
<th>Clinic GP registrar</th>
<th>Physician assistant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice Nurse</td>
<td>Prescribing Nurse</td>
<td>Paramedic</td>
<td>Specialist Paramedic</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of patients you treated without input from supervising GP / patients seen by Clinic GP</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Number of patients you saw who required input from supervising GP</th>
<th>Prescription (inc EPS)</th>
<th>Complex issue</th>
<th>Referral for another service / test</th>
<th>Patient requested GP input</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Please indicate reasons for GP input, and number of patients requiring that input</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Number of patients who were asked to return for routine appointment for same issue</th>
<th>Number of patients seen for whom you felt the urgent clinic was not appropriate</th>
</tr>
</thead>
</table>

**Supervising GP only:**
What other and how many tasks did you complete above supervising the UC team?

**Prescribing Nurses only:**
Number of patients you gave prescriptions to