

# Audit of the Urgent Care Clinic

December 2018  
Full Report



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## Executive Summary

Brookside Group Practice is an innovative three-site teaching practice in West Berkshire, with a patient population of 27,000.

Following increasing pressure on all appointments and an unsatisfactory urgent care system/process, a new model of urgent care was introduced in 2017. The model aimed to provide a robust service to appropriately treat patients who required same-day appointments. It eliminated the GP telephone triage system, and instead utilises the skills of the multi-disciplinary team, with support and overview from a supervising GP.

An initial audit was conducted in December 2017 to measure and understand the impact and efficiency of the new model, the results from which have been collated in a separate report. A second audit was undertaken in December 2018, which explored the same areas as the first audit as well as assessing the impact of the new point of care (POC) tests that were introduced into the clinic in November 2018.

The results from the second audit demonstrated that of the patients seen by non-GP staff, just under a third (29.5%) were seen and treated without the involvement of the supervising GP. Whilst this is lower than the December 2017 audit (47%), it continues to demonstrate that the clinic model enables a number of patients to be treated by non-GP members of the multi-disciplinary team. The main reasons for the involvement of the supervising GP were for complex patients (48.9%) and prescriptions (46.3%). This reflects the findings of the 2017 audit.

Further analysis of the complex patients found that 23.5% were 16 years old and under, a reduction in this age range from the first audit (41%). Respiratory illness and fever accounted for 21% of presenting complaints within the complex patient group (compared to just under 40% in the first audit). The second most common presenting complaint was eye, ear, facial pain which accounted for 18.7% of complex patients.

While it is interesting to note the differences in the results of the two audits, it is not possible to draw firm comparisons. The patients and the reasons why they presented to the urgent care clinic will be different during the two audit periods. Furthermore, there have been changes within the staffing of the clinic, with new staff joining the clinic team. The new roles include physician associates and physician associate students, who require all their patients to be assessed by the supervising GP. While this would have had an impact on the number of requests for input from the supervising GP, when these staff are removed from the audit figures there is not a noticeable difference in the percentage of patients seen without input from the supervising GP. This finding could be an indication that the patients attending the urgent care clinic are more complex and therefore require input from the supervising GP.

The results of both the 2017 audit and this audit can be used to highlight areas where additional training could further increase the efficiency of the clinic by enabling a greater number of patients to be managed without input from the supervising GP. Similar to the

2017 audit, the results demonstrated that an increase in the number of staff with prescribing rights would enable non-medical staff to manage more patients without input from the supervising GP. The results revealed that for clinicians without prescribing rights, over half (53.5%) of patients requiring supervising GP input was for prescriptions.

A comparison of the non-elective admissions and emergency department attendances from Brookside Group Practice during working hours demonstrated that between December 2015 and December 2018 there was a 31% increase in non-elective admissions and a 6.8% increase in emergency department attendances.

A comparison of the non-elective attendances and emergency department attendances from all GP practices within the Berkshire West CCG region in December 2015 and December 2018 reflected a similar picture, with a 25% increase in non-elective admissions and an 8.2% increase in emergency department attendances in December 2018.

However, a comparison of the figures from Brookside Group Practice between December 2015 and December 2017 revealed different results, with a reduction in both non-elective admissions and emergency department attendances of 26% and 6% respectively. While such comparisons between years are interesting it is not possible to draw conclusions from this as there are numerous and varied factors affecting admissions and attendances at hospitals and emergency departments.

Two POC tests were introduced into the urgent care clinic in November 2018, and all clinicians within the clinic have the ability and access to use the tests when needed. During the audit period, seven tests were used and as such the data capture was extended to March 2019 during which time 60 patients received a POC test. The results demonstrated 60% of test results confirmed the clinicians' thinking and did not alter the management plan. However, for the remaining 40% the results impacted on the consultation outcome including 18% of these patients were referred to secondary care, 10% were referred for further tests and nearly 12% received a different prescription.

If the POC tests had not been available, nearly a quarter of this patient cohort would have been referred to secondary care. This equates to a possible avoidance of 14 admissions to hospital. The POC test enables the primary care clinicians to have a more meaningful discussion with secondary care clinicians about the possible need for admissions or the most effective management plan within primary care. The impact of the POC tests is continuing to be assessed within the Practice.

While some of the audit results differ from the 2017 audit, this audit demonstrated the model of urgent care clinic model within Brookside Group Practice to be an efficient and effective way of utilising the skills of the multi-disciplinary team to see urgent patients within primary care. The model also provides regular training opportunities for clinicians, as they discuss individual cases with the supervising GP. The second audit has also highlighted potential areas for further efficiency and the benefit of having access to POC tests, both for patients and the wider healthcare economy.

## Introduction

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, pharmacists, physician associates and physician associate students. The overarching aim of the Practice is to provide a high standard of healthcare by making appropriate and innovative use of limited NHS resources.

An initial audit looking at the outcomes and effectiveness of the same-day urgent care clinic was undertaken in December 2017, the results of which have been published in a separate report (June 2018). This report presents the findings of a second audit undertaken in December 2018, as well as providing a comparison of the two sets of results.

### Summary of the Urgent Care Clinic

The urgent care clinic model has been in operation for over 18 months and continues to be viewed positively by both patients and clinicians. Below is a brief overview of the clinic model in place.

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 Registrars, paramedics, prescribing nurses, physician associates, physician associate students and GPs. The physician associates and physician associate students are relatively new to the clinical team, having commenced in September 2018. The students are required for all their patients to be assessed by the supervising GP.

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.



## The Approach

The initial audit was undertaken in December 2017 and captured outcomes from the urgent care clinic that cannot be extrapolated from routinely collected activity and performance data. 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. Non-elective admissions and Emergency Department attendances from the Practice's population were also reviewed.

This audit was replicated in December 2018, enabling outcomes of the clinic to be assessed plus a comparison from the previous audit results.

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

An additional element was included in the second audit, to understand the impact of the POC tests introduced within the clinic in November 2018.



## Audit Findings

The audit was carried out from Monday 3<sup>rd</sup> December – Monday 31<sup>st</sup> December 2018. Clinics were held each weekday with the exception of Tuesday 25<sup>th</sup> and Wednesday 26<sup>th</sup> December, due to these being Bank Holidays. Every clinician working in the clinic had one audit form to complete per clinic (Appendix 1).

A comparison with the 2017 audit results have been included where feasible. However, it should be noted that while a comparison of the two audits is interesting, it is not possible to draw firm conclusions as the patients and the presenting complaints during the two audit periods will be different. Furthermore, there have been staff changes within the clinic, with new members of staff joining the team. This may also have impacted on the requests for input from the supervising GP.

### Overview

	December 2017	December 2018
Number of clinics	36	38
Number of forms submitted	220	232
Number of patients seen	948	808

### Number of Patients Per Clinic

On average, 21 patients were seen in each clinic. There was a slight increase in the average number of patients seen in the morning clinic, with 23 patients seen compared with an average of 20 patients seen in the afternoon clinics.

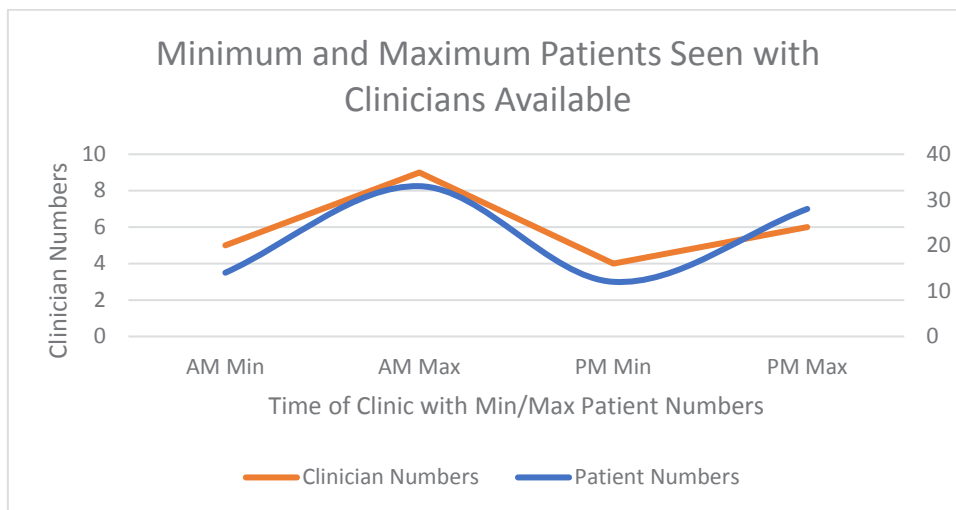
These results are lower compared with the 2017 audit which reported an average of 26 patients per clinic, with there being no difference in the morning and afternoon clinics.

The difference in the number of patients seen in the two audit periods can be explained by the removal of four clinic GP slots per clinic prior to the start of the December 2018 audit. The reason for this was to create more routine appointment slots due to the increasing waiting time for routine appointments, which had increased from five days to over two weeks. However, it has always been the intention to reduce the clinic GP availability within the urgent care clinic as the model becomes more embedded into practice and the clinical team becomes more confident in managing and treating patients safely and appropriately.

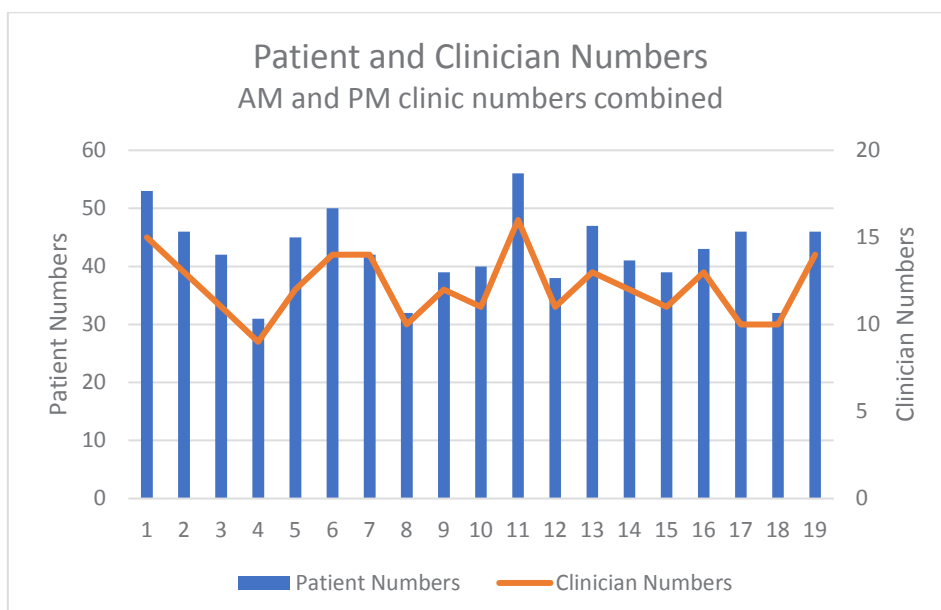
There was a large difference in the maximum and minimum number of patients seen in one clinic. This, however, was accompanied by a corresponding difference in the number of clinicians in the clinic. These figures are very similar to the 2017 audit findings.

		<b>Number of Patients</b>	<b>Number of clinicians (date)</b>
AM clinic	Minimum	14	5 (28 <sup>th</sup> )
	Maximum	33	9 (17 <sup>th</sup> )
PM clinic	Minimum	12	4 (12 <sup>th</sup> )
	Maximum	28	6 (27 <sup>th</sup> )

The graph below clearly illustrates the relationship between the number of patients seen with the number of clinicians available in the clinic.

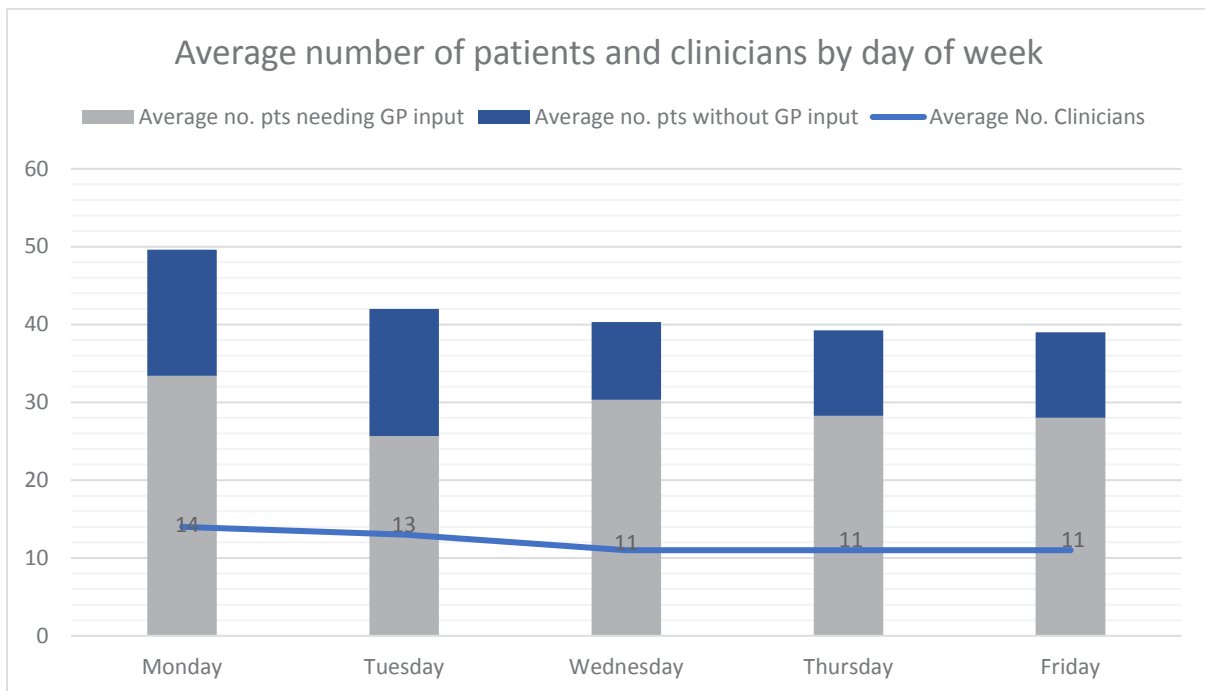


The graph below shows the same information, but for all dates on which the audit was conducted. Data from morning and afternoon clinics have been combined.



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. Similar findings were also seen in the December 2017 audit.

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.



Again, this is consistent with the results from the December 2017 audit. However, while both audits demonstrate that Monday has the greatest number of attendances, the 2018 audit showed a more consistent number of patients over all five days, particularly over Wednesdays, Thursdays and Fridays.

#### Patients asked to return for same issue

Seventy-three patients (9%) were asked to return for another appointment for the same issue, either to the urgent care clinic or a routine clinic. This represents an increase in the number of patients asked to return when compared with the December 2017 audit (38 patients).

The number is still relatively small in relation to the total number of patients seen. However further in-depth analysis of these patients would be required to understand the specific reasons why the patients were asked to return.

### Inappropriate attendances

4.5%, or 36 patients, were considered to be inappropriate attendances at the urgent care clinic. This is a reduction compared with the December 2017 audit (93 patients), which may reflect that patients are more aware of and comfortable using the other methods of engaging with the practice, such as the routine clinics, telephone or website.

### Did Not Attend (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. These figures are much lower compared to the December 2017 audit, which demonstrated a total 28 DNAs and an average per clinic of 0.8.

	Number of DNAs	Average per Clinic
All Clinics	13	0.3
AM Clinics	6	0.3
PM Clinics	7	0.4

### Summary of patients requiring supervising GP input

As well as there being a supervising GP in each clinic, there is often a GP working within the urgent care clinic. However, unlike the December 2017 audit, the figures below do not exclude clinic GPs. This is because on a small number of occasions, clinic GPs requested the input of the supervising GP for complex cases.

Number of patients seen	808
Number of patients seen <b>without</b> supervising GP input	248
% patients seen <b>without</b> supervising GP input	30.7%
Average number patients per clinic seen <b>without</b> supervising GP input	7

In order to understand the impact of the non-GP clinicians within the urgent care clinic the figures below have excluded the clinic GP. This also enables a comparison with the December 2017 audit, in which no patients seen by the Clinic GPs had input from the supervising GP.

Number of patients seen (excluding those seen by clinic GP)	790
Number of patients seen <b>without</b> supervising GP input	233
% patients seen <b>without</b> supervising GP input	29.5%
Average number patients per clinic seen <b>without</b> supervising GP input	6

These figures demonstrate a reduction in the number of patients seen by non-GP clinicians who did not require input from the supervising GP, compared with the December 2017 audit (47.4%). Further analysis of these patients would be required to understand why more patients required input from the GP, i.e. is it a result of increased complexity of the presenting complaint, experience of the clinician assessing the patient?

As the December 2018 audit included new roles that were not part of the previous audit and clinicians who were required to have all their patients reviewed by the supervising GP, the table below shows the impact of removing these clinicians from the audit results:

	Total patients seen	Patients seen without GP input	% seen <b>without</b> GP input
Removal of: PA student & registrar	780	234	30%
Removal of: PA student	802	247	30.8%
Removal of: PA student, registrar & physician associate	722	221	30.6%
Removal of: PA student & physician associate	752	240	31.9%

Compared with the table on the previous page, the impact of removing different roles on the percentage of patients seen without supervising GP input is minimal. As the reduction in patients seen without supervising GP input compared with the previous audit cannot be explained by the newly recruited clinicians and clinicians in training roles, this may indicate that the patients seen in the clinic are more complex and therefore require more involvement from the supervising GP.

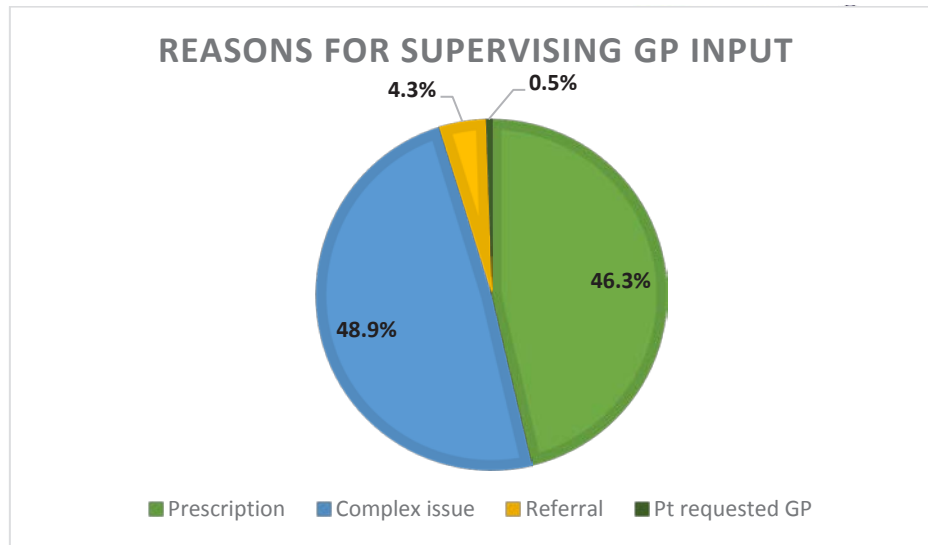
#### Breakdown of Reasons for Supervising GP Input

560 patients (69.3%) required input from the supervising GP. As highlighted above, this is a greater percentage compared with the December 2017 audit.

The audit gave four options for GP input:

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

Reason for supervising GP Input	Patient Numbers	Percentage
Prescription	259	46.3%
Complex issue	274	48.9%
Referral for other service or test	24	4.3%
Patient requested GP input	3	0.5%



The significant majority of requests for input from the supervising GP was due to the patient presenting with a complex issue (48.9%) or a prescription being required (46.3%). This very much reflects the outcomes of the December 2017 audit.

Breakdown by role

Role	Total pts seen	Av pt / clinic	% seen without GP input	For those requiring supervising GP input: % breakdown of reasons			
				Prescription	Complex issue	Referral	Pt request
Clinic GP	18	5	83.3%	0%	100%	0%	0%
Practice nurse	291	4	24.1%	55.2%	40.3%	4.1%	0.4%
Registrar	28	3	64.3%	0%	90%	10%	0%
Specialist paramedic	130	4	33.1%	49.4%	49.4%	0%	1.2%
Paramedic	159	4	15.1%	51.9%	40.7%	6.7%	0.7%
Prescribing nurse	126	5	55.6%	0%	92.9%	7.1%	0%
Physician associate	56	3	14.3%	58.3%	39.6%	2.1%	0%

By looking at individual roles and the reasons for GP input, it offers the opportunity to consider potential areas for additional training. For example, across the practice nurses, paramedics and physician associates more than 50% of requests for supervising GP input was for prescriptions. If some clinicians were able to gain prescribing rights, this could further increase the efficiency of the clinic.

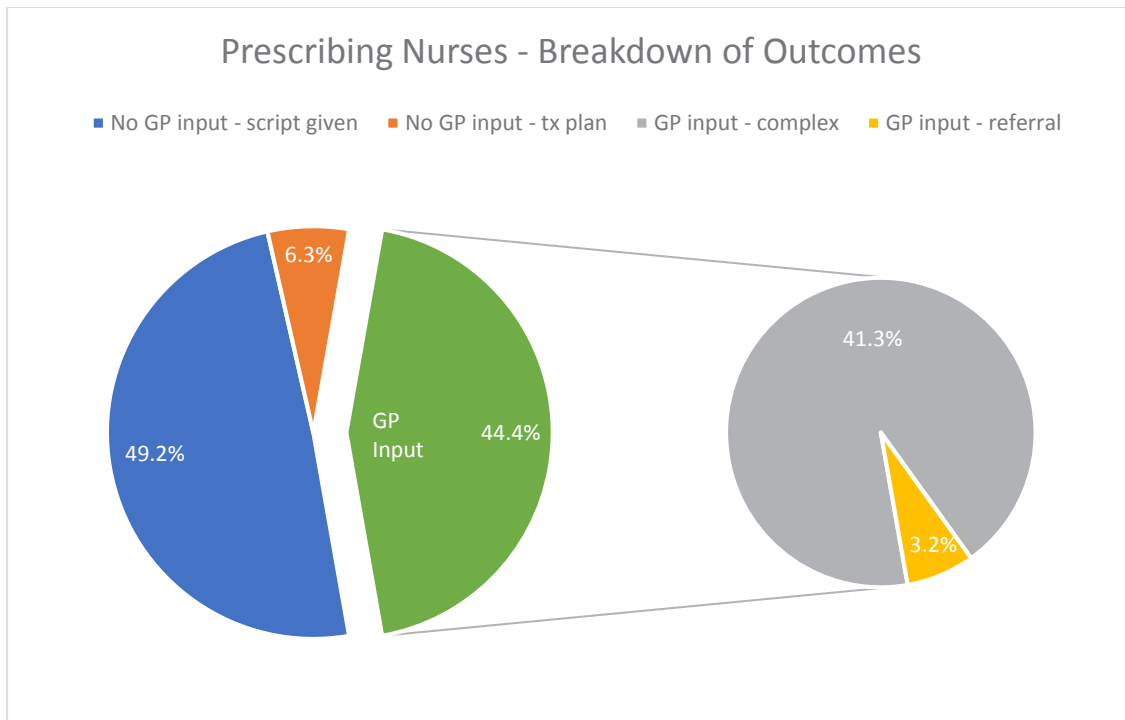
Similar results were demonstrated in the December 2017 audit.

**Prescribing nurses**

Prescribing nurses saw a total of 126 patients. Of these, the nursing staff dealt with 70 patients without input from the supervising GP (55.6%).

A total of 49.2%, or 62 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.





### Comparison of Prescribing Nurses and Non-Prescribing Clinicians

Role	Total pts seen	Av pt / clinic	% seen <b>without</b> GP input	For those requiring supervising GP input: % breakdown of reasons			
				Prescription	Complex issue	Referral	Pt request
Prescribing nurses	126	5	55.6%	0%	92.9%	7.1%	0%
Non-prescribing clinicians*	636	4	22.8%	53.5%	42%	3.9%	0.6%

\*practice nurse; specialist paramedic; paramedic; physician associate

Consistent with the outcomes of the 2017 audit, there is a difference in the number of patients who do not require input from the supervising GP – 55.6% for prescribing nurses and 22.8% for those in non-prescribing roles. These results demonstrate that both groups had a slight drop in the number of patients who were seen without GP input compared to 2017 (60.4% and 32% for prescribing nurses and non-prescribing clinicians respectively).

The main reason for the difference between GP input for prescribing nurses and non-prescribing clinicians is due to prescriptions. Over half (53.5%) of the patients seen by non-prescribers and who required input from the supervising GP, was due to prescriptions. This was consistent with the outcome in the 2017 audit (53%).

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 64.2%. Consideration should therefore be given to increasing the number of prescribers within the clinic, which would further reduce the demand for supervising GP input. The 2017 audit provided a very similar picture, as the same assumption revealed an increase in patients not requiring GP input to 68%.

## Further Analysis of ‘Complex Patients’

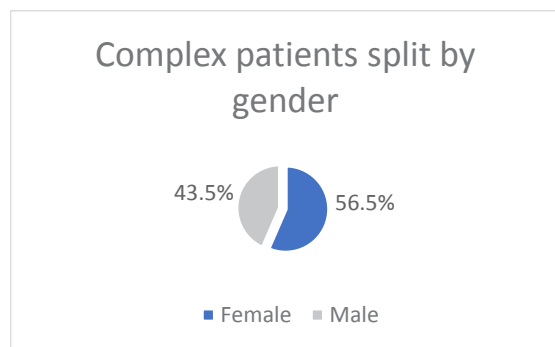
A more in-depth look at the patients requiring supervising GP input for ‘complex’ reasons was undertaken following the audit. As the audit forms did not request patient details to be recorded, a review of each clinic from the audit period was undertaken on the Practice’s electronic patient record system.

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 a greater number of patients (391) have been included in this further analysis, rather than the 270 ‘complex’ patients indicated in the audit.

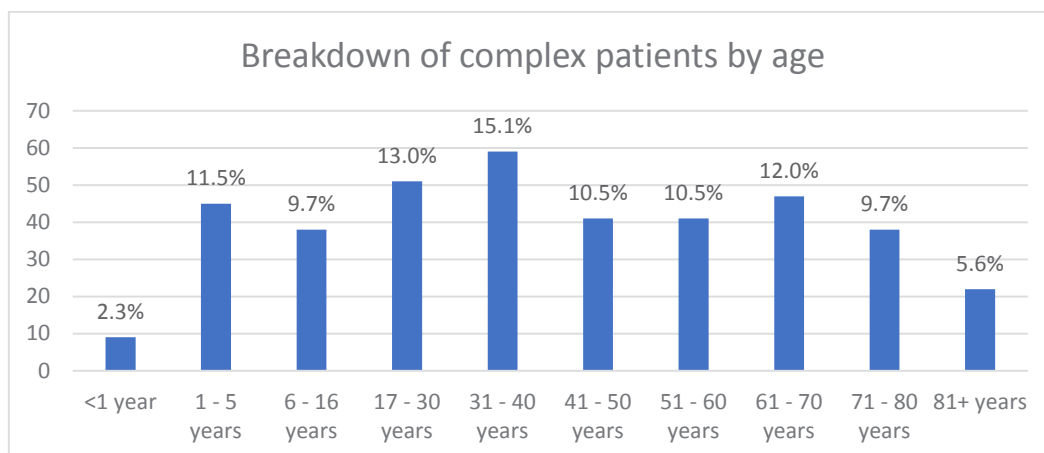
### Summary of Patients

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

	Number of Patients Seen
Female	250
Male	193
Total	391

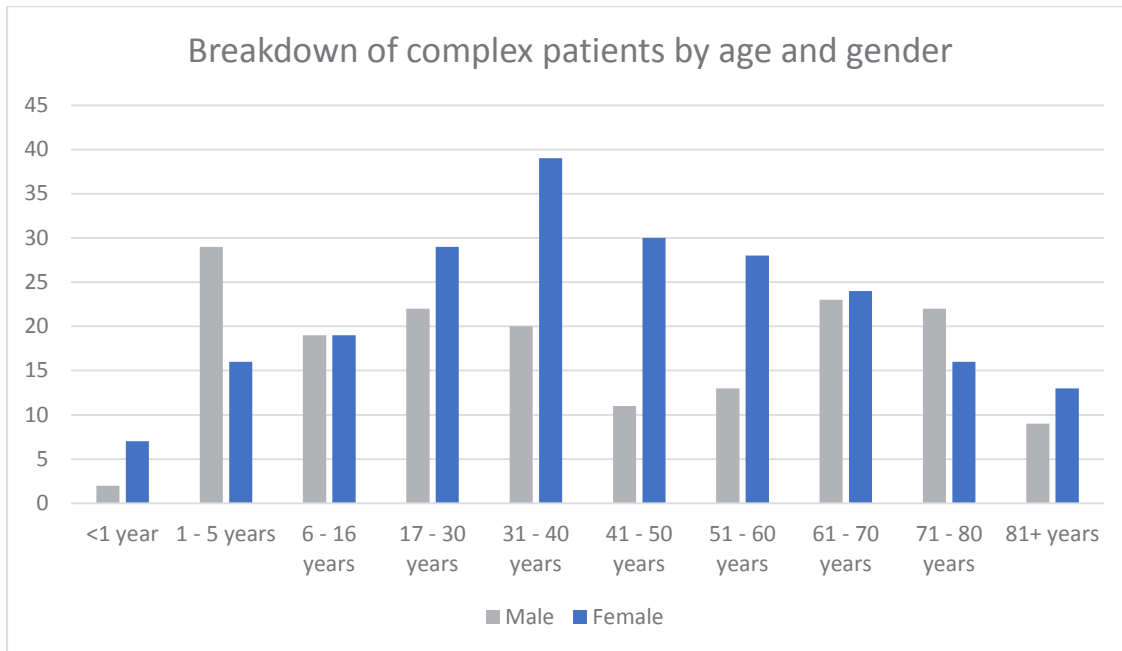


The graph below provides a breakdown of the patients by age, with the largest age group requiring supervising GP input being the 31 – 40 year olds. This is different to the December 2017 audit, which demonstrated that 1 – 5-year olds required the greatest input from the supervising GP (18.6%), followed by 6 – 16 year olds (17.8%).



Patients who were 16-years old and under accounted for 23.5% of complex patients. This is much less than the previous audit which showed 40.7% of complex patients were 16 years and under.

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 more of the complex patients in each age group. These findings are the same as the previous audit.

### Breakdown of Complex Patient by Presenting Complaint

The presenting complaints 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 (21.0%)
2. Eye, ear, facial pain (18.7%)
3. Back, shoulder, neck, joint pain (12.8%)

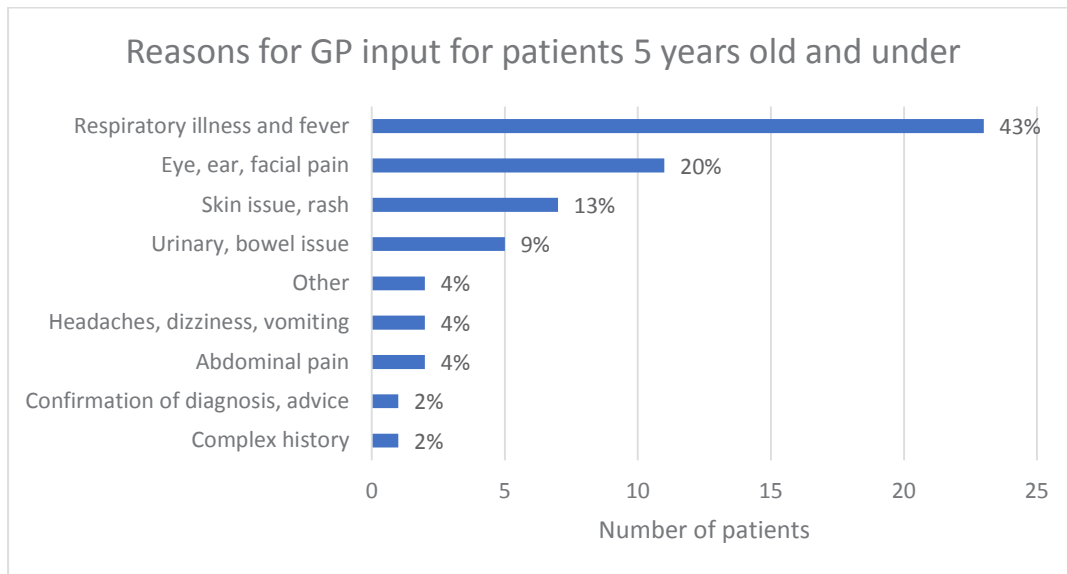
Reasons	Male	Female	Total	% of Total
Abdominal pain	6	14	20	5.1%
Back, shoulder, neck, joint pain	31	19	50	12.8%
Breast lump, pain	1	5	6	1.5%
Cardiac	2	6	8	2.0%
Complex history	1	1	2	0.5%
Confirmation of diagnosis, advice	3	1	4	1.0%
Eye, ear, facial pain	31	42	73	18.7%
Gynae issues	0	8	8	2.0%
Headaches, dizziness, vomiting	10	11	21	5.4%
Issue during pregnancy	0	12	12	3.1%
Medication review	3	0	3	0.8%
Respiratory illness and fever	39	43	82	21.0%
Skin issue, rash	18	26	44	11.3%
Urinary, bowel issue	17	27	44	11.3%
Other*	8	6	14	3.6%
<b>TOTAL</b>	<b>170</b>	<b>221</b>	<b>391</b>	<b>100.0%</b>

*allergic reaction	0	1	1
*anxiety	1	0	1
*generally unwell	0	3	3
*issue post RTA	2	0	2
*neuropathic pain	1	0	1
*patient requested GP input	0	1	1
*referral to secondary care	1	1	2
*sepsis	1	0	1
*sick certificate required for work	1	0	1
*unexplained bruising	1	0	1

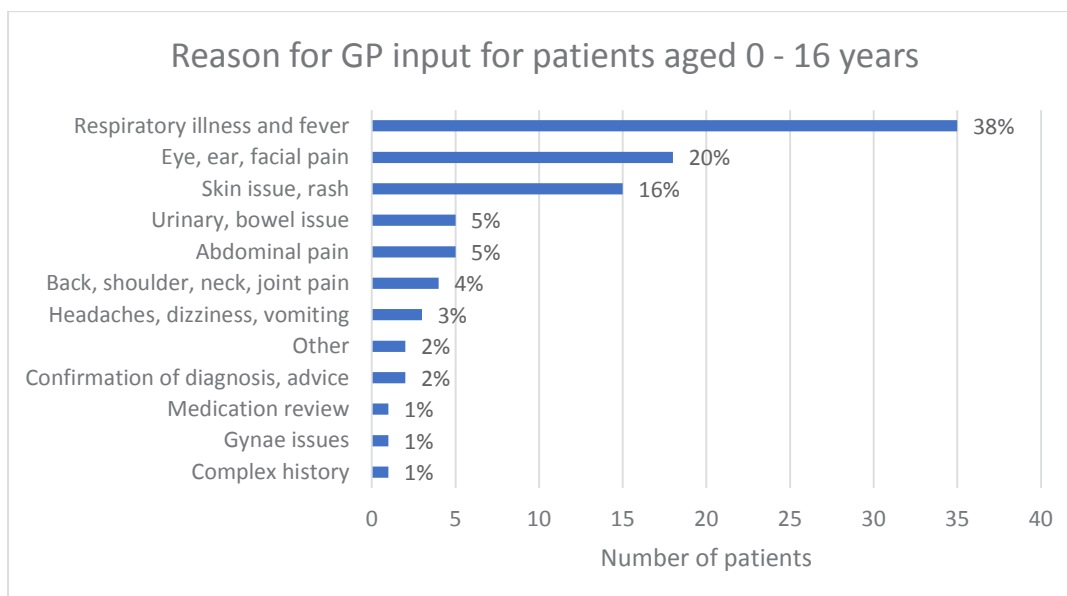
The top three presenting complaints are largely comparable to the December 2017 audit results. Respiratory illness and fever was the top reason for supervising GP input across both audits, while eye, ear and facial pain was the third most common reason for

supervising GP input in the previous audit. Skin issue / rash was the second most common reason in the 2017 audit, with 15.3% of complex patients falling under this category.

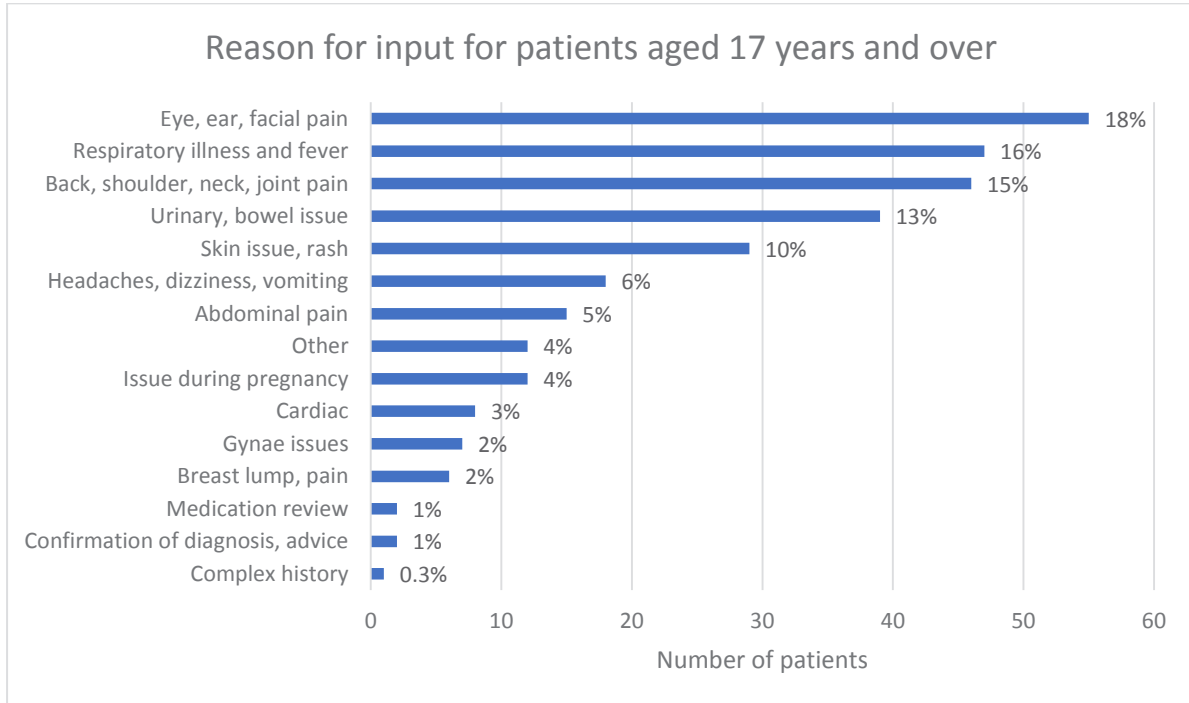
The graph provides a breakdown of the presenting reasons for patients aged 5 years and under who required input from the supervising GP. Just under half of these patients present with respiratory illness or fever. This is similar to the previous audit which showed 50% of this age group presented with the same reason. The top three presenting reasons for this age group are comparable with the previous audit (skin issue, rash: 20%; eye, ear and facial pain: 9%).



The graph below provides the breakdown of presenting complaints for complex patients aged 0 – 16 years. Similarly to the 0 – 5 age group, the top three reasons are the same. This also reflects the results from the 2017 audit.



The graph below shows the same breakdown for complex patients aged 17 years and over.



A review of the breakdown of complex patients and their presenting complaint by age group shows that the most common presenting complaint was respiratory illness and fever in five out of the ten age groups. This is different to the previous audit which demonstrated this was most common reason in nine of the age groups.

The 2018 audit demonstrated greater variety between the age groups for the most common presenting complaint, compared with the December 2017 audit.

Whilst the grouping of reasons provides a high level overview, it does not provide the detail as to why the supervising GP was required. Further in-depth analysis would enable the Practice to understand the areas where further training could be beneficial.

## Point of Care Testing

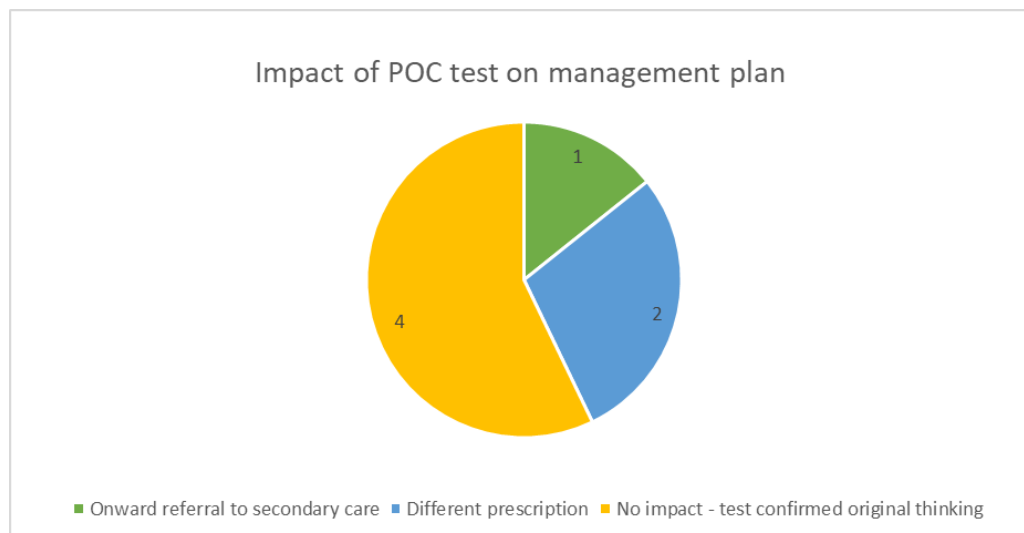
In November 2018 the Practice introduced two point of care (POC) tests which measure:

- CRP (C-reactive protein): blood test marker for inflammation in the body
- Full blood count: provides information about the kinds and number of cells in the blood
- Urea and electrolytes: provides information regarding renal function
- Lactate: high levels of lactate in the blood may indicate a lack of oxygen; the test can be used if the clinician suspects sepsis, shock, heart attack, severe heart failure, kidney failure or uncontrolled diabetes

The test results are available within minutes, and all clinicians within the clinic can use these tests.

The audit incorporated additional questions specifically to show the impact of the POC tests – did the test result change the management plan, and if the test had not been available what course of action would the clinician have taken.

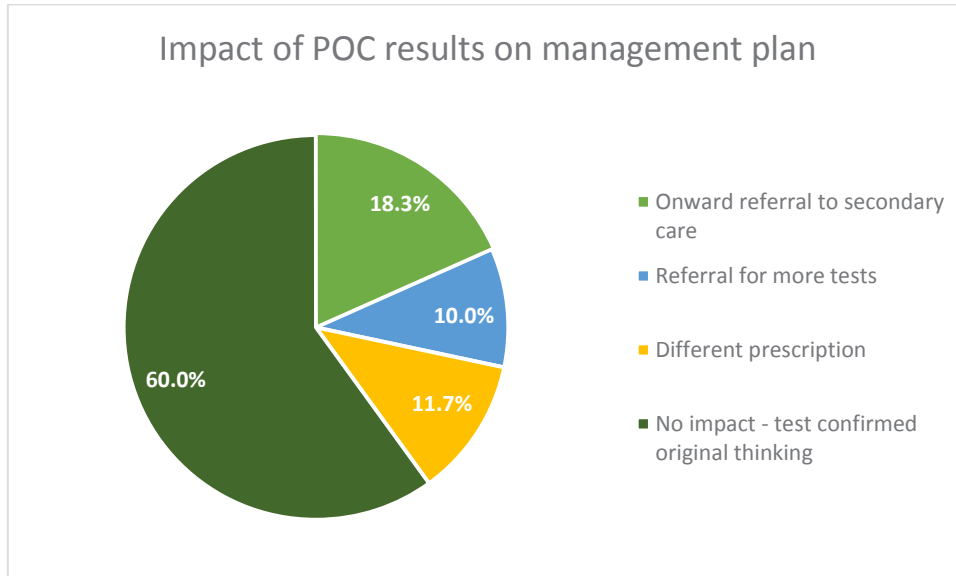
During the audit period, seven patients had a POC test carried out during their appointment. While this number is too small to draw conclusions, it is interesting to note the results:



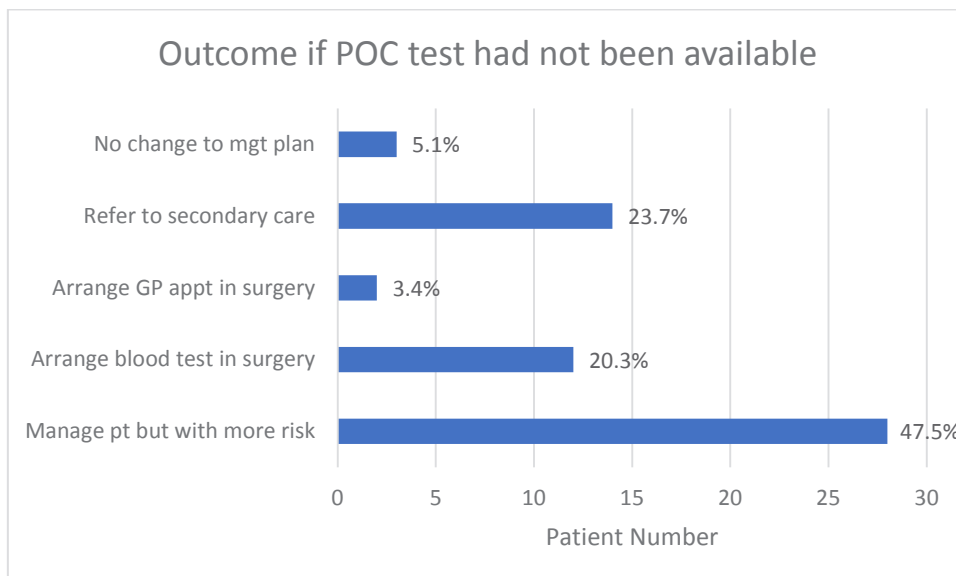
Clinicians reported that if the POC test had not been available, four of the patients would have been managed within primary care but with more risk and two patients would have had a blood test in the surgery. This question was unanswered for one patient.

Due to low numbers, data on the impact of the POC tests continued to be collated until March 2019, and the graphs below outline these results.





As shown, in 60% of patients who received a POC test the results confirmed the clinicians' thinking and did not alter the management plan. However, for the remaining 40% (24 patients) the POC had an impact on the outcome of the consultation. This included different prescriptions to ensure the condition / infection was treated appropriately, the patient being referred for further tests, or the patient being referred to secondary care. In some such cases, the result of the test provided confirmation to the acute hospital that the patient did require admission.



The chart above outlines what the management would have been if the POC test had not been available. In nearly 50% of cases, the clinician would have continued to manage the patient in primary care but with more risk. In 20.3% of cases, tests would have been arranged in primary care at a later date, meaning that treatment would possibly be delayed.

In 3.4% of cases, a follow-up appointment would have been arranged in the GP surgery and as such the POC test has enabled appointments to be avoided. In nearly a quarter (23.7%) of patients receiving the POC test, the test avoided a referral to secondary care. In this small audit, this equates to a possible 14 admissions to hospital being avoided. The results from the POC test enable the primary care clinician to have a more meaningful discussion with secondary care clinicians about the possible need for admission to hospital, or if admission is not required the most effective management plan within primary care.

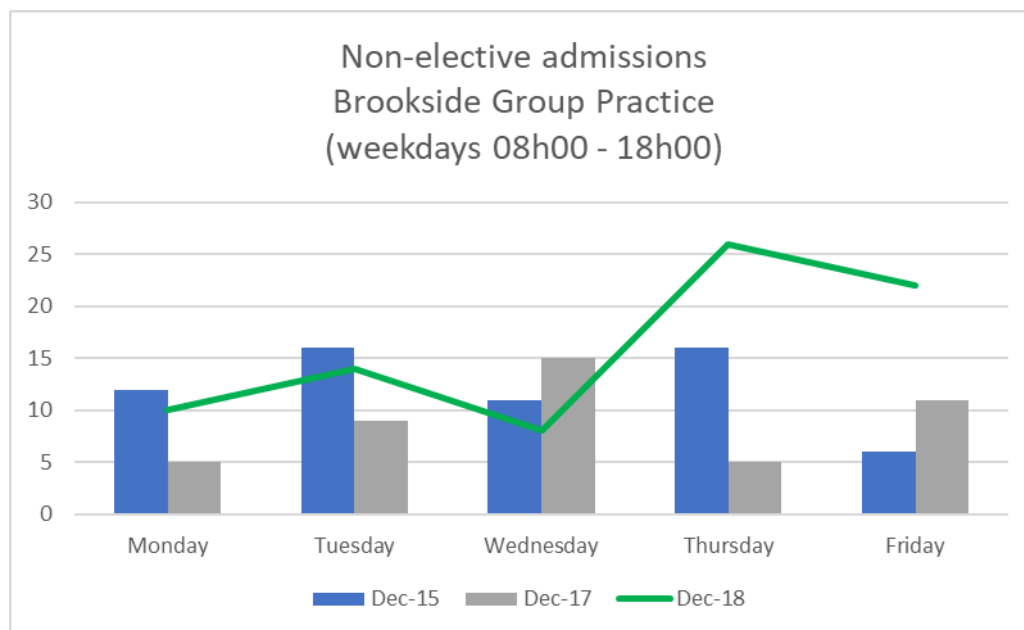
## Non-Elective Admissions and Emergency Department Attendances

As per the previous audit report, a snapshot of the non-elective (NEL) admissions and Emergency Department (ED) attendances from the Brookside Group Practice population has been reviewed. Any changes in the number of NEL admissions and ED attendances from a GP practice population are the result of many factors, and therefore direct correlations cannot be drawn with one individual working practice.

Data from December 2015, December 2017 and December 2018 has been 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, December 2017 and December 2018.

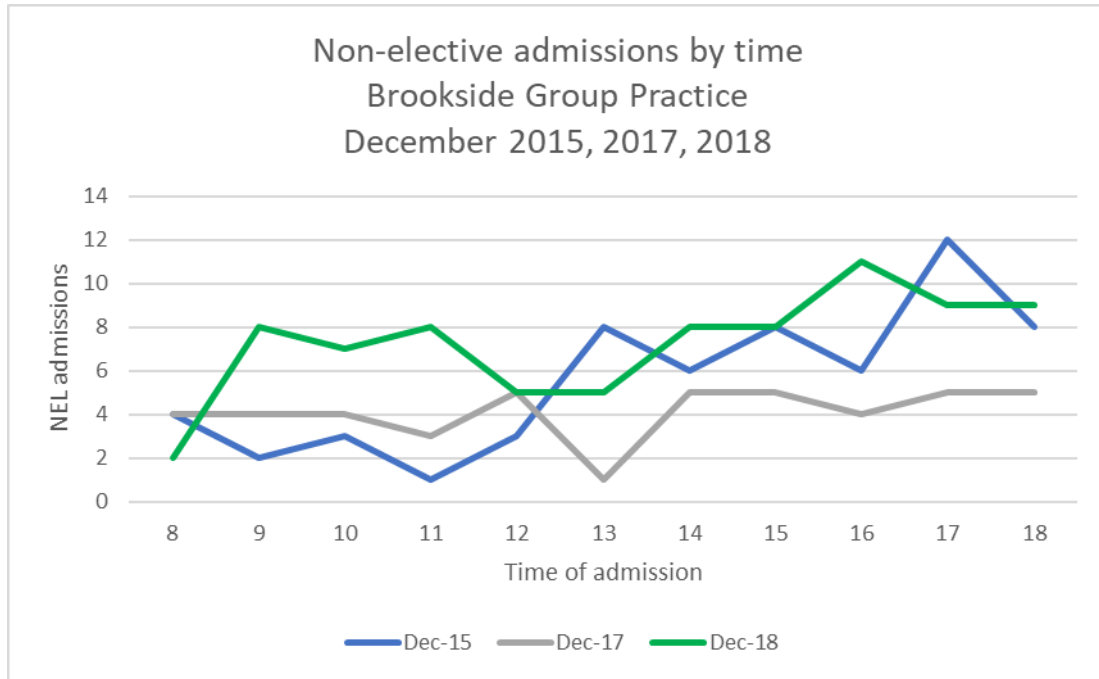


Compared to December 2015, there was a 31% increase in NEL admissions in December 2018 from the Brookside Group Practice population. As shown on the chart above, the NEL admissions during working hours in December 2018 are, with the exception of Wednesdays, consistently greater than those in December 2017.

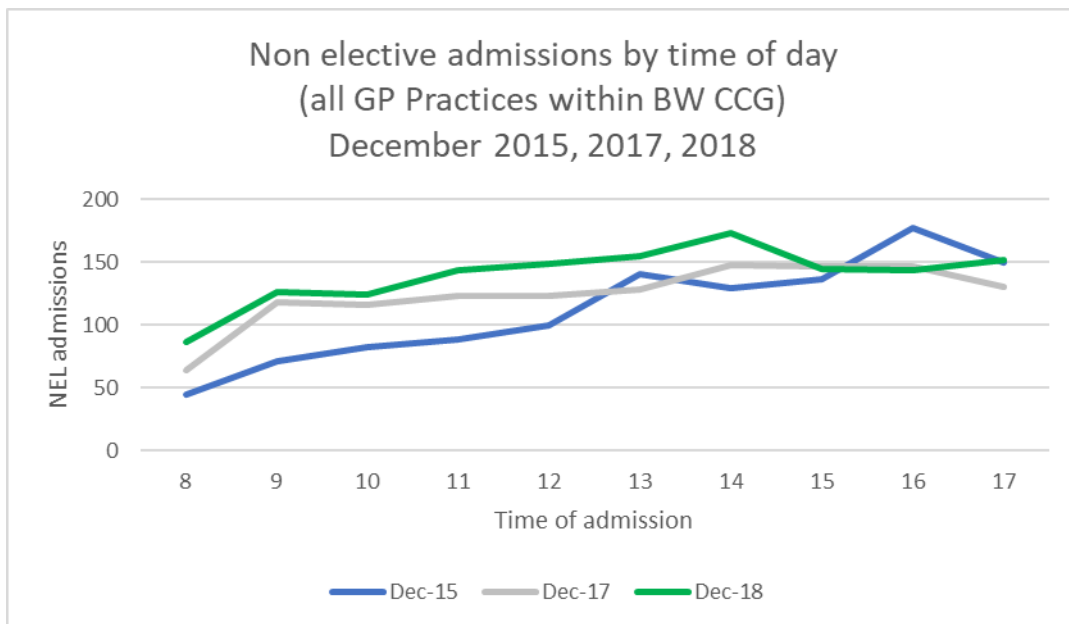
A review of the NEL data from all GP practices within the Berkshire West CCG region, comparing the same time period (December 2015 and December 2018), revealed a 25% increase in NEL admissions in December 2018.

The chart below highlights the number of NEL admissions from the Brookside Group Practice population by time of admission. This demonstrates in December 2018 there was a

more varied spread of admissions across the working day, with a peak in the afternoon, unlike December 2017.

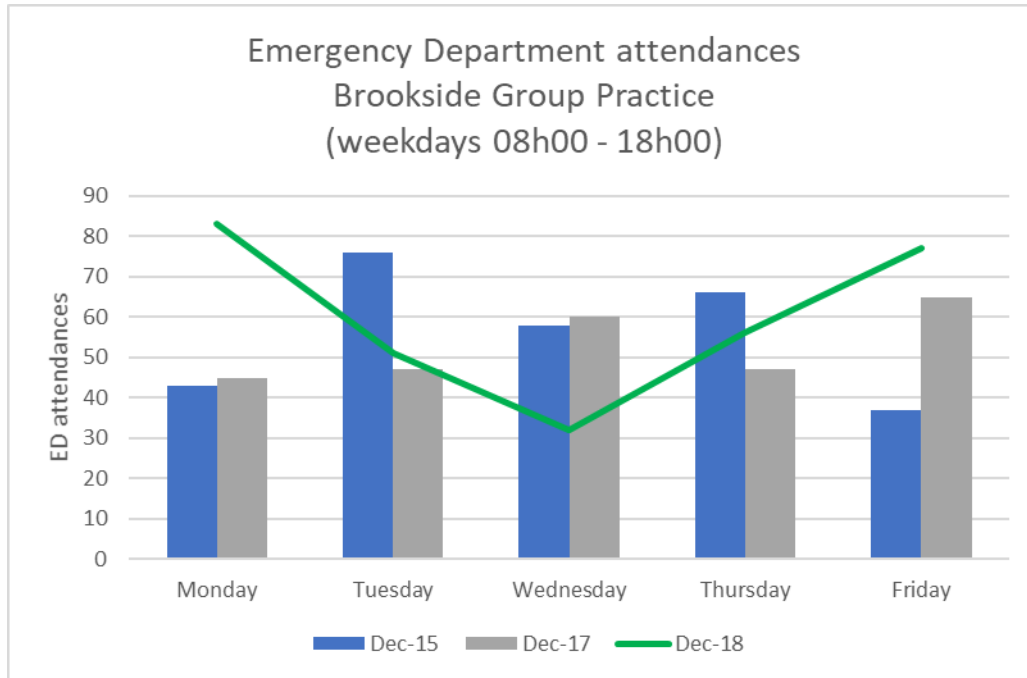


The chart below shows the same data from all GP Practices within the Berkshire West CCG region. This demonstrates a greater number of patients were admitted across the morning and early afternoon in December 2018 compared to December 2015 and December 2017, with a small decline in admission numbers in mid to late afternoon.



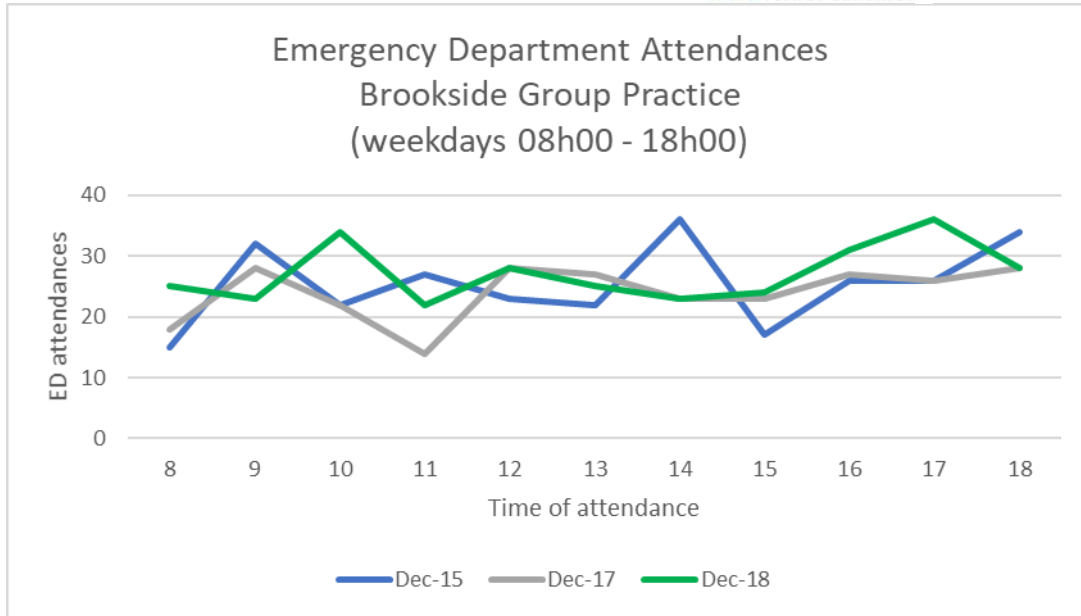
### Emergency Department Attendances

The chart below compares ED attendances from the Practice between December 2015, December 2017 and December 2018.

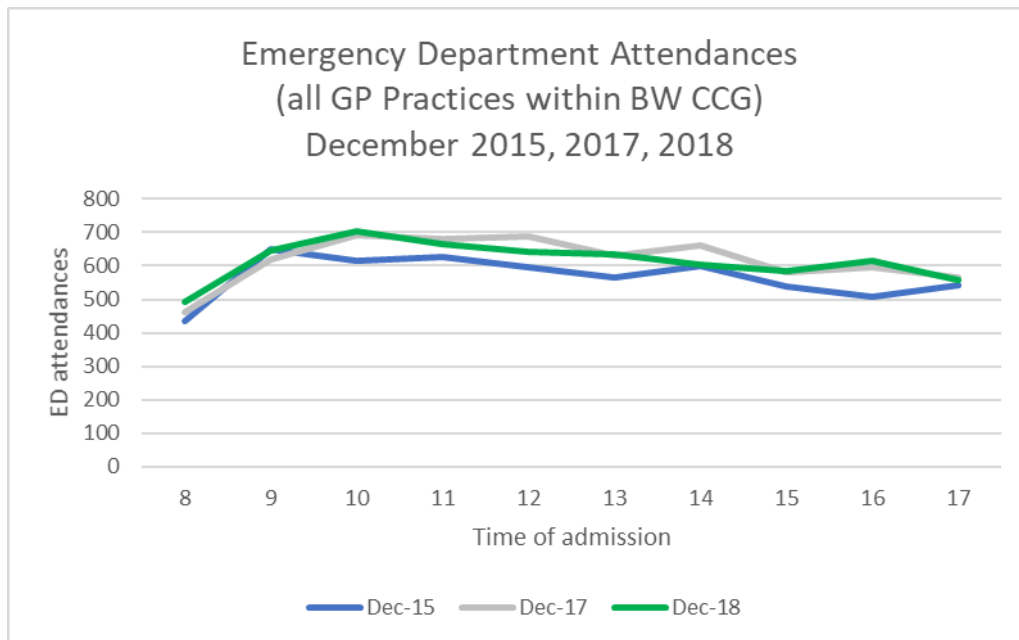


Compared to December 2015, there was a 6.8% increase in ED attendances in December 2018. As can be seen, there is a drop in the number of attendances on Wednesdays compared to previous years, while Mondays and Fridays have the greater number of ED attendances. A review of the ED attendance data from all GP practices within the Berkshire West CCG region, comparing the same two months, revealed a similar increase in ED attendances (8.2%).

The graph below highlights the number of ED attendances by time of admission. In December 2018 the time of attendances is roughly comparable to those in December 2015 and 2017, with a slight increase in attendances between 15h00 and 17h00.

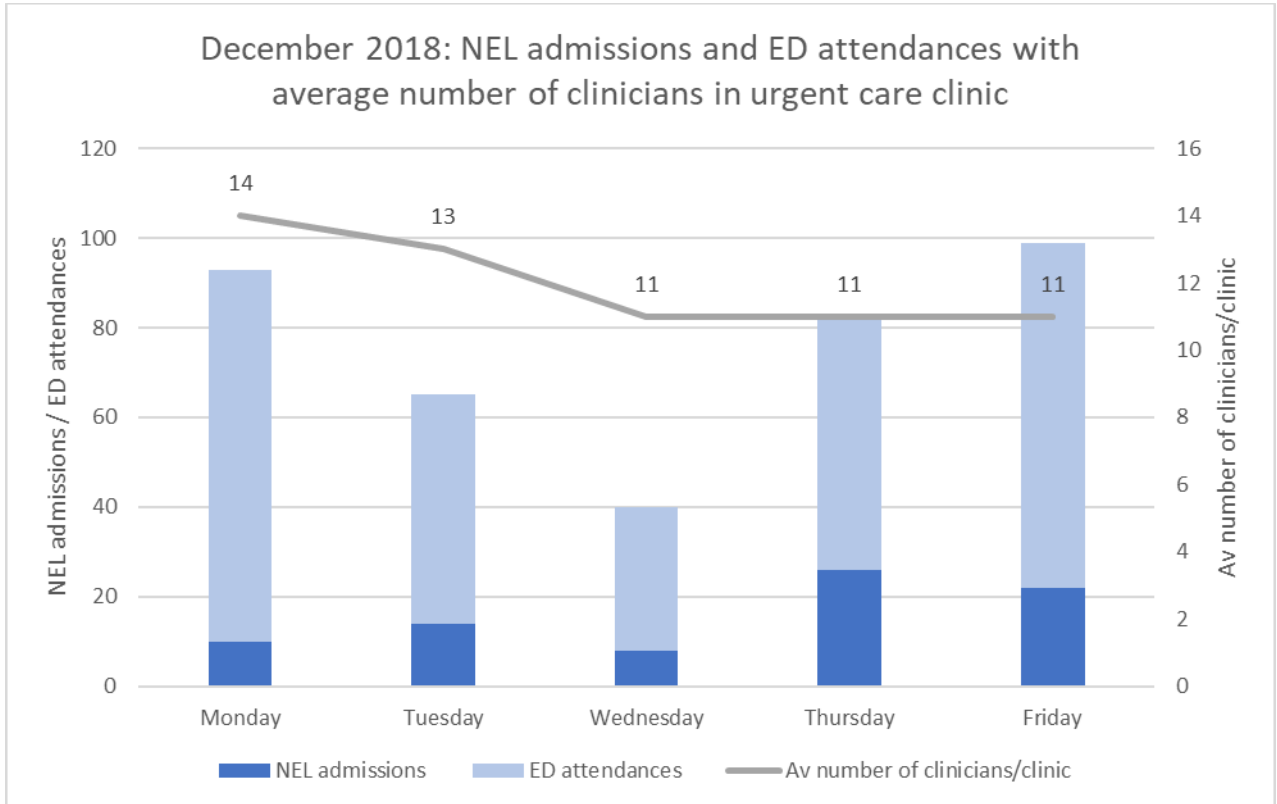


The same data for all GP Practices within the Berkshire West CCG region shows a very similar pattern in terms of time of ED attendance between December 2015, December 2017 and December 2018.



### 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.



Whilst it is interesting to compare the number of clinicians in the urgent care clinic with the NEL and ED activity figures, it is not possible to determine correlations between these. Much more detailed information and analysis would be required to draw definitive conclusions.



## Contacts

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## Appendix 1

### Audit Form

### **Urgent Care Clinic – Audit**

We are working with the Oxford AHSN to re-audit the impact of the urgent care clinic, including the new POC test. 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\*\***

1	Date and time of clinic	Date:	AM	PM			
2	Your role in clinic:	Supervising GP	Clinic GP	Prescribing Nurse			
	Your initials: _____	Practice Nurse	Paramedic	Specialist Paramedic			
3	Number of patients you treated <u>without</u> input from supervising GP / patients seen by Clinic GP						
4	Number of patients you saw <u>who required input</u> from supervising GP						
5	Please indicate reasons for GP input, and number of patients requiring that input:	Prescription (inc EPS)	Complex issue	Referral for another service / test	Patient requested GP input		
6	Number of patients asked to return for routine appointment for same issue						
7	Number of patients seen for whom you felt the urgent clinic was not appropriate						
8	Did you use the POC test? Please indicate number of patients	Yes	No				
9	If POC test used, did the results change the management plan? Indicate number of patients	Yes: onward referral to secondary care	Yes: referral for more tests	Yes: different prescription	No: test confirmed my original thinking		
10	If POC test had not been available, what would you have done? Indicate number of patients	Manage patient but with more risk	Arrange blood test in surgery	Arrange GP appointment within surgery	Refer to secondary care	No change to management plan	Refer to another agency (please specify)
11	<b>Supervising GP only:</b> What other <u>and how many</u> tasks did you complete above supervising the UC team?	For example: EPS, UC phone calls, other phone calls, letters/ referrals, Docman					
12	<b>Prescribing Nurses only:</b> number of patients you gave prescriptions to						

