Better Local Care Hampshire Multispecialty Community Provider Vanguard

Deep Dive Evaluation Report: Same Day Access Service (SDAS)

June 2017

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EXECUTIVE SUMMARY

The Same Day Access Service (SDAS) is an urgent primary care hub based in Gosport War Memorial Hospital. It provides patients from four Gosport practices with easier access to same-day consultations with an appropriate healthcare professional.

The SDAS was first introduced in January 2016 with £383,500 of funding from Better Local Care. It is intended to help address growing demand for urgent primary care, and increase the proportion of cases dealt with through means other than face-to-face GP appointments such as non-GP practitioner appointments, use of community providers and self-management solutions. A key objective is to filter routine cases and provide GPs more time with patients who have complex clinical needs or long term conditions (LTCs).

The SDAS currently provides a service for patients from four of Gosport's eleven GP practices: Waterside Medical Centre; Stoke Road Medical Centre; Brune Medical Centre; and Forton Medical Centre. It is located at Gosport War Memorial Hospital and comprises one full-time, core GP (supported by Southern Health) with input from several locums and GPs from participating practices providing specialist sessions. Specialist non-GP support is also provided by a physiotherapist (0.4 FTE), several practice nurses and a paediatric nurse practitioner. The service is expected to expand into more local practices later in 2017.

Methodology

This report assesses SDAS activity from the start of its implementation (January 2016) through to April 2017. The evaluation used a mixed method approach which is expanded upon in detail in Appendix 2. The methods employed during the Deep Dive research included:

- Desk research: analysis of SDAS service data for the period January - December 2016 including:

  - SDAS service data:

    – Call volumes and times;

    – Call response time;

  - Triage outcome data:

    – Proportion of calls redirected to other care sources;

    – Proportion resulting in telephone / face-to-face consultation;

    – Demographic profile of patients using the service;

  - Patient experience and outcomes:

    – Patient clinical outcomes tracked using SDAS outcome codes; and

    – Patient experience (measured using patient surveys conducted by the SDAS service in May (n=137) and December (n=129) 2016). Patients were self-selected i.e. those that agreed to participate in the survey following a telephone call with the service.

- Staff surveys: RSM PACEC carried out a programme-wide survey of clinical and management staff involved with the Hampshire Better Local Care vanguard. This data includes the views of 16 staff who responded to the survey and were involved in the SDAS, which has been analysed to inform this report.

- **Staff interviews:** In-depth, semi structured telephone interviews with clinical and administrative staff (n=4) covering collaborative working and team development, service sustainability, key lessons learned, and barriers in replication, roll-out and scalability

Methodology Limitations

The evaluation team would like to thank all staff from Southern Health, Better Local Care and the SDAS team for their support regarding background information and data requests. There are, however, some limitations to the data including:

- Data access: Regulatory changes regarding the use and publication of Secondary Users Service (SUS) data on secondary care (hospital) settings has reduced the scope of the quantitative analysis for a number of SDAS outcomes.
- Workforce changes: The evaluation plan originally sought to measure changes in locum usage to assess the extent to which the service was freeing up GP time. However, the departure of several GPs from the area has led to an increase in locum usage, making it more difficult to assess capacity impacts.
- Quality of data: Data quality more generally was a limiting factor. Relatively small sample sizes (self-selected for the patient survey), patient experience data that relates to non-equivalent months, and the lack of any control group limits the extent to which the evaluation can provide concrete conclusions regarding the impact of the service.

Evaluation findings

Context and need

Evidence on the health profile of the local population found a clear need for the service, and a strong fit against the key themes of demand growth, access to services and enhancing GP time for patients with Long term conditions (LTCs). Specific system and healthcare drivers of demand in Gosport, to which the service seeks to respond, include:

- Increasing percentage of patients with long term conditions: When compared to the England average, Public Health England data for Gosport shows above average levels of premature mortality and major diseases such as cardiovascular and smoking-related conditions.
- GP workload and associated retention issues: GP retirement and significant recruitment challenges, the number of patients per WTE GP in SDAS practices in 2015 (3,457) was higher than the national average (2,553 patients per WTE GP).
- Growing dissatisfaction among patients with all aspects of GP access: Largely facilitated by the above points.

The SDAS was set up in Gosport in response to a very specific and pressing need to sustain GP services in the locality in the face of these pressures. It was established via a consultative process with all GP practices in the locality, and subsequently via a Clinical Model Development Group that provided clinical leadership for implementing substantive change.

Evaluations of similar interventions support the efficacy of a same day access model, providing evidence of improved access, reduced waiting time, increased numbers of appointments, and longer (12 minute) pre-planned care appointments for those who have more complex issues.

SDAS Activity

Key points to note from a review of SDAS activity data include:

- The number of calls triaged by the service between January and December 2016 was 44,793 (with an average of 3,700 per month);
- In total, 28,331 (63%) of patients triaged had their issue dealt with over the telephone;
- In total, 16,462 (37%) had their issue dealt with through face to face appointments;
- The proportion of GP face-to-face calls fell sharply after the first two months and remained low for the rest of the year so that by December, GPs were dealing with less than one quarter of face-to-face appointments arranged;
- The time taken for call-backs to occur fell gradually throughout the year; and
- As the service has progressed the proportion of face-to-face appointments has decreased.

Success Factors

Both monitoring data and patient satisfaction surveys suggest improved service performance in the months following initial implementation. The extent to which SDAS has been attaining some of its key targets (using their wording and targets) are outlined below.

Target	Evidence	Progress
Patient recommendations	85% of patients would 'probably or definitely' recommend the practice.	Using May and December survey data this target has been consistently reached, with an average of 94% of patients or carers (n1=137, n2=129) reporting that they would definitely or probably recommend the service.
Patient Satisfaction	Patients would experience 'ease of appointment and satisfaction with waiting times' (90% satisfaction for all participating practices).	Data is not broken down in the patient survey at the level of individual surgeries, however the average number of patients in May and December reporting that they were completely satisfied was 84% (May n=137, December n=129).
Non face-to-face resolution	40% of patients would have their issue resolved on the same day through non face-to-face contact.	This target has been consistently achieved by the service. The maximum proportion of face-to-face appointments during the period was 39.4% in August.
Quality of patient care	Staff report increased control and improved care for patients	RSM PACEC's programme-wide staff survey asked about the extent to which staff agreed that "*Patients in this area are more independent and better able to self-manage as a result of the interventions funded by BLC*". 36% of respondents (n=11) who had been involved in SDAS (n= either agreed or strongly agreed with the statement. This was higher than perceptions from other non-SDAS HBLC staff, of whom 25% agreed or strongly agreed.
Longer Appointments	Demonstrable increase in the number of longer appointments (more than ten minutes for those with LTCs)	In-depth interviews with representatives within SDAS practices indicated that two of the four SDAS practices have been able to introduce 15 minute appointments as a result of the service.

In addition, the SDAS has also seen progress towards other outcomes outlined in its Logic Model. For example, 74% of patients surveyed in December 2016 said they were called back within one hour of initial contact (n=96, base 129). This was an improvement from findings in May 2016 of 61% (n=84, base=137). The evaluation plan originally sought to measure changes in locum usage to assess the extent to which the service was freeing up GP time. However, the departure of several GPs from the area has led to an increase in locum usage, making it more difficult to assess capacity impacts. Data on locum numbers was also unavailable, although the evaluation team has been able to analyse changes in locum allowance spending. There was no indication from staff or otherwise during RSM PACEC's evaluation that these staff departures happened because of the SDAS.

Challenges / Learning

While there have been several positive findings emerging from the evaluation research, challenges and areas for future learning have also been identified below. These represent the views of a small sample of staff.

Implementation: Some interviewees noted that the staffing and skills mix may not have been fully optimised at the outset, though this was overcome in the first few months. There were also some start-up issues related to having correct equipment (right number of beds in consultation rooms). These issues were quickly addressed, though future planning could potentially mitigate these risks more fully by more thoroughly consultation in the project planning stages.

Referral Systems: It was noted that referrals to services such as ultrasounds had proven problematic for the SDAS because multiple referral systems are operating in parallel. However, the same staff member expressed optimism that this would soon be resolved through the introduction of a single J code.

External Collaboration: Whilst there was generally very positive feedback about collaboration within the four practices involved in SDAS. It was raised that outreach should be done to try expand the service to the Gosport practices that are not yet involved.

Future Expansion: Plans to roll out the pilot at scale have the potential to be affected by step changes in costs (including determining the optimal number of clinicians), and nuanced efficiencies within the local context (namely the merger of several local practices) that may not be replicated in spread areas. Some consultees felt that the current staff capacity and mix is optimised to the existing population, and that the current model may not necessarily work across a wider geographic area where the registered population and associated needs may differ.

Accessibility: Feedback surveys asked patients about how the new service could be improved. One common theme related to accessibility, both on site regarding parking charges or room location within the hospital, and more generally, with some patients saying that Gosport War Memorial Hospital was *"too far to travel"*.

Conclusions

Evaluation findings suggest that the service has performed well against numerous targets. Limited access to key data due to changes in rules governing Secondary Use Statistics has limited the extent of analysis regarding some logic model outcomes (this methodology limitation is outlined in greater detail in Appendix 1).

It is notable that an analysis of practice's locum allowances shows that there has been a considerable decrease in the value of allowances among SDAS practices, especially when compared to large increases seen in other Gosport practices who remain uninvolved in the service.

A basic analysis of costs and cost savings shows cost per patient falling by approximately 15% as the proportion of GP / Nurse cases has been shown to fall. This is assuming that all people who weren't seen by GPs would have gone to their practice and been seen by GPs at the same unit cost or cost per consultation, SDAS delivered approximately £56,359 in savings in the 2016 financial year.

Recommendations for continued improvement of the SDAS

Based on the findings of this evaluation, feedback from staff and patients and obstacles encountered within this analysis RSM PACEC has outlined some key recommendations to facilitate the continued improvement, uptake and monitoring of the SDAS service in the future.

Recommendation 1: Consultation on non-cost factors. Based on staff feedback of implementation issues upon service launch, RSM PACEC suggest extensive consultation on non-cost factors prior to any escalation or growth in participating practices. This would require a full understanding of the relationships between clinicians and administrators in both the practices and the hub as well as prior consultation with staff to ensure any necessary equipment or resources are available as expected.

Recommendation 2: Accessibility: As outlined in section 2.1.4 several patients have expressed that they are happy to travel further for a GP appointment. Before any increased roll-out RSM PACEC recommends modelling the travel and distance effects of future services beforehand. There exists a risk of sudden fall-off in the distances patients are willing to travel to receive a same-day appointment, which could dramatically affect assumptions regarding scalability. On a smaller level, this includes monitoring of on-site accessibility, as some patient feedback noted some difficulties at the GWMH.

Recommendation 3: Interoperable record system. Development of interoperable record system to allow rapid analysis and comparison between the hub and services delivered in practices. This will be key to ensure sufficient evidence on demonstrating the benefits to support replication and roll-out elsewhere. This should include development of more robust service monitoring and evaluation within practices to better understand the impact and service trends. There should be clearer ways of tracing the impact on GP time (i.e. proportion of cases in practices taken by non-GP staff, amount of and changes in locum use).

Recommendation 4: Monitoring potential demand and displacement risks. In addition, SDAS should continue to monitor service demand, and understand reasons for reduced call volumes over time (reflected in section 4.2.1). In addition, SDAS staff should set up methods to monitor any possible adverse impacts on healthcare delivery and continuity of care at the individual practice level due to the reallocation of staff for the service.

1 INTRODUCTION

RSM PACEC were appointed by Southern Health on behalf of the Hampshire MCP Vanguard to complete an evaluation of the NHS Vanguard Pilot to implement a Multispecialty Community Provider (MCP) new care model with GPs, known locally as Better Local Care (BLC). The BLC aim is:

> *To improve the health, well-being and independence of people living in our natural communities of care, making Hampshire an even greater place for all our residents to live.*

At the time of project implementation, Better Local Care had four key themes:

- Improving access to care: So that it's easier for people to get a same-day or urgent appointment at their GP surgery, and so people with complex health problems get more input from their GP.

- Joining up the professionals that support the same people: So that doctors, nurses, social and voluntary sector workers and volunteers are part of the same extended team, making care more straightforward (especially for people with complex needs).

- Bringing specialist care nearer to patients: So patients can see the professional they need, sooner: For example physiotherapists and mental health workers in local GP surgeries.

- Concentrating on prevention: To support people earlier, and help them make the right choices about their health and wellbeing, to stay independent and reduce the need to go to hospital.

The BLC Vanguard is a partnership of GPs, NHS providers and commissioners, Hampshire County Council, local councils of voluntary services, several local community, voluntary and charity organisations.[1]

This report is one of a series of Deep Dive Evaluation Reports which aim to evaluate some of the projects supported under Better Local Care to explore the outputs, outcomes and impacts, the successes and challenges, and importantly the learning which can be used to improve the projects in the future.

This Deep Dive Evaluation Report focuses on the Same Day Access Service (SDAS), an urgent primary care hub based in Gosport War Memorial Hospital which provides registered patient populations from four Gosport practices with easier access to same-day consultations with a healthcare professional. It is intended to help address growing demand for urgent primary care, and increase the proportion of cases dealt with through other means such as non-GP practitioners, community providers and self-management.

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[1] *Southern Health – Inside Better Local Care. Available at: southernhealth.nhs.uk/inside/better-local-care/*

2   CONTEXT, NEED AND OBJECTIVES

2.1 Gosport demographics and deprivation

2.1.1 Demographics

Gosport has a total population of approximately 85,000 and is covered by 11 GP practices. The locality has an ageing population, with the age profile of registered patients aged 65+ across the eleven practices that make up the locality is broadly in line with South Eastern Hampshire CCG figures, and considerably higher than the England average, as illustrated in Figure 2.1 below.

Figure 2.1: Gosport Population Age Distribution
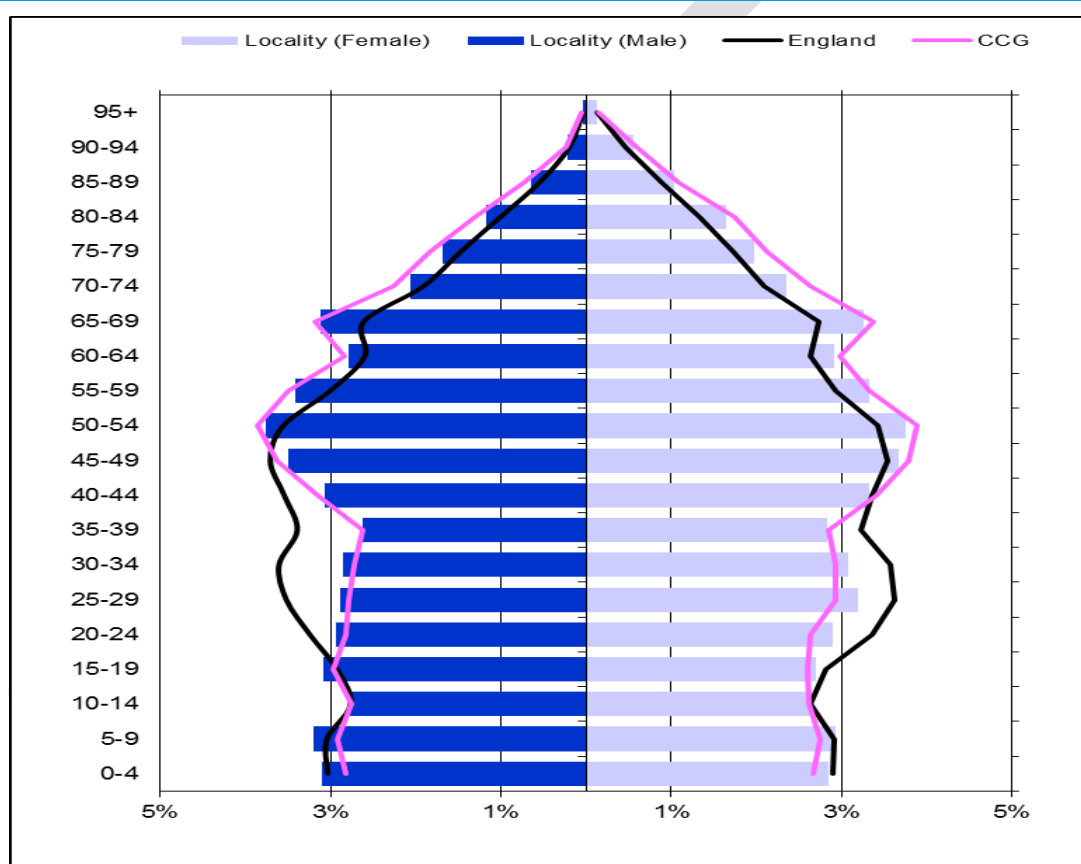
Source: South Eastern Hampshire CCG Baseline Locality Packs – Gosport practices

2.1.2 Deprivation and health in Gosport

The overall need for the project was identified in the Better Local Care *Value Proposition*, which notes that a higher proportion of Gosport population experience poor health outcomes compared to the national average. According to the 2015 Indices of Multiple Deprivation, Gosport has an average Index of Multiple Deprivation (IMD) Score of 20.25.[2] This is below average levels of deprivation in England (index score of 21.8). There are concentrated pockets of deprivation within the locality, and some neighbourhoods are amongst the most deprived quintile nationally. The GP practices involved within SDAS (Brune Medical Centre, Forton Medical Centre, Stoke Road Medical Centre and

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[2] *Based on average data of IMD Scores of 52 registered practices*

Waterside Medical Centre) are located in areas of comparatively high deprivation, as illustrated in Figure 2.2 below and in Table 2.1.

Figure 2.2: GP practices by Index of Multiple Deprivation score within the local CCG area
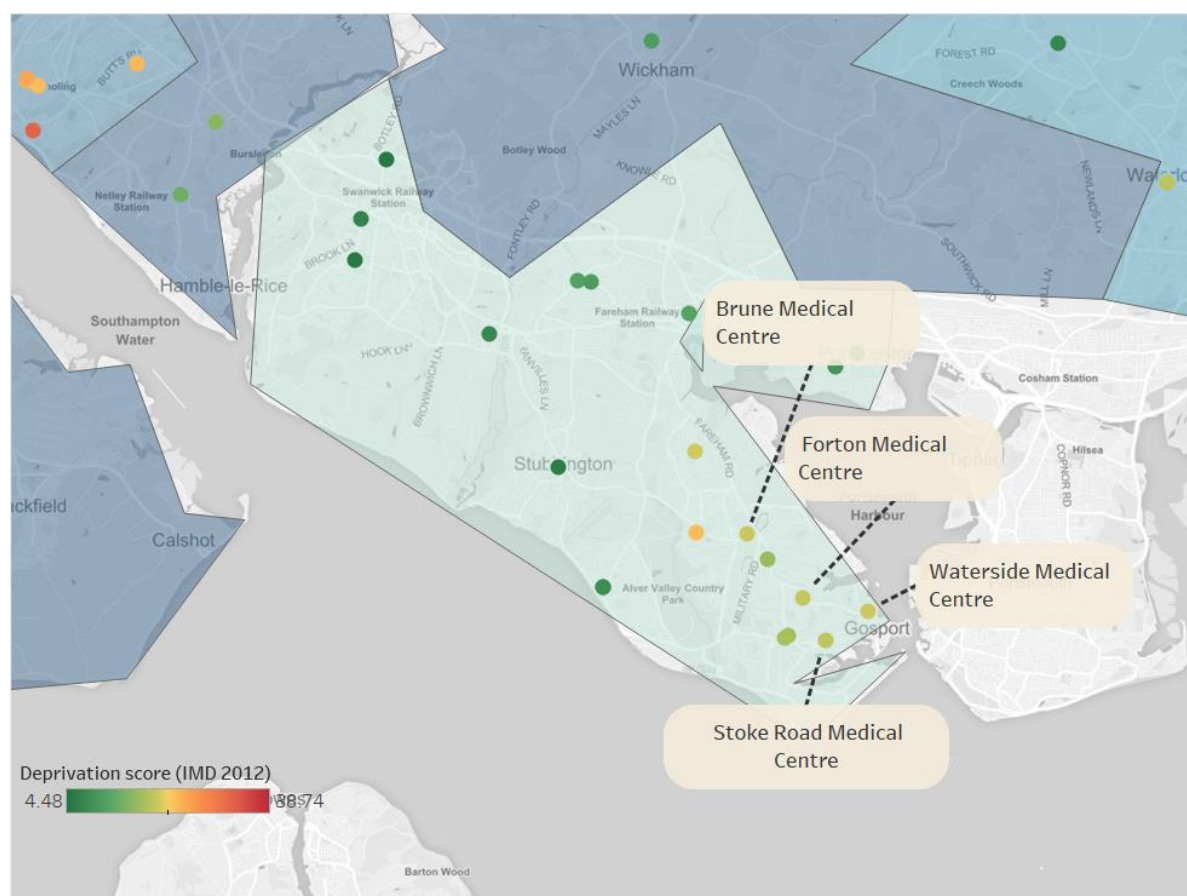
Source: ONS, Indices of Multiple Deprivation, 2012

Table 2.1: Deprivation scores of Individuals SDAS Practices:

SDAS Practice	Deprivation Score (2015)	Compared to Gosport and Fareham CCG Average (13.6)	Compared to England Average (21.8)
Brune	24.0	Higher	Higher
Forton	23.2	Higher	Higher
Stoke Road	21.5	Higher	Lower
Waterside	22.8	Higher	Higher

Source: PHE Fingertips GP Practice Profiles

Public Health England data shows above-average instances of health inequality in a number of areas, including premature mortality rates for major diseases such as cardiovascular and smoking-

related conditions, at rates considerably above the England average.[3] Table 2.2 outlines other key metrics in SDAS practices and how they compare with the local CCG and England averages.

Table 2.2: Participating Practice Profiles

Target	Detail	Age	Value (# or %)	Compared to CCG	Compared to England
Registered Population (#) *CCG: 9,676* *England: 7,586*	Brune	All ages	9,116	Lower	Higher
	Forton		9,324	Lower	Higher
	Stoke Road		8,444	Lower	Higher
	Waterside		11,810	Higher	Higher
% Aged 65+ *CCG: 21.5* *England: 17.2*	Brune	65+ years	17	Lower	Lower
	Forton		20.1	Lower	Higher
	Stoke Road		22.6	Higher	Higher
	Waterside		18.5	Lower	Higher
% with long standing condition *CCG: 54.5* *England: 53.2*	Brune	18+ years	62.1	Higher	Higher
	Forton		57.4	Higher	Higher
	Stoke Road		58.4	Higher	Higher
	Waterside		55.8	Higher	Higher
% with caring responsibility *CCG: 17* *England: 17.8*	Brune	18+ years	16	Lower	Lower
	Forton		31.3	Higher	Higher
	Stoke Road		18.8	Higher	Higher
	Waterside		9.5	Lower	Lower
% nursing home patients *CCG: 0.8* *England: 0.5*	Brune	All ages	0.7	Higher	Lower
	Forton		0.3	Lower	Lower
	Stoke Road		0.7	Higher	Lower
	Waterside		0.7	Higher	Lower

Source: PHE Fingertips GP Practice Profiles (Using most recent scores accessed May 2017)

2.1.3 Pressure on health services

Health services in Gosport are under pressure, affected by nationwide problems of resourcing, ageing and a shortage of staff and funds. Additionally, Gosport has struggled to recruit clinical staff to work in the area, resulting in a capacity crisis in local General Practice. A survey undertaken in 2015 of the four practices now involved in SDAS asked about recruitment of clinical staff and workforce retention, namely of Nurses and GPs. As shown in Table 2.3 the survey found that all three practices that tried to recruit new staff, failed to do so as planned, demonstrating these resourcing challenges.

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[3] *Public Health England – Gosport district profile (2016)*

Table 2.3: Recruitment of clinical workforce (2015)

Practice	Have the practice recently advertised / tried to recruit clinical workforce?	If yes, was it successful?
Brune	Yes	Yes
Forton	Yes	No
Stoke Road	Yes	No
Waterside Medical Centre	No	No

Source: Workforce Access Survey Gosport Data

Table 2.4 shows that there had been an increase in pressure on GP capacity in the year leading up to the service commencing (December 2015) across the four practices involved in SDAS. The data show an average increase of registered patients per GP of nearly 39% over the period. The growth in some practices – such as Forton where registered patients per doctor doubled in a year – is likely attributable to GPs leaving post. Further, the number of patients per WTE GP in SDAS practices is higher (3,457 in 2015), than the national average (2,553 patients per WTE GP)[4].

Table 2.4: Number of patients per WTE GP (WTE = 9 sessions)

Practice	Patients per WTE GP (WTE = 9 sessions)		
	2015	2016	Difference
Brune	2,806	3,383	+577
Forton	2,419	4,473	+2,054
Stoke Road	1,977	2,600	+623
Waterside MC	2,977	3,371	+394
Total	10,179	13,827	+3,648
Average	2,545	3,457	+912

Source: SDAS Activity Data (October 2016), GP Workforce Census. WTE = whole time equivalent.

2.1.4 Patient Perspective

An online locality survey conducted and administered by Fareham and Gosport CCG in April 2015 received over 1,400 responses from patients from all Gosport practices. The survey was independently analysed by Hampshire Health Watch. Amongst other key findings, the survey indicated that most respondents would be prepared to travel a little further to ensure a same-day or routine appointment, even if it meant that they didn't see someone from their own GP practice.[5] In addition, most were happy for a person other than their GP to be able to see their case history and treat them appropriately.

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[4] *HSCIC General Practice Trends in England (2015)*
[5] *Detailed in the SDAS Outcome Report, Better Local Care*

2.1.5 Evidence from other initiatives

There have been several high-profile care hub pilots in England in recent years. Two recently-evaluated cases are discussed below:

St Austell[6]**:** An Acute Care Hub based in St Austell is led by GPs and staffed by a multidisciplinary team, with the aim of providing same day appointments for all patients. Five practices merged, covering a patient population of 32,000. The evaluation of the hub found that the service has improved access, waiting time and the number of appointments. As a result, pre-planned care appointments for those who have more complex issues were lengthened to twelve and a half minutes.

Herefordshire[7]: Practices across Herefordshire, Arden and Worcestershire are offering patients greater access to primary care services through the Taurus Healthcare Hub, covering a much larger patient population of 185,000 over 21 practices. An evaluation of the hub has estimated that the service resulted in providing an additional 23,000 additional telephone appointments with 93% of patients surveyed described their experience as either 'excellent' or 'very good'.

2.2 National Policy Context

The General Practice Forward View (GPFV) identifies workload pressure as the defining issue facing practitioners in the coming years. The GP Forward View aims to 'reduce practice burdens and help release time', promising to 'make better use of the wider workforce', co-ordinating with nurse practitioners, community pharmacists and other specialists.

The GPFV additionally notes that GPs find it increasingly difficult to offer timely appointments and often struggle to provide enough time for patients with complex needs. As part of its pledge to support MCPs, the Forward View promises to 'get away from the treadmill of the 'one size fits all' 10 minute consultation followed by outpatient referral or prescription.' The MCP's goal is to provide 'a stronger focus on population health, prevention, and supporting and mobilising patients and communities' and supplying 'more integrated urgent care as part of a reformed urgent and emergency care system'.

The GPFV responds to the findings of the 2015 Primary Care Foundation / NHS Alliance report into GP workload pressures, *Making Time in General Practice*[8]. This report noted the strength of British general practice as 'its personal response to a dedicated patient list' and its weakness as 'its failure to develop consistent systems that free up time and resources to devote to improving care for patients.'

Recent research into measures to reduce emergency admissions to hospitals and GP practices highlights the role of intermediate care and out-of-hospital/ at-home services amongst the most popular responses piloted elsewhere in England.[9] Evidence on local care models suggests that care co-ordination works most effectively when organised at the community level, levering in the knowledge and expertise of local civil sector and community organisations.[10] In response to these issues, attempts have been made to change emergency care provision and staff roles to provide a

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[6] *Andrews, J, Evidence to support the development of on-the-day access hubs, January 2017*
[7] *Prime Minister's Challenge Fund: Improving Access to General Practice, First Evaluation Report, October 2015.*
[8] *PCT/NHS Alliance (2015) 'Making Time in General Practice' Available at: http://www.nhsalliance.org/wp-content/uploads/2015/10/Making-Time-in-General-Practice-FULL-REPORT-01-10-15.pdf*
[9] *Ham et al 2010, 'Avoiding Hospital Admissions: Lessons from evidence and experience', The King's Fund*
[10] *Goodwin et al 2013, 'Co-ordinated care for people with complex conditions', The King's Fund*

more patient-focused, convenient and joined-up service outside of hospitals which takes pressure off acute care services and GPs.

In a report on effective approaches in urgent and emergency care, NHS Interim Management and Support (NHSIMAS) highlights that:

- Primary care can smooth demand for ambulance conveyance by responding rapidly to requests for urgent home visits and ensuring they are not "batched" at the end of surgeries. This helps reduce mid-afternoon arrival peaks in ED departments and assessment units that causes crowding and increases admission rates.

- Practices should consider the guidance of the Primary Care Foundation[11] to ensure that avoidable access issues do not provoke patients to call ambulances or by-pass the practice to seek help in emergency departments.

2.3 Local Policy Context and Rationale

As previously described, General Practice in Gosport has been under increasing pressure with growing demand for services, and challenges in recruitment and retention of primary care staff. Adding to the challenge, a number of GPs are set to retire within the next five years.

In October 2014, the CCG facilitated a workshop for all eleven practices in the Borough together with community providers and voluntary organisations, to agree a way forward that could address resource and demand issues. The practices agreed to create a central hub with a range of clinical and non-clinical services shared across all eleven practices, to be implemented for the winter period 2015. The hub was expected to mitigate the shortage of GPs by pooling resources and delivering economies of scale.

A Clinical Model Development Group was established to provide clinical leadership to support changes in service delivery to meet these challenges. The changes proposed included:

- Reduction in the number of clinical sessions needed to provide urgent care through providing the service at scale through federated primary care services;

- Using additional capacity to look at pro-active intervention for patients and to focus efforts on patients that frequently attend general practice;

- Increased support for patients with long term conditions through offering longer appointments within the additional capacity released in General Practice;

- Creation of a sustainable model of primary care for GP practices in Gosport through federative General Practice and primary care at scale for the delivery of urgent access; and

- Reduction in locum usage, meaning an increase in continuity of care.

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[11] *Primary Care Foundation, 2009, 'Urgent Care: A Practical Guide to Transforming Same Day Care in General Practice', 2009, Department of Health*
http://www.primarycarefoundation.co.uk/images/PrimaryCareFoundation/Downloading_Reports/Reports_and_Articles/Urgent_Care_Centres/Urgent_Care_May_09.pdf)

2.4 Overview of SDAS Objectives

The SDAS was established in four Gosport practices in December 2015 with initial BLC funding of £383,500. Its overarching aim is to establish a service which can offer same day urgent appointments across the 11 Gosport practices and deliver upon several of the changes outlined above (especially the last three).

The service's main objectives are set out within the SDAS's May Outcomes Report's logic model. These key outcomes have been listed by HBLC theme in Table 2.5 below.

Table 2.5: SDAS Logic Model outcomes by HBLC Theme

Outcome
Patient Outcomes
High patient satisfaction with SDAS (access /mode of contact/outcome)
Improved patient satisfaction with all aspects of primary care
Staff Outcomes
Increase in staff wellbeing
Improved recruitment and retention of clinicians
Service Outcomes
Reduction in CAU admissions from 4 practices
Reduction in admissions to the acute hospital Children's Assessment Unit
Reduction in emergency admissions by condition and age group
Rates of attendance at Urgent Care services reduced
Increased routine appointments in primary care
Decrease in waiting times for routine appointments
Increased number of longer appointment slots for patients with complex needs
Reduction in use of locums in participating practices
Improved clinical outcomes for patients with long-term conditions
Reduction in calls to 111 & use of out of hours services Monday to Friday (8-8)

Within these larger themes the service also holds more specific targets, set out in Table 2.6.

Table 2.6: SDAS Targets

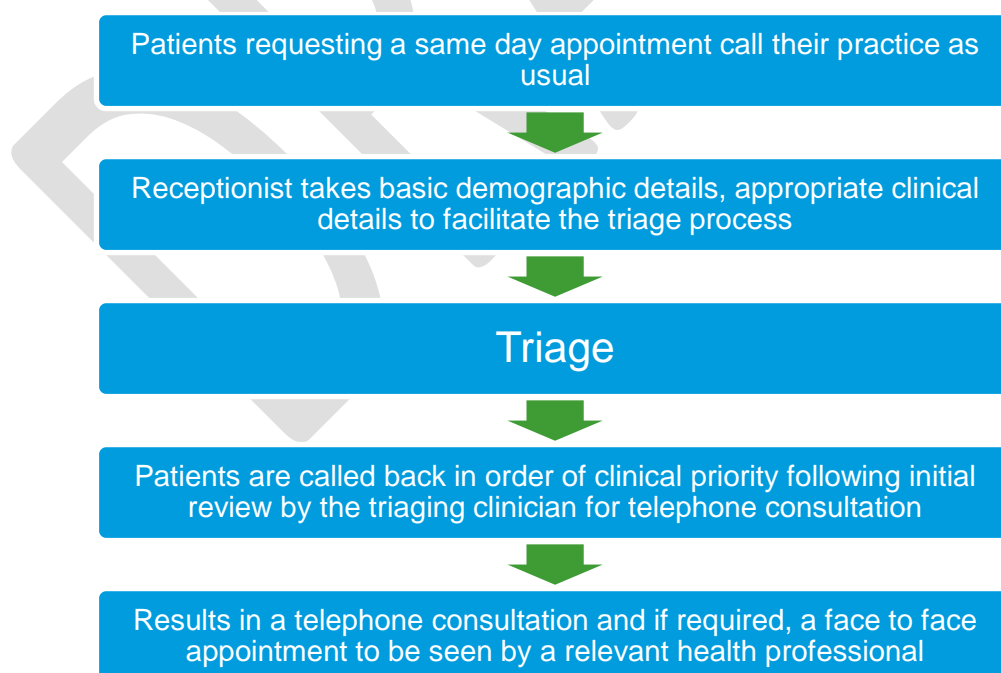| Target	Detail
Patient recommendation	85% of patients would 'probably or definitely' recommend the practice;
Patient Satisfaction	Patients would experience 'ease of appointment and satisfaction with waiting times' (90% satisfaction for all participating practices);
Non face-to-face resolution	40% of patients would have their issue resolved on the same day through non face-to-face contact;
Patient care	Staff report increased control and improved care for patients; and
Longer Appointments	Demonstrable increase in the number of longer appointments (more than ten minutes for those with LTCs).

3 MODEL AND ACTIVITY TO DATE

3.1 Model

The SDAS is located at Gosport War Memorial Hospital, comprises one full-time, core GP (supported by Southern Health) with input from several locums and GPs from participating practices providing specialist sessions. Specialist non-GP support is provided by a physiotherapist (0.4 FTE), several practice nurses and a paediatric nurse practitioner. It was first introduced in in January 2016 with BLC funding of £383,500.

The SDAS currently provides a service to patients from the four Gosport GP practices to sign up for the pilot: Waterside Medical Centre (11,911 registered patients); Stoke Road Medical Centre (8,458); Brune Medical Centre (8,838); and Forton Medical Centre (9,497). These represent a total registered patient list size of 38,704 (c.46% of the total list size in Gosport Locality). In 2016 the SDAS triaged just under 45,000 calls.

The service pools the same day primary care workload and workforce for the four practices into a single service that operates from the War Memorial Hospital. The service is open from 8am-7pm on Monday – Friday. Figure 3.1 outlines the triage referral model used to process patients. A key efficiency saving in the model occurs at initial dial-in, where the telephone operator can ask the patient for permission to access their medical records to expedite the call-back and triage process.

Figure 3.1: Clinical Model

Patients requesting a same day appointment call their practice as usual

Receptionist takes basic demographic details, appropriate clinical details to facilitate the triage process

Triage

Patients are called back in order of clinical priority following initial review by the triaging clinician for telephone consultation

Results in a telephone consultation and if required, a face to face appointment to be seen by a relevant health professional

Source: SDAS Outcome Report (September 2016)

Separating urgent and routine general practice activity and supplementing the same day urgent care workforce with new roles is expected to free up GP time to concentrate on those patients with more

complex and chronic health needs. Where needs are deemed to be of limited clinical urgency, or judged as being primarily related to social wellbeing, a non-GP community practitioner is able to provide appropriate signposting and guidance.

Prior to implementation, Gosport practices measured their demand over a week-long period in order to model the capacity needed to implement the service. As a result, the capacity modelling made the following assumptions:[12]

- Call handlers take 3 minutes per call (in the individual practices), i.e. they have capacity to take up to 20 calls per hour;

- Nurse Practitioners take 7 minutes per call, (up to 8 calls per hour);

- General Practitioners take 5 minutes per call, (up to 12 calls per hour);

- Nurse Practitioners and General Practitioners take 10 minutes per face to face consultation (up to 6 appointments per hour);

- Further capacity is required during morning sessions, with SDAS providing enhanced capacity on a Monday morning rather than Tuesday-Friday to best meet demand.

The practices involved provide GPs, nurses, and nurse practitioners as a clinical resource. For those practices unable to directly provide clinical resource, a sub-contracting agreement is arranged with other Gosport Practices and paid for by the practice sub-contracting the arrangement. Advanced Paediatric Nurse Practitioner input is provided by the Solent NHS Trust and Physiotherapist input is provided by Southern Health NHS Foundation Trust.

3.2 Service activity to date

Service level KPIs are tracked by the SDAS team and compiled in a dashboard on a routine basis. The timeframe for data collection and reporting varies as set out in Table 3.1 below. The sub-sections below discuss each KPI in turn.

Table 3.1: Key Performance Indicators – scope of data

Monitoring KPI	Data timeframe
Number of calls (subdivided into hourly time bands)	January 2016– December 2016 (weekly)
Number of patients triaged	January 2016 – December 2016 (monthly)
Number resulting in face-to-face with a clinician	January 2016 – December 2016 (monthly)
Demographics of service users	May and December 2016 – (by age band)
Call times	February 2016 – December 2016 (weekly)
Call-back timeframe	May 2016 and December 2016 (while data is collected monthly, only data relating to May and December 2016 was provided to the evaluation)

Source: SDAS monitoring data provided March 2017

3.2.1 Number of calls and patients triaged

Across the full year, the number of calls triaged by the service was 44,793 (an average of 3,700 per month). The number of calls received was highest in quarter one, with over 30% of the total number of calls received in this period. Within this quarter, February and March were the busiest months with 4,602 (10.3%) and 4,549 (10.2%) of all calls triaged respectively. August saw the fewest calls made with 3,200 (7.1%). This is broadly in line with the fluctuations in demand seen in general practice, which typically feature a spike in emergency attendance cases at A&E in the winter months (27.9% in winter compared with 25.8% in the summer)[13].

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[13] *Winter Pressure in accident and emergency departments: Third report of session 2016-17, House of Commons Health Committee, October 2016*

Month	Triaged Calls
January	4,156
February	4,602
March	4,549
April	3,830
May	3,555
June	3,531
July	3,410
August	3,200
September	3,423
October	3,362
November	3,720
December	3,455
Total	**44,793**

Source: SDAS Activity Data (December 2016)

The number of calls triaged and the rate of conversion into face-to-face appointments is displayed below in Figure 3.2. In total, 28,331 (63%) of patients triaged had their issue dealt with over the telephone, with 16,462 (37%) resulting in face to face appointments.

Call Volume and Conversion
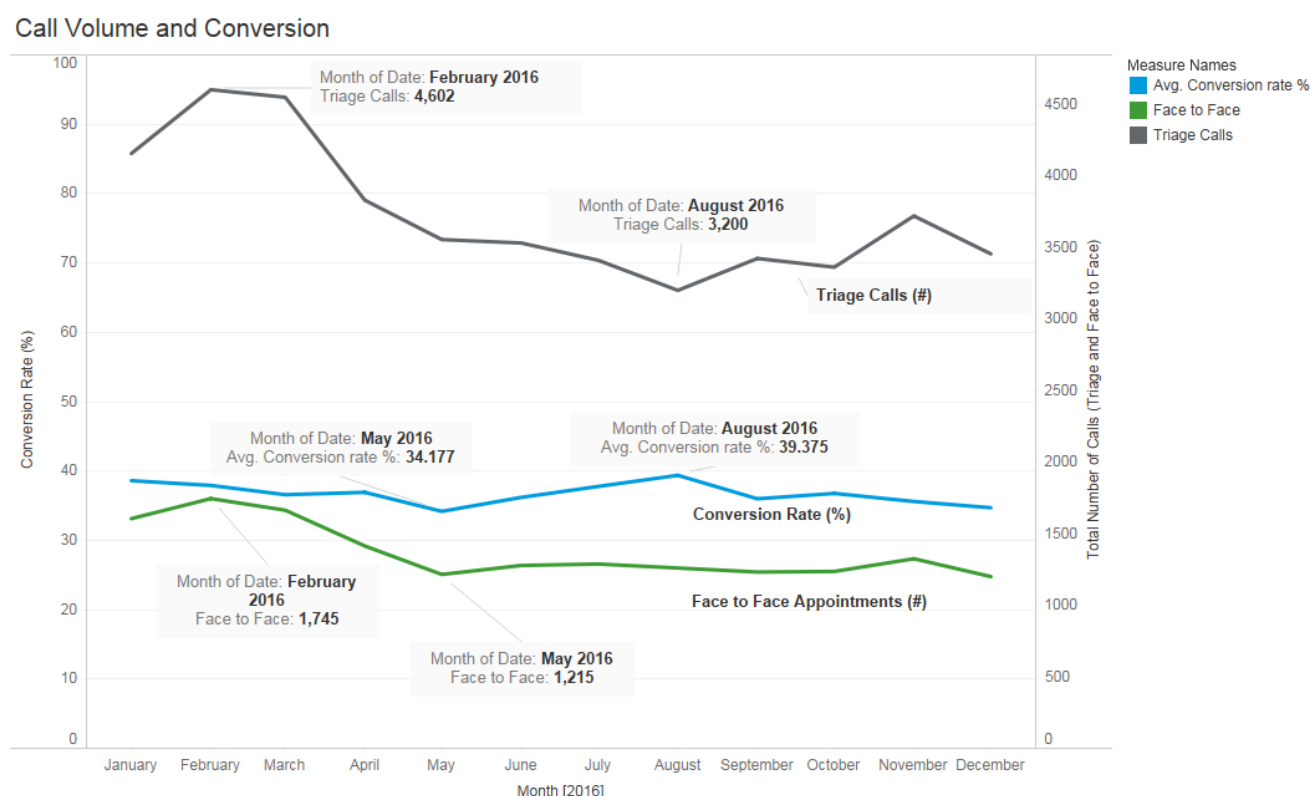
Source: SDAS Activity Data (December 2016)

The number of patients receiving a face-to-face appointment following triage fell from a peak of just under 1,750 appointments in February 2016, to a low of 1,215 appointments in May 2016. The average rate at which triaged calls resulted in face to face appointments remained relatively constant throughout the year, peaking at 39.4% in August, compared to a low of 34.7% in December. The service is consistently meeting the target of keeping conversions below the 40% ceiling listed in the KPIs. Interviews with SDAS staff suggest that falls in the number of both 'overall' face-to-face appointments as well as GP face-to-face appointments is evidence of growing confidence in the service, and in the health care provision provided by the non-GP workforce in particular.

The analysis in Figure 3.3 considers the triage calls in more detail, showing face-to-face appointments broken down by type of clinician. The data shows that after an initial two months where GPs dealt with nearly half of all calls, the proportion of GP face-to-face calls fell sharply and remained low for the rest of the year. By December, GPs were dealing with less than one quarter of face-to-face appointments arranged.

Face to Face Appointments by Health Professional

February:
GP **42%**
Nurse **45%**
Paediatrics **8%**
Physio **5%**

December:
GP **24%**
Nurse **59%**
Paediatrics **12%**
Physio **5%**
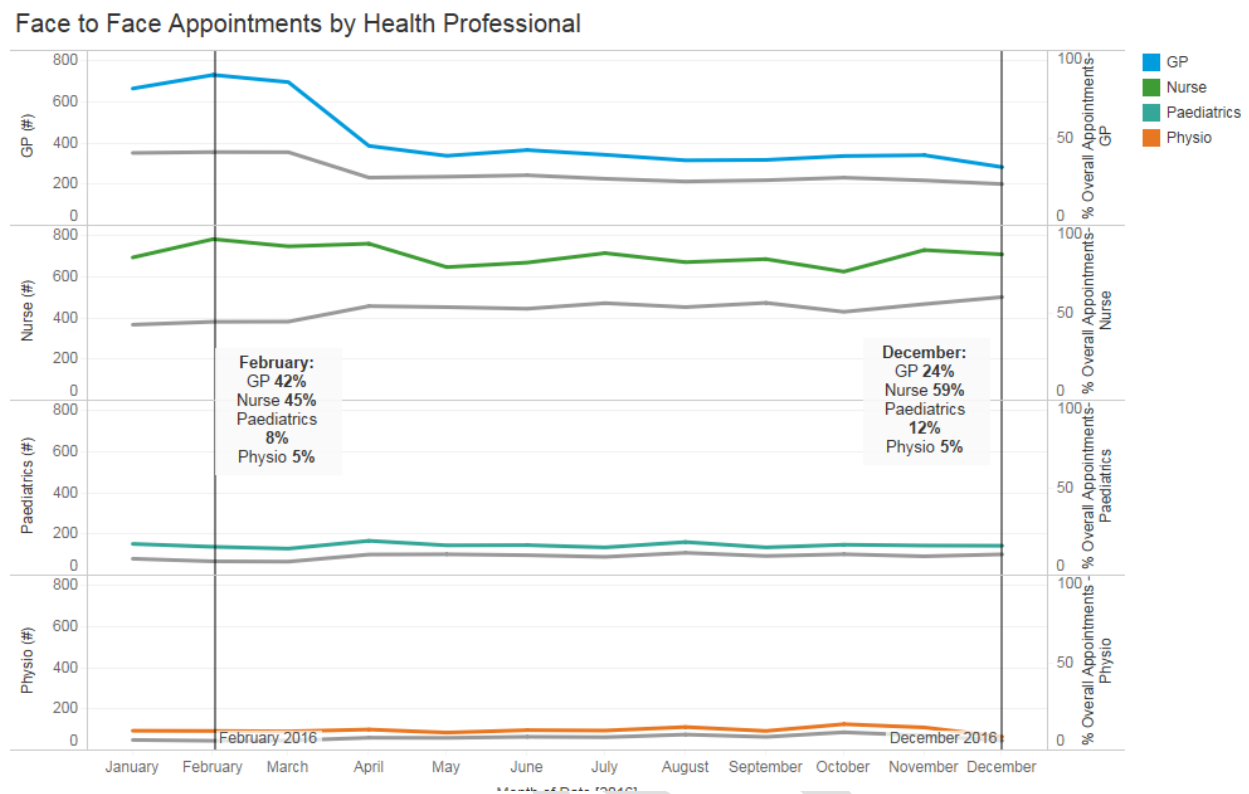
Source: SDAS Activity Data (January – December 2016)

3.2.2 Timing of calls

Figure 3.4 below shows calls made to the service for every month in 2016 broken down by the hour in which the call was made. Throughout the year, a notable majority of calls were received in first hour of the morning (08:00-08:59).

Figure 3.4: Triage calls by appointment time – full year 2016
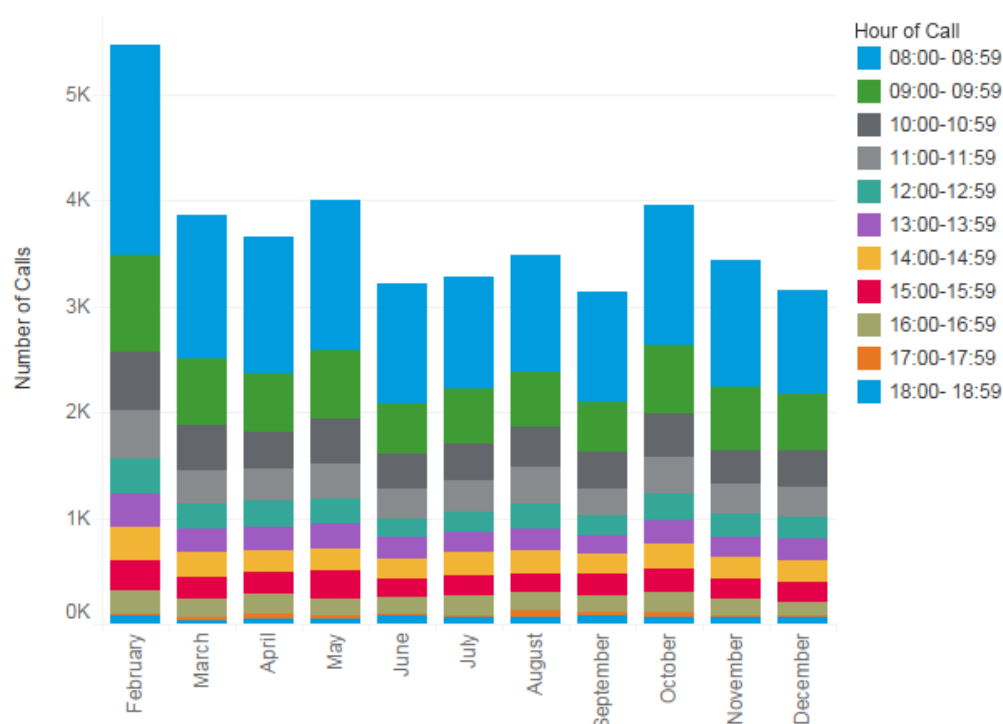
Source: SDAS Activity Data (2016)[14]

3.2.3 Summary of process / output KPI analysis

- The number of calls triaged by the service in 2016 was 44,793 (with an average of 3,700 per month).

- In total, 28,331 (63%) of patients triaged had their issue dealt with over the telephone.

- In total, 16,462 (37%) had their issue dealt with through face to face appointments.

- As the service has progressed the proportion of face-to-face appointments has decreased and is consistently meeting the target of keeping conversions below 40%.

- The proportion of GP face-to-face calls fell sharply after the first two months and remained low for the rest of the year so that by December, GPs were dealing with less than one quarter of face-to-face appointments arranged.

- The time taken for call-backs to occur was lower in December 2016 (74% of call-backs within 1 hour) than it had been in May (61%).

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[14] Call volumes lower in the final week of 2016 as a result of the unit being open for fewer days over the holiday period.

3.3 Challenges and learning to date

Due to limited data availability identifying key feedback themes was more difficult. This caveat should be kept in mind as the below feedback, whilst still of importance, is based on small data sets, occasionally at the individual level.

3.3.1 Staff Survey Feedback

Via a programme wide Better Local Care staff survey, SDAS staff were invited to give detailed comments on areas of improvement or strength. One member of staff not involved in the SDAS alluded to a potential displacement effect i.e. that using nursing resource in support of the SDAS risks causing capacity constraints and potential care quality implications among other practices. While this is obviously a single data point, it is important that the service monitors any potential displacement risks.

In addition, when asked to *"briefly explain what practical steps could be taken in future to improvement the impact that BLC has on patient experience and outcomes in the future"* a member of staff reporting involvement with the SDAS noted a need for funding, claiming that *"we need some funding for projects in the north such as the proposed SDAC"*.[15]

3.3.2 Staff Interview Feedback

In-depth interviews were also conducted with staff leads to explore issues regarding best practice, scalability and lessons learned during the implementation of the service.

Some of the key issues identified by staff in these interviews, based on previous experience with the service included:

Implementation: One staff member commented that the staffing and skills mix were sub-optimal at the outset of the pilot, although this was overcome in the first few months. There were also issues with equipment, such as not having beds in consultant rooms as needed. Whilst staff claimed these issues were quite quickly addressed, they suggested that more thorough consultation in the project planning stages could have helped mitigate these issues.

Referral Systems: One staff member noted that referrals to services such as ultrasounds had proven problematic due to a lack of awareness of the SDAS and multiple referral pathways. However, interviewees were hopeful that this was to be soon resolved through the introduction of a single J code.

Collaboration: Whilst there was generally very positive feedback about collaboration within the four practices already involved in SDAS, it was noted that more outreach is required to try expand the service to the remaining practices. Again, while this issue has been raised by a single respondent, it is of sufficient importance to flag to the service via this report.

Future Expansion: Plans to roll out the pilot at scale have the potential to be hampered by marked increases in costs, and the extent to which the nuanced context within which the service originated prevails in other areas. Some interviewees felt that the current staff capacity and mix is optimised to the existing population, and that the current model may not necessarily transfer to a wider geographic

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[15] *Assumed to mean SDAS or SDA Centre*

area, where the primary care context, and needs of the registered population may differ. Widening the geographical area would therefore require sensitive recognition of local demand factors prior to scaled-up implementation. Extracts from evaluation interviewees include:

- *"It felt very rushed and it was very disorganised on the first day. [We were] learning on our feet [but] we've coped with that and made it successful"*.

- "*We need to work with the other seven* [practices] *to see why they're not joining"*.

Consultation with primary care providers and patients, and detailed demand and cost modelling will be required in new localities before any future expansion for the service.

3.3.3 Patient Feedback

In the December 2016 SDAS patient survey service users were asked *"What parts of this new service do you think we need to improve?"* Common themes in the feedback related to waiting times and accessibility. Some extracts include:

- "Directions to SDAS could be better from Bury Road entrance";

- "Answering time at main GP surgery needs improving";

- "Hard to diagnose skin conditions over phone";

- "Call back waiting times too long";

- "Parking charges";

- "Would like to see a GP closer to work place";

- "Should move downstairs / nearer hospital entrance as too far to walk when unwell"; and

- "Gosport War Memorial Hospital is too far to travel when ill".

4 OUTPUTS AND OUTCOMES

Figure 4.1 presents key outcomes detailed in SDAS's logic model in line with Better Local Care's overall thematic schema (outcomes at the patient, staff and service level). This report assesses progress towards short and medium term outcomes.

Figure 4.1: SDAS Logic Model Outcomes by BLC Themes

Short term outcomes	Medium term outcomes	Long term outcomes
High patient satisfaction with SDAS (access/mode of contact/outcome)	Improved patient satisfaction with all aspects of primary care	Sustainable Primary Care services in Gosport
Increase in staff well-being	Improved recruitment and retention of clinicians	Improved health for the population of Gosport
Increased number of longer appointment slots for patients with complex needs	Improved clinical outcomes for patients with long term conditions	
Reduction of CAU admissions from 4 practices	Reduction in emergency admissions by condition and age group	
Decrease in waiting times for routine appointments	Reduction in calls to 111 and use of out of hours services	
Increased routine appointments in primary care	Reduction in admissions to the acute hospital Children's Assessment Unit	
Rates of attendance at Urgent Care Services reduced		
Reduced use of locums in participating practices		

Patient Outcomes

Staff Outcomes

Service Outcomes

*Source: SDAS Login Model - Outcome Report (September 2016)*

4.1 Patient outcomes

The SDAS measures patient satisfaction with the service through a monthly questionnaire given to patients and carers. Survey findings from the 6-month point of the service in May 2016 (n=137) and December 2016 (n=129) have been disclosed to the evaluation team and are presented below. Patients were asked to participate in survey research as part of the delivery of the service and as such are self-selected to some degree.

4.1.1 Patient Satisfaction

Patients were asked *"Was the main reason for which you called the SDAS dealt with to your satisfaction?"* to gain insight into patient satisfaction. In May 80% of respondents said they were completely satisfied with the service and 18% claimed they were satisfied to some extent. Only 2% claimed they were unhappy with the service. December's survey (n responders=122) similarly demonstrated high levels of satisfaction, with 89% completely satisfied, 11% satisfied to some extent and only 1% unsatisfied with the service. The average response across both May and December are reflected in the chart below which shows patient responses to the question "Was the main reason for which you called the SDAS dealt with to your satisfaction?"

Figure 4.2: SDAS Patient Satisfaction Survey
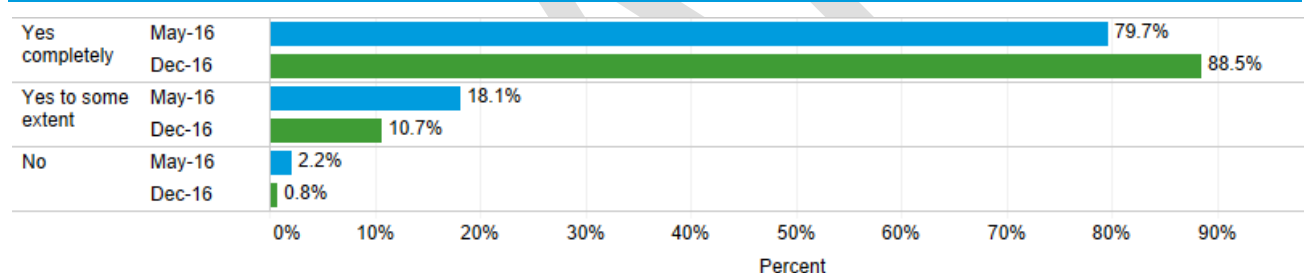
4.1.2 Patient Experience

Patients also reported highly positive experiences of the SDAS as a whole. When asked *"overall, how would you describe your experience of the SDAS?"* 77% claimed it was very good in May, with 20% reporting it was fairly good, 1% neither good nor poor and 1% fairly poor or very poor. In December, there was no negative feedback, with 79% reporting it was very good and 21% reporting it was fairly good. The average response across both May and December is reflected in Figure 4.3 below.
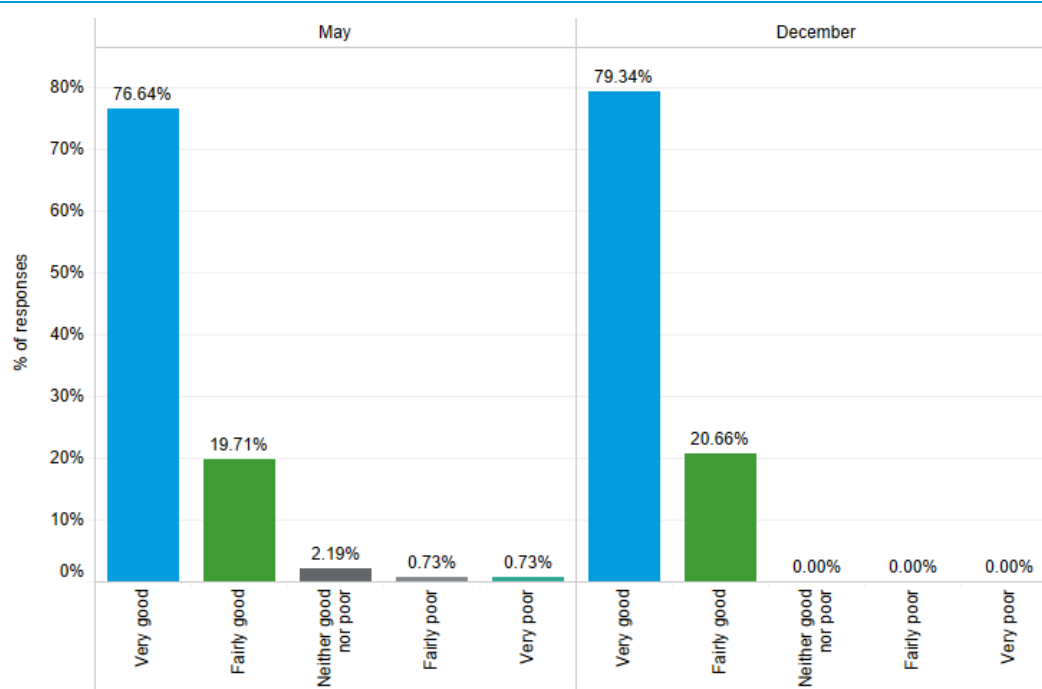
4.1.3 Recommendation of the service

One of the SDAS's key targets is for 85% of patients to recommend the service to others. In the survey, when asked this question, the response was generally very positive. In May 94% said they would recommend or probably recommend, 2% said they probably or definitely would not recommend and 5% said they were not sure[16]. In December (n=121) 94% said they would definitely recommend or probably recommend the service, 1% said they probably or definitely would not recommend and 5% said they were not sure. The average response across both May and December are reflected in Figure 4.4 below.

Figure 4.4: Patient recommendation of the SDAS service

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[16] *Rounded data provided to RSM PACEC the May and December sums to 101%*
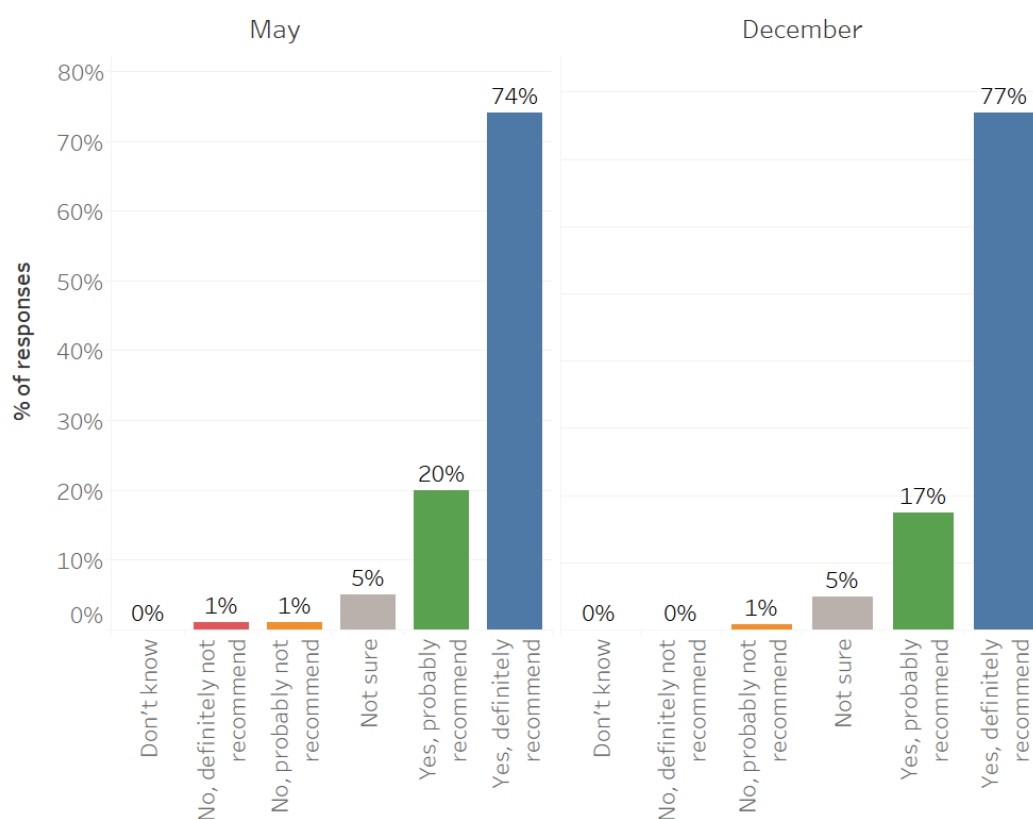
4.1.4 Increased control over care

One of SDAS's targets is for staff to report increased control and improved care for patients. The programme wide Better Local Care staff survey invited SDAS staff (base= 16, n=11) to record the extent to which they agreed with the statement *"Patients in this area are more independent and better able to self-manage as a result of the interventions funded by BLC"*. Of the small number of respondents to the survey, nine percent of respondents strongly agreed, 27% agreed, 45% neither agreed nor disagreed, 9% disagreed and 9% responded that they did not know.
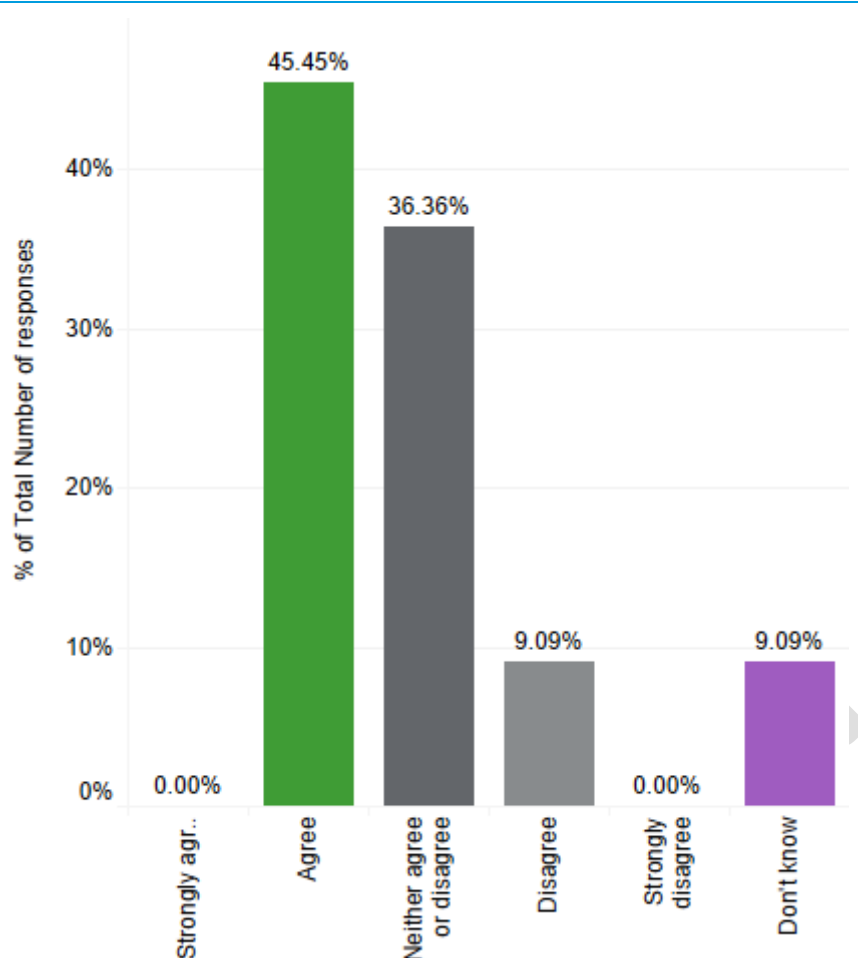
4.1.5 Other comments

Patients surveyed by the service in December were asked *"What parts of the SDAS did you think we are doing particularly well?"* Patients had had numerous positive comments about the SDAS's operation. Several commented on staff friendliness, the service speed (at replying and arranging appointments) and clarity. Comments included:

- "Quick reply from initial phone call";
- "Quick appointment time offered";
- "Short waiting time to be seen";
- "Polite & friendly staff";
- "Informative & clear instructions given";
- "Very efficient"; and
- "Triage works well - professional advice & signposting useful".

Patient input on areas of improvement are reflected in section 3.3.2.

4.2 Service outcomes

The extent of data available for measuring service outcomes has been limited due to regulatory changes to the transmission and publication of secondary uses (SUS) data to third parties. This affects the evaluation's ability to report on some outcomes outlined in the SDAS logic model (see Appendix 1). Findings on the reduction in the use of locums in participating practices (through analysis of reduced locum costs) and reduction in overall emergency admissions as well as other service level outcomes are outlined below.

4.2.1 Call back time

Figure 4.6 presents aggregated service data provided by the SDAS team for call-back times on all calls for the full year of the pilot (Jan-Dec 2016). The individual data points represent the average of all data from a given week.

The data show a gradual decline over 12 months in the average call back each week, implying improved performance over time. Using the grey trend line (average over the sample timeframe), the time a patient would expect for a call back falls from over 4 hours at the beginning of the measurement period, to approximately 2.5 hours by the end of the measurement period.

Some consideration should be provided for the effect of changes in patient call volumes on response times, which would likely fluctuate depending on demand for the service. Call-back times would be expected to be close to zero during quiet periods and very high during peak demand, although the data itself provides few clues on the nature of this relationship.

Figure 4.6: Time elapsed until call-back
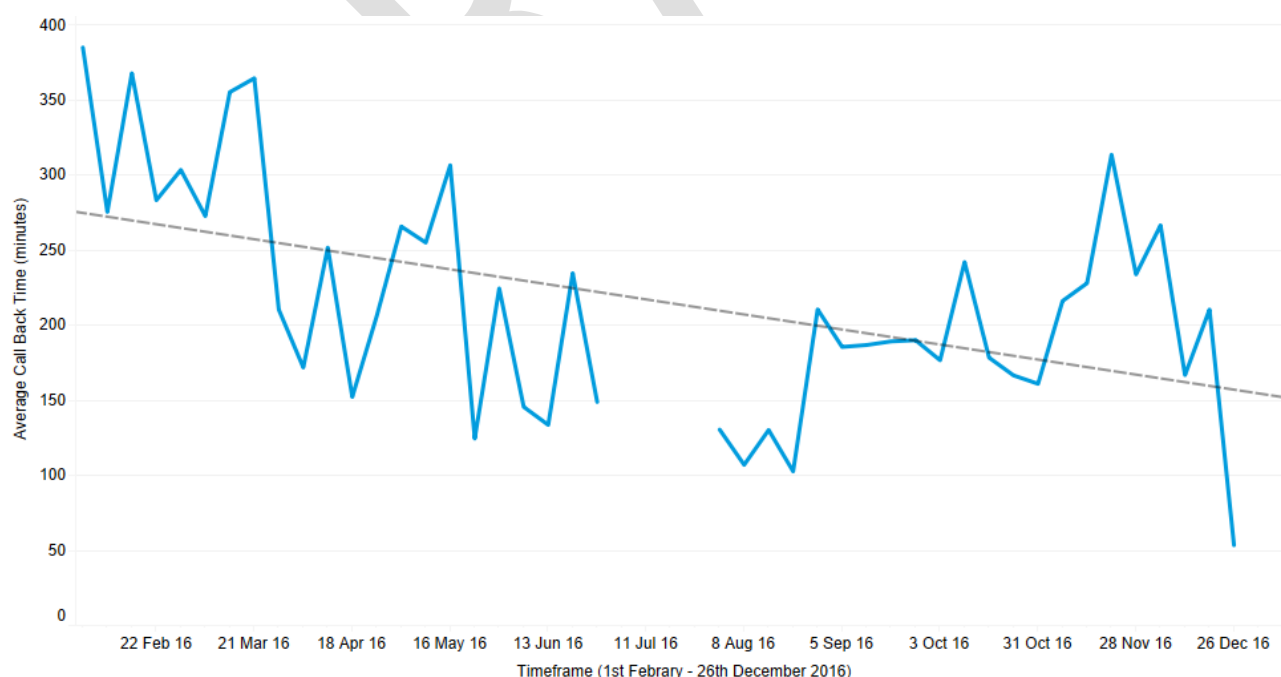
Source: SDAS Outcomes Report (May 2016), SDAS Patient Survey data (December 2016)

As illustrated in Figure 4.7, findings in May 2016 indicate that 61% (n=84, base=137) of surveyed patients stated they were called back within an hour of initial contact. By December 2016, the proportion of patients stating they were called back within an hour of initial contact increased to 74% (n=96, base=129, p=0.03).

Figure 4.7: Call-back timeframes – May and December 2016
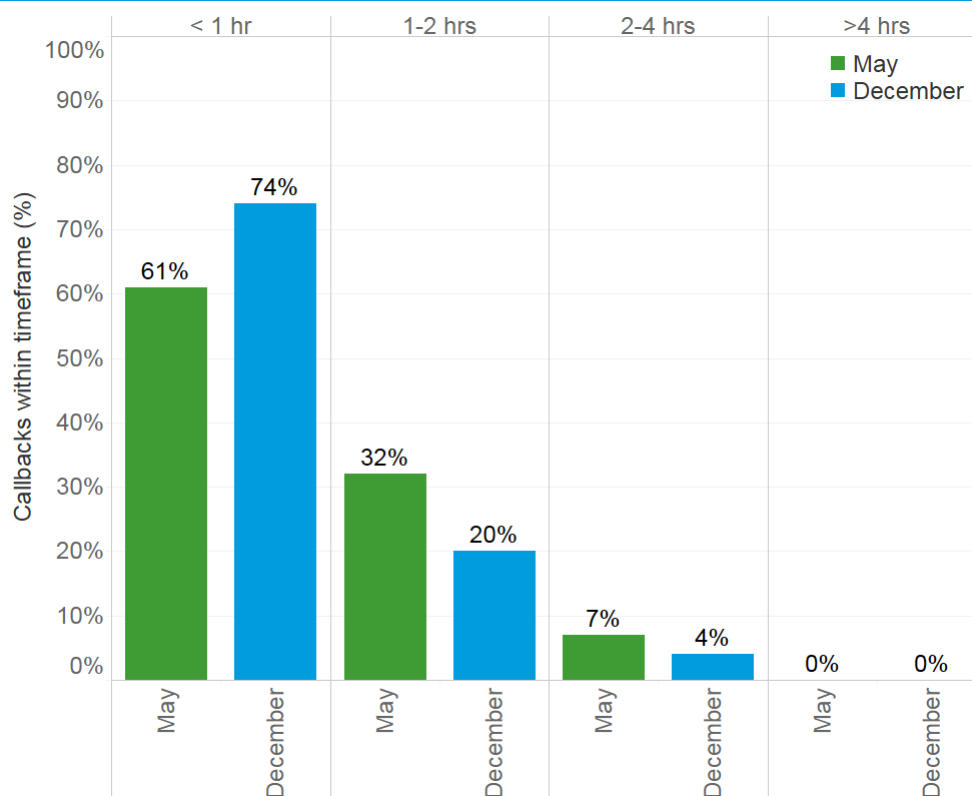
Source: SDAS Activity Data (2016)

The improvement in call-back timeframes may be due to a number of factors, positive or otherwise including: more efficient service provision by a SDAS team of similar capacity; additional SDAS resource to deal with call volumes; or a reduction in demand for the service more generally.

Additional information regarding the reasons for improved call-back timeframes was requested but not provided within the timescale of this report due to capacity issues. Whatever the reason for shorter call-back timeframes, SDAS should continue to monitor service demand, and understand reasons for reduced call volumes over time.

4.2.2 Reduction in the use of locums in participating practices

Another key service outcome for the SDAS is the reduction in the use of locums in participating practices. Data on exact number of locum staff was not available to the evaluation, but trends in locum spending allowances indicate promising trends in this direction. Table 4.1 below presents the average locum allowances for practices by financial year. The average locum allowance among those practices involved in SDAS decreased by £3,528 between the financial years 2014/15 and 2015/16. It is not certain whether this is an impact caused by SDAS alone, given that the average locum allowance in SDAS practices was already more than ten times the allowances in non-SDAS practices. However in comparison, those practices in the Fareham and Gosport CCG and those

locally in Gosport which were not involved in SDAS experienced an overall increase in average locum allowance between the financial years 2014/15 and 2015/16.

Table 4.1: Total locum allowances

Practice	Average locum allowances 2015-16	Average locum allowances 2014-15	Difference
SDAS practices (4 practices)	£2,607	£6,135	-£3,528
Non-SDAS CCG practices	£9,011	£2,711	+£6,300
Non-SDAS Gosport practices (7 practices)	£913	£528	+£385

Source: NHS Payments to General Practice, The Health and Social Care Information Centre England (Data from 2014-15 and 2015-16 publications)

4.3 Staff Outcomes

Semi-structured interviews with SDAS staff pointed to the following outcomes.

Increased Capacity in Practices: As a result of the service staff have reported increased capacity within practices, allowing patients to be seen who previously may not have been within a comparable timeframe. Consultations also found that staff overtime has reduced and further, staff feel lower stress and enhanced job satisfaction and capacity to support patients. While the perspectives among participating practice staff were broadly positive, the improvements have not prevented staff departures at some participating practices.

Multidisciplinary teams: Staff also reported several benefits from working in multidisciplinary teams that allowed colleagues to share knowledge and expertise. The 'hub' room where all staff work with each other was especially praised for fostering a supportive network of knowledge exchange.

Staff Comments
"I have a happy and motivated team who are keen to be here. Patients are treated quickly, effectively and safely and the staff have proper lunch breaks and go home on time"
"The mix of clinicians is a benefit. There'll be somebody in the team who knows. In general practice you're quite isolated. You become tunnel-visioned in general practice."
"We all work together in that room. Sharing knowledge, exchanging advice with each other. Different clinical strengths and weaknesses. It's a hub, a hive of activity, exciting atmosphere. Anybody who's doing a face to face with a patient can just come into the Hub and ask people."

5 VALUE FOR MONEY

5.1 Projected costs and savings

The project costs for the SDAS were set out in its original funding bid, summarised below.

Table 5.1: Project Costs

Item	Unit / WTE	6 Month Pilot Cost	12 Month Recurrent Cost
Telephony	New system for GWMH	£33,054.40	£1,380.00
IT	20 Workstations required (16 with room for growth)	£42,129.00	£4,955.00
Estate	Collingwood move of existing teams, fitting and furniture for service	£47,140.00	£0.00
Equipment	Nebuliser, ECG, Spirometer, and Fax Machine Safe Haven	£2,500.00	£0.00
EMIS Migrations and software costs	For three practices moving to EMIS from a hosted service	£30,000.00	£0.00
EMIS Clinical Services	Patient Record System (7 practices)	£18,555.00	£9,600.00
EMIS additional migration costs	6 x £5000	£30,000.00	£0.00
Evaluation Management time	0.5 WTE Band 6 Information Analyst	£10,000.00	£0.00
Total Non-Recurring Costs		**£213,378.40**	**£15,935.00**
Recurring Costs			
GPs	3 sessions per week funded (covered by Deputy Chair Funding)	£21,600.00	£46,800.00
GPs	Provided by practices	£0.00	£0.00
Nurse Practitioners	Provided by practices	£0.00	£0.00
GP Supervision	Role for Governance and Clinical Supervision	£13,000.00	£26,000.00
Supervisor	1 WTE Band 6 with on costs	£10,000.00	£20,000.00
Administrator/Receptionist	2 x 1 WTE Band 2 with on costs	£23,000.00	£46,000.00
Telephone license and bills	Ongoing GWMH AND Practice telephony costs	£17,500.00	£35,000.00
Estates (Rent)	£300 per sq./m: Hub Space (tab 1)	£18,802.50	£37,605.00
Emergency Care Practitioner	2 x Band 7 WTE pump primed	£45,000.00	£90,000.00
Physiotherapists	Band 7 WTE pump primed (£731 per week for 2.5 days)	£17,556.00	£35,112.00
Indemnity	For additional workforce	£3,750.00	£7,500.00
Call Handlers	Provided by practices	£0.00	£0.00
Total Recurring Costs		**£170,208.50**	**£344,017**
TOTAL COSTS (Non-recurring and recurring)		£383,586.90	£359,952.00

Source: SDAS Costs (Data provided November 2016)

5.1.1 Cost Savings

The original business plan for the SDAS and the overall Value Proposition paper highlight several areas in which cost saving could be achieved. Primarily, SDAS aims to provide an improved use of primary care resources through:

- Timely access to acute primary care access centres which are expected to result in:
  - Reduced attendances at A&E by 3% in 16/17; and
  - Same day resolution of care needs for 40% of patients.

The following section models potential cost savings of SDAS in relation to face-to-face contacts as a result of non-GP practitioners taking on a greater share of face-to-face cases. The figures are subject to several key assumptions described below, but still provide insight into the potential for cost savings if the service were to be delivered at scale.

5.1.2 Unit Costs

Unit cost are taken from the Personal Social Services Research Unit's (PSSRU) unit costs of health and social care for 2015.[17] The unit cost directory includes an extensive list of clinicians outlined in Table 5.2 below. Cost per unit of time is highly variable depending on the care setting and personnel, and a number of important caveats are explained in the commentary below.

Table 5.2: Unit costs of clinical practitioners (2015)

Clinician	Code	Gross cost	Cost inc qualifications
Nurse (GP Practice)	A1	£36	£43
Nurse (GP Practice)	A2	£47	£56
Advanced nurse (clinical nurse specialist, senior specialist)	A3	£52	£59
Advanced nurse (clinical nurse specialist, senior specialist)	A4	£89	£101
Advanced nurse (clinical nurse specialist, senior specialist)	A5	£22	£25
General Practitioner	G1	£107	£129
General Practitioner	G2	£171	£207
General Practitioner	G3	£59	£49

Source: L. Curtis and A. Burns, 'Unit Costs of Health and Social Care' Personal Social Services Research Unit (PSSRU), University of Kent (2015).

General practitioner costs cited above are exclusive of direct staff costs, normally assumed to include the cost of one 0.5 FTE band 6 GP practice nurse per GP in primary care settings. These costs have been excluded because practice nurse costs are being treated separately in this case.

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[17]

Qualifications costs refer to the annual cost of pre-registration and postgraduate medical education annualised over the expected working life of a GP using Department of Health data. Nursing qualifications are calculated by the PSSRU using the methodology outlined in Netten et al.[18]

Table 5.3: Costs per patient in Jan-Mar 2016 verses Oct-Nov 2016

Quarter	No. Patients	Doctor (G2)	Nurse (A4)	Total	Cost / patient
Calendar Q1	4317	£72,174	£37,454.2	£109,628.2	£25.39
Calendar Q4	3025	£33,154.5	£34,744.0	£67,898.5	£22.45

Source: PSSRU (2015). Total cost assuming 10 minute consultations.

The cost estimates in Table 5.3 compare the cost of face to face consultations of GP staff and nursing staff for FY 2016 to provide an academic estimation of cost savings delivered as a result of the service. The total cost of a Doctor (G2) and Nurse (A4) assumes all patients are seen for consultations with an average length of ten minutes. The data show the cost per patient falling by approximately 15% as a result of the proportion of GP:nurse cases falling from 48:52 in Q1 to 32:68 in Q4 (see section 3.2.1 Number of Patients Triaged).

Nursing consultations and GP consultations take the same amount of time. In practice, it is highly likely that significant GP input is involved in nurse practitioner consultations, raising the real unit cost considerably. Research by Hollinghurst et al (2006) found that unit costs per consultation of GPs and nurse practitioners in UK primary care settings almost equalised once the cost of GP input to nurse practitioner consultations was accounted for, with GP costs at £28.14 per consultation compared to nurse practitioner costs of £30.35 per consultation.[19]

The costing assumes that all people who weren't seen by GPs would have gone to their practice and been seen by GPs at the same unit cost or cost per consultation. The estimates in Table 5.4 below show the difference in costs had the GPs continued to deliver the same proportion of face to face consultations throughout the year as in Q1.

Table 5.4: Cost saving resulting from reduced GP utilisation relative to nurse utilisation

Aggregate cost / year	GP (G2)	Nurse (A4)	Total
At Q1 average ratios	£226,708.9	£117,609.9	£344,318.8
At actual values	£145,920.0	£142,039.7	£287959.7
(Difference)			**£56,359.14**

[18] *Netten et al, Development of a ready reckoner for staff costs in the NHS, PSSRU (1998)*
[19] *Hollinghurst et al, Comparing the cost of nurse practitioners and GPs in primary care: modelling economic data from randomised trials, British Journal of General Practice (2006)*

6 CONCLUSIONS AND RECOMMENDATIONS

6.1 Conclusions

Overall, the evidence available to the evaluation suggests that the SDAS has performed well against targets, detailed below:

Target	Detail	Progress
Patient recommendations	85% of patients would 'probably or definitely' recommend the practice	Using May and December survey data this target has been consistently reached, with an average of 94% of patients or carers (n1=137, n2=129)) reporting that they would definitely or probably recommend the service.
Patient Satisfaction	Patients would experience 'ease of appointment and satisfaction with waiting times' (90% satisfaction for all participating practices)	Although data is not broken down in the patient survey at the level of individual surgeries, the average number of patients in May (n=137) and December (n=129) reporting that they were completely satisfied was 84%.
Non face-to-face resolution	40% of patients would have their issue resolved on the same day through non face-to-face contact	This target has been consistently achieved by the service. The maximum proportion of face-to-face appointments during the period was 39.4% in August.
Quality of patient care	Staff report increased control and improved care for patients	Staff who are involved in SDAS were asked the extent to which they agreed that "*Patients in this area are more independent and better able to self-manage as a result of the interventions funded by BLC".* 36% either agreed or strongly agreed with. This was higher than perceptions from other non-SDAS HBLC staff, of whom 25% agreed or strongly agreed.
Longer Appointments	Demonstrable increase in the number of longer appointments (more than ten minutes for those with LTCs)	Two of the four SDAS practices have been able to introduce 15 minute appointments owing to the of the service

Due to limited access to key data as a result of changes in Secondary Uses data access rules there has been greater difficulty clearly mapping progress and trends at the level of wider logic model outcomes (this methodology limitation is outlined in greater detail in Appendix 1). It is notable that an analysis of practice's locum allowances shows that there has been a considerable decrease in the allowances among SDAS practices, especially when compared to large increases seen in other Gosport practices who remain uninvolved in the service. However, further detail is required on average costs of locums and the number of locums in the area to ascertain the extent to which these changes can be attributed to the SDAS.

The basic costing analysis also shows cost per patient falling by approximately 10% as a result of SDAS as the proportion of GP: Nurse cases have been shown to fall. Assuming that all people who weren't seen by GPs would have gone to their practice and been seen by GPs at the same unit cost or cost per consultation, SDAS delivered roughly £16,931 in savings in the 2016 financial year.

6.2 Recommendations

Based on the findings of this evaluation, feedback from staff and patients, and experience of data availability, the evaluation has outlined some key recommendations to facilitate the continued improvement, uptake and monitoring of the SDAS service in the future.

Recommendation 1: Consultation on non-cost factors. Based on staff feedback of implementation issues upon service launch, RSM PACEC suggest extensive consultation on non-cost factors prior to any escalation or growth in participating practices. This would require a full understanding of the relationships between clinicians and administrators in both the practices and the hub as well as prior consultation with staff to ensure any necessary equipment or resources are available as expected.

Recommendation 2: Accessibility: As outlined in section 2.1.4 several patients have expressed that they are happy to travel further for a GP appointment. Before any increased roll-out RSM PACEC recommends modelling the travel and distance effects of future services beforehand. There exists a risk of sudden fall-off in the distances patients are willing to travel to receive a same-day appointment, which could dramatically affect assumptions regarding scalability. On a smaller level, this includes monitoring of on-site accessibility, as some patient feedback noted difficulties at the GWMH.

Recommendation 3: Interoperable record system. Development of interoperable record system to allow rapid analysis and comparison between the hub and services delivered in practices. This will be key to ensure sufficient evidence on demonstrating the benefits to support replication and roll-out elsewhere. This should include development of more robust service monitoring and evaluation within practices to better understand the impact and service trends. There should be clearer ways of tracing the impact on GP time (i.e. proportion of cases in practices taken by non-GP staff, amount of and changes in locum use).

Recommendation 4: Monitoring potential demand and displacement risks. In addition, SDAS should continue to monitor service demand, and understand reasons for reduced call volumes over time (reflected in section 4.2.1). In addition, SDAS staff should set up methods to monitor any possible adverse impacts on healthcare delivery and continuity of care at the individual practice level due to the reallocation of staff for the service.

Recommendation 5: Improved evaluation techniques. Current measurement tools (patient feedback questions in particular) may be subject to bias and should be reviewed as part of the ongoing service evaluation.