NIHR | Collaboration for Leadership in Applied Health Research and Care Greater Manchester

Clinical audit assessment of Salford Wide Extended Access Pilot (SWEAP) appointments

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1. Executive summary

- National Institute for Health Research Collaboration for Leadership of Applied Health Research and Care Greater Manchester (NIHR CLAHRC Greater Manchester) are conducting an evaluation of the Salford Wide Extended Access Pilot (SWEAP) programme for NHS Salford CCG. The evaluation is to support ongoing delivery and commissioning of the extended access service in Salford. The evaluation will be a mixed-methods evaluation and contain an audit, a process and a summative evaluation.
- This report presents findings from the clinical audit evaluation of patients using the service. This was conducted by a review of case notes of a sample of 211 appointments at SWEAP hubs during the period June to November 2018. Appointments were selected to ensure coverage of all 5 hubs and to cover a variety of appointments based on practice proximity and usage of the service.
- Based on the results of this case note review, it was felt that the SWEAP service is providing a safe, effective service to the majority of patients that use it. Key findings include:
    - 94% of the clinical notes sampled were either *satisfactory* or *reasonable with some omissions*
    - In most cases the SWEAP service met the needs of the patients attending:
        - 76% of appointments sampled were not followed by re-consultation in in-hours GP practice for the same issue in the 2 months following the SWEAP appointment
        - For the 24% of appointments with re-consultation it was felt that the SWEAP appointment added value to care in most cases (52/69), but generated duplication of work in the remaining 17
    - 45% of SWEAP appointments resulted in additional follow-up work for the patients' in-hours registered practice such as ordering imaging results or sending referral letters. It was not possible to quantify whether this additional follow-up work would have occurred had the patient been seen by their own GP rather than a SWEAP clinician.
- The audit led to a number of suggestions for the delivery of the SWEAP service:
    - In order to provide more efficient seamless care, hub clinicians would benefit from having full access to the patient's records, including secondary care letters, during hub appointments.
    - Improving continuity of care may not clinically benefit the majority of patients attending hub appointments, however some patients may benefit from improved continuity. The option to enable follow up with a named hub clinician could be considered. An alternative could be screening of patients booking into SWEAP appointments to assess their need for continuity.
- While efforts were taken to review a variety of appointments based on practice proximity to hubs and practice usage of appointments, the findings of the audit may not be generalisable across other SWEAP appointments, for different calendar periods, or for the service over time.

2. Background and context

The provision of extended access to general practice services in the evening and at weekends is a key national health policy priority. The General Practice Forward View[1], published by NHS England in 2016, states a commitment to providing additional funding "to enable CCGs to commission and fund extra capacity across England to ensure that by 2020, everyone has access to GP services, including sufficient routine appointments at evenings and weekends to meet locally determined demand, alongside effective access to out of hours and urgent care services." Such a drive to improve access to general practice has been supported, at a national level, by the £50 million Challenge Fund[2], launched in October 2013 to fund twenty pilots to deliver improved access and stimulate innovative ways of providing primary care services. A further wave of 37 pilots was funded in 2015/16, under the £100 million General Practice Access Fund[3] programme.

At a local level, Greater Manchester policy concerning extended access has reflected that seen at a national level. The 2014 Healthier Together Primary Care Standard for Greater Manchester[4] stated that by the end of 2015 "everyone is Greater Manchester who needs medical help will have same-day access to primary care, supported by diagnostic tests, seven days a week". The provision of extended access to primary care was also one of eight early implementation priorities associated with the devolution of health and social care for Greater Manchester. Since 2014, National Institute for Health Research Collaboration for Leadership of Applied Health Research and Care Greater Manchester (NIHR CLAHRC Greater Manchester) have worked with NHS England (Greater Manchester) and, more recently, the Greater Manchester Health and Social Care Partnership, to independently evaluate the various programmes focused on extended access in the region. More information about our previous evaluations is available here: http://www.clahrc-gm.nihr.ac.uk/organising-healthcare/

NHS Salford CCG commissioned the Salford Wide Extended Access Pilot (SWEAP) in April 2017, the aim of which is to establish, and support implementation of, evening and weekend general practice appointments across all five Salford neighbourhoods. As stated in the service specification "the vision for NHS Salford CCG is to provide a high quality primary care service that addresses the needs of patients and is sustainable. Extended Access would provide a complimentary but seamless service to what is currently seen as "in-hours" primary care."

The SWEAP scheme covers five neighbourhoods in NHS Salford CCG: Swinton, Eccles & Irlam, Little Hulton & Walkden, Ordsall & Claremont, and Broughton. A common hub specification was commissioned (one located in each neighbourhood). Types of extended service available differ over week days (Table 1). During a weekday the hubs were to be

[1] https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

[2] https://www.england.nhs.uk/gp/gpfv/redesign/improving-access/gp-access-fund/wave-one/

[3] https://www.england.nhs.uk/gp/gpfv/redesign/improving-access/gp-access-fund/wave-two/

[4] https://healthiertogethergm.nhs.uk/what-healthier-together/primary-care/

open for 1.5 hours a day (18:30-20:00) and staffed by a receptionist with appointments delivered by GPs and Advanced Nurse Practitioners (ANP). Saturdays were to be open for 3.5 hours (10:00-13:30) and staffed by a receptionist with appointments delivered by GPs, ANPs, practice nurses, healthcare assistants and included phlebotomy services. Sundays were to be open for 2.5 hours (10:00-12:30) and staffed by a receptionist with appointments delivered by GPs, ANPs and practice nurses. Appointments were to be mainly pre-bookable up to four weeks in advance. Initially, access to neighbourhood hubs would be for patients registered with a practice within the neighbourhood. From April 2018 all patients registered with a practice in NHS Salford CCG would be able to access any hub.

Table 1 Planned hub hours and appointments provided by discipline over the week

	Weekday (6:30pm-8:00pm)	Saturday (10:00am-1:30pm)	Sunday (10:00am-12:30pm)	Total**
GP clinics*	1.5 hrs 6 appts	3.5 hrs 14 appts	2.5 hrs 10 appts	13.5 hrs 54 appts
Practice Nurse	2 hrs 8 appts	4 hrs 16 appts	3 hrs 12 appts	17 hrs 68 appts
ANP clinics		4 hrs 16 appts	3 hrs 12 appts	7 hrs 28 appts
Healthcare Assistant		4 hrs 16 appts		4 hrs 16 appts
Phlebotomy		4 hrs 16 appts		4 hrs 16 appts
Receptionist	2 hrs	4 hrs	3 hrs	17 hrs

*+0.5 admin per day.
NHS Salford CCG give 5 appointments per hour for ANP, HCA, phlebotomy services
**Total NHS Salford CCG weekly extended access appointments equal 910 (182 per hub), giving an annual commissioned capacity of 47,320 extended access appointments (9,464 per hub).

Mobilisation of the pilots varied (see Table 2). Variations in mobilisation occurred at the request of Salford Primary Care Together (SPCT) due to procurement extension (commencement moved from 1st April 2017 to 8th May 2017) and IT and estates issues (implementation of the service and opening of buildings and provision of security at weekends respecttively).

Table 2 Neighbourhood hub activation dates

Neighbourhood	Proposed mobilisation date	Actual mobilisation date	Hub
Swinton	April 2017	14th August 2017	Swinton Gateway
Eccles & Irlam	July 2017	9th October 2017*	Eccles Gateway
Little Hulton & Walkden	September 2017	23rd March 2018	Walkden Gateway
Ordsall & Claremont	December 2017	22nd March 2018**	Pendleton Gateway
Broughton	March 2018	16th January 2018	Newbury Place

*Sundays from 12th November 2017 **Saturday/Sunday from August/September 2018

As part of their ongoing collaboration with NIHR CLAHRC Greater Manchester, NHS Salford CCG has approached NIHR CLAHRC Greater Manchester to conduct an evaluation of the SWEAP programme to support ongoing delivery and commissioning of the extended access service in Salford. The evaluation will be a mixed-methods evaluation and contain an audit, a process and a summative evaluation. In particular the evaluation will cover:

1) Quantitative assessments of i) the cost of delivering the extended access service, ii) activity associated with the service, iii) associations with service use elsewhere in the system (secondary care, Out-Of-Hours, and NHS 111), and iv) associations with patient perceptions of access to general practice
2) A clinical audit of patient records of patients using the service and interviews with providers and general practitioners
3) Qualitative analysis of the implementation and impact of the new service.

The current report presents findings from the clinical audit of patients using the service. This was conducted by a review of case notes of a sample of patients attending appointments at SWEAP hubs during the period June to November 2018.

3. Aim

The aim of the clinical audit was to assess the impact of the extended access service on patients and in-hours general practice.

4. Methodology

A proforma was developed to facilitate examination of case notes of a structured sample of patients that attended extended access appointments at SWEAP hubs (Table 3). Data were gathered from patients' full clinical notes, the data were in the form of both free text about the appointment and quantitative data on any interventions and subsequent use of health care services. Information on SWEAP consultations are recorded in the Vision Anywhere system and returned to the patient's practice (which could use the Vision or EMIS system). The researcher was a single auditor who was also an experienced GP.

Table 3: Data collected and mode of analysis

Audit questions	Mode of analysis
Was sufficient information about the appointment recorded in the clinical notes by the clinician?	The judgement of the auditor reviewing the free text of the case notes was used to ascertain whether documentation was appropriate. Information was classified as either: Satisfactory (complete, no clear omissions) Reasonable (some clear omissions) Unsatisfactory (no data/entry)
Reason for attendance	Free text in notes categorised using Halter's classification system*: Minor (includes presentation with more than one minor problem) Chronic (a condition present for 6 months or more) Acute (potentially life threatening required immediate action) Process (an administrative issue e.g. re-issue of a previous sick note)
Were the needs of the patient met by the SWEAP appointment?	Whether an appointment met the patient's need was assessed in two ways: Records were assessed to identify any use of health care services in the 2 weeks before and after an appointment. The judgement of the auditor was then used to decide whether this use suggests the need for the patient was not met The outcomes of an appointment were reported
Did the SWEAP appointment generate follow-up activity for patients' regular practices?	Records were examined to explore any aspects of a SWEAP consultation that resulted in follow-up activity in in-hours general practice (excluding non-planned re-consultations).

* Capturing complexity in clinician case-mix: classification system development using GP and physician associate data. Halter M et al. BJGP Open 2018; DOI:10.3399/bjgpopen18X101277

Broader impacts in the episodes of care provided by SWEAP were also explored using qualitative methodology. As well as documenting prescribed quantitative outcomes, the auditor examined the patient's journey through the health care system in relation to their use of SWEAP, as documented in their record. Records were compared to one another using a constant comparison approach and themes/issues that were elucidated from sets of notes were examined in subsequent records.

5. Sampling

Due to restrictions with IT access and data protection, patient records had to be examined in a patient's registered practice. Time and access therefore guided the number of practices from which we were able to select patients. The sampling strategy was purposive; NHS Salford CCG wanted to include data from appointments provided at all five neighbourhood hubs. For each practice, the hub that tended to be used by their patients was identified and then one practice for each hub was selected to be audited. NHS Salford CCG selected practices to provide a range of levels of use of the SWEAP service and proximity to a hub location. The practices selected, and their characteristics are shown in Table 4. Data on hub usage and proximity was provided by the NHS Salford CCG.

Table 4: Characteristics of sampled practices

Practice	Hub used by majority of practice patients accessing SWEAP	Is the practice co-located at the site of the hub?	Usage level of SWEAP~ (high/medium/ low)	Proximity to nearest hub~ (co-located/ near/medium/far)
Newbury Green^	Broughton	Yes	High	Co-located
SPCT (3 practice sites)^	Eccles	Yes 1 No 2*	Medium Medium?	Co-located Medium
Pendleton^	Pendleton	Yes	Medium	Co-located
Silverdale^^	Swinton	No	Low	Near
Ellenbrook^^	Walkden	No	High	Far

~NHS Salford CCG provided the groupings for these categories
* One of the three practice sites was co-located with the hub
^Vision system
^^EMIS system

The auditor was provided with a list of all patients from the sampled practices that booked an appointment at any SWEAP hub from 1st June 2018 till 31St November 2018. This was a total of 890 appointments. Excluding did not attend (DNA) appointments (197) and Health Care Assistant (HCA) nurse appointments (39) gave a total of 654 SWEAP appointments.

The 654 appointments were organised chronologically. The number of records to be audited was limited by time constraints. Number of records was calculated from the time available at the practice, and the average time to conduct an audit per patient. Records were then selected by taking every nth record in the list, where n is the total number of appointments on the list divided by the number of appointments that could be audited during the time available. For example, if there were 100 records and there was time to process 20, the auditor would have chosen every fifth record in the list of patients. To this extent the sample represents a random selection of patients attending SWEAP appointments from each of the five selected practices over the time of the study. In all, we

sampled a total of 211 (32%) of the appointments for the review (Newbury Green: 56 appointments, SPCT: 49, Pendleton: 22, Silverdale: 39, and Ellenbrook: 45).

6. Results

6.1 Was sufficient information recorded in the clinical notes by the clinician?

Notes were assessed by the auditor for completeness. Notes were recorded as *unsatisfactory* if there was insufficient documentation to ascertain what had happened during the consultation. Notes were classified as *reasonable with some omissions* if the purpose and outcome of the visit was evident but other information was missing. This was information that could help other clinicians understand what happened during the consultation and would normally be expected to be recorded during a similar consultation. For example, the specified follow up was unclear, examination findings were not recorded, or red flags symptoms were not recorded. Table 5 gives the classification of information recorded in the appointments audited. The vast majority of the records were judged to be *satisfactory* by the auditor (87%). 14 sets of notes were judged to be *reasonable with some omissions* (7%) and 13 set of notes were judged to be *unsatisfactory* (6%).

Table 5: Rating of clinical note documentation

Information classification	Number of records	% records audited
Satisfactory	184	87%
Reasonable with some omissions	14	7%
Unsatisfactory	13	6%
Total	**211**	**100%**

Satisfactory: insufficient documentation to ascertain what had happened during the consultation
Reasonable with some omissions: purpose and outcome of the visit was evident but other information was missing
Unsatisfactory: no data/entry

6.2 Reasons for attendance

Table 6 shows the reasons for each patient's attendance. The majority of appointments were solely for minor problems (74%). 21% of appointments were solely for chronic health conditions. 59 of the 211 sampled appointments (30%) were taken by patients who were on a chronic disease register or who had a significant long-term medical condition.

Table 6: Reason for patient attendance

Reason for SWEAP appointment	Number of records	% records audited
Minor	148	74%
Chronic	42	21%
Not clear/not recorded	11	5%
Minor + process	3	1.5%
Acute	2	1%
Minor + chronic	2	1%
Process	1	0.5%
Prevention (e.g. discussion about a screening test)	1	0.5%
Minor + prevention	1	0.5%
Total	**211**	**100%**

Minor: includes presentation with more than one minor problem
Chronic: a condition present for 6 months or more
Acute: potentially life threatening required immediate action
Process: an administrative issue e.g. re-issue of a previous sick note

6.3 Were the needs of the patient met by the SWEAP appointment?

To inform whether the extended access service were meeting patient needs we assessed information contained in patient records regarding the use of healthcare services two weeks before and 2 weeks after an appointment and the outcome of the extended access appointment.

Did the patient consult their own practice/other providers about the same issue in the 2 weeks before or after the SWEAP appointment? Attendances elsewhere in the health system before and after a SWEAP appointment are detailed in Table 7.

Table 7: Attendance elsewhere in the system before or after a SWEAP appointments

Activity	Number of records	% records audited
2 weeks before SWEAP appointment		
General practice	8	4%
Other provider (111/A+E/secondary care)	13	6%
2 weeks after SWEAP appointment		
General practice	34	17%
Other provider (111/A+E/secondary care)	5	2%
48 days prior to SWEAP appointment		
General practice	11	5%
48 days after SWEAP appointment		
General practice	51	24%

^patients could present at general practice and at other providers meaning the total may not amount to the summation of general practice and other providers

Eight patients (4%) had consulted at their regular practice for the same issue as the SWEAP appointment in the 2 weeks prior to their SWEAP appointment. Only two of these eight subsequent SWEAP consultations appeared to be for “second opinions”. Thirty-four patients (17%) consulted at their regular practice for the same issue as the SWEAP appointment in the 2 weeks after their SWEAP appointment.

Although we initially decided to use 2 weeks as a cut off for re-consultation, it became evident that many patients were re-consulting more than 2 weeks after their SWEAP appointment. When we looked at subsequent GP appointments up to 48 days after the SWEAP consultation, the re-consultation rate rose to 51 (24%), including appointments for the same issue that was addressed during the SWEAP consultation.

Eighteen (8.5%) patients consulted another provider (111/A+E/secondary care) in the two weeks before or after their SWEAP appointment for the same issue. Four (2%) patients were followed up and reviewed by the SWEAP hub service for the same issue as their baseline consult. A proportion of these re-consultations appear to be entirely clinically appropriate and unavoidable. This issue is discussed later in the results.

In total, 54 (25%) patients were seen by their own GP or other providers, for the same clinical issue, in the two months after the SWEAP consultation. Of these 54 appointments, 17 (8.5% of total appointments reviewed) were as a result of issues with the set-up of SWEAP hub services and may be seen as ‘avoidable’ (Table 8). In the other 37 consultations it was felt that the extended access appointment “added” to the management of the patient’s issue.

Table 7: Reasons for appointments resulting in avoidable subsequent attendance in general practice

Reason for subsequent appointment in general practice	Number of patients
Referral or bloods requested from SWEAP clinician was not performed by GP practice	3
Lack of access to notes/letters/investigation results for SWEAP clinician	3
SWEAP clinician altered long term condition management which was then changed back by in-hours GP	3
Unclear	3
SWEAP patient wanted to see a female GP	2
SWEAP clinician appears unaware of local services	1
Should have been seen in different clinic e.g. stop smoking rather than SWEAP	1
SWEAP clinician unhappy to issue fit to work note (MED3)	1
Total	17

6.4 What were the outcomes of appointments?

The outcome of each visit was classified using the categories in Table 9. These outcomes are difficult to attribute to needs being addressed, this would require inference from further use of health care and enquiries with patients. However, the outcomes give an understanding of the type of work generated by SWEAP appointments.

Table 8: Appointment outcomes

Outcome of appointment^	Number of records	% of records
1 or more prescriptions issued	79	39%
Advice only given	40	20%
Blood tests requested	32	16%
Referral to another service	26	13%
X-ray or other imaging request	20	10%
Asked to see in hours GP	8	4%
Stool/self-swab/nail clippings requested	4	2%
Urine sample (MSU) requested	3	1.5%
Electrocardiogram (ECG) requested	3	1.5%
Emergency admission	2	1%
Fit for work note (MED3) issued	2	1%
Gynaecological swabs taken in appointment	1	0.5%
Echocardiogram requested	1	0.5%

^The total number of records does not equal 211 since some consultations, other than those recorded "advice only given", have multiple outcomes e.g. a patient may have had a prescription + referral + blood test request.

6.5 Did the SWEAP appointment generate follow-up activity for patients' regular practices?

48% of appointments resulted in follow-up work for the patient's in-hours registered practice. This does not include non-planned re-consultation or contact with the patient's regular practice (Table 10).

Table 9: Activity post-SWEAP appointment

What work did a patient's registered practice have to do after the SWEAP appointment	Number of records^	% of records
No further work	107	52%
Order and/or chase up blood/imaging/investigation results	42	21%
Create/send referral letter	25	12%
Review a patient	24	12%
Practice to review correspondence which EA clinician could not access	4	2%
Alteration of repeat prescription	1	0.5%
Practice to try and expedite a secondary care appointment	1	0.5%

^More than one activity could be generated from an appointment

7. Other themes and issues elicited from the audit

7.1 Continuity of care

Continuity of care is a complex construct and here we use the term to refer to whether a patient sees the same clinician in different appointments. It is inevitable that most patients accessing SWEAP will have reduced long-term continuity of care by the fact they are seeing a clinician outside of their regular practice. A sizeable number of patients in regular practice do not see the same clinician on each occasion.

Continuity of care can be looked at from a particular episode of care as well as a patient's long-term care. In 70% of hub consultations, continuity of care with a particular clinician was not deemed to be important to the outcome of the issue/issues dealt with at the SWEAP appointment. There were also 61 multiple (30%) consultations where continuity of care might have improved patient care, satisfaction, safety and efficiency. Examples include:

- Review of long-term mental health issues where the patient had seen a regular GP for the same problem several times before
- First presentation of mental health problems that required follow up
- A management strategy was commenced for long term IBS/gastro issues by the patients regular GP which was changed by the SWEAP clinician and then changed back again by the patient's regular GP
- Long term poor control of asthma.

In some instances the hub clinician was so keen to maintain some continuity of care that they created a "work around" for the system, including three instances where a hub GP arranged follow up of a patient with themselves in their regular in-hours surgery.

8. Conclusions

Based on the results of this case note review, the SWEAP service is providing a safe, effective service to the majority of patients that use it. It was found that 94% of the clinical notes sampled were either *satisfactory* or *reasonable with some omissions* and clinical actions deemed necessary by the hub clinician were passed to practices who carried them out.

In most cases in our sample, the SWEAP service met the needs of the patients attending. In the majority of cases within the sample (76%), patients did not re-consult with their in-hours GP practice for the same issue in the 2 months following their SWEAP appointment

(17% in the two months following the appointment). Of those patients that did re-consult, it was felt by the auditor that the SWEAP appointment added value to care in most cases (52/69), but generated duplication of work in the remaining 17 (8.5% of total sampled consultations).

45% of SWEAP appointments resulted in additional follow-up work for the patients' in-hours registered practice such as ordering imaging results or sending referral letters. It is not possible to quantify whether this additional follow-up work would have occurred had the patient been seen by their own GP rather than a SWEAP clinician.

In order to provide more efficient seamless care, hub clinicians would benefit from having full access to the patient's records, including secondary care letters, during hub appointments.

Improving continuity of care may not clinically benefit the majority of patients attending hub appointments, however some patients may benefit from improved continuity. The option to enable follow up with a named hub clinician could be considered. An alternative could be some form of screening of patients booking into SWEAP appointments to access their need for continuity.

8.1 Strengths and Limitations

The key strength of this audit is that it involves in-depth analysis of individual case notes using independent clinical judgement, which enabled the assessment of the utility of SWEAP appointments in several ways. Importantly, the methodology can be replicated in other areas, or in Salford at future timepoints.

There are also several limitations to the methodology adopted. Firstly, while the sampling strategy was designed to cover all areas and different kinds of practice, a different approach to practice selection may affect the findings here. It is also worth noting that the nature of SWEAP activity may differ in other time-periods. The dates selected include mainly summer months, with lower usage and often different types of appointment needed (e.g. more flu likely in winter) and there would likely be more pressure on in-hours appointments over winter. In addition, the audit does not take into account qualitative changes in provision, such as improvements to SWEAP clinician induction process or developments around IT provision. It is therefore important to note that the findings may not be generalisable across other practices in Salford and other time points.

Finally, as the audit focused on actual appointments, it does not shed any light on the reasons for, or impact of, cancelled appointments or unavailable sessions.

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The information in this report/brochure is correct at the time of printing.