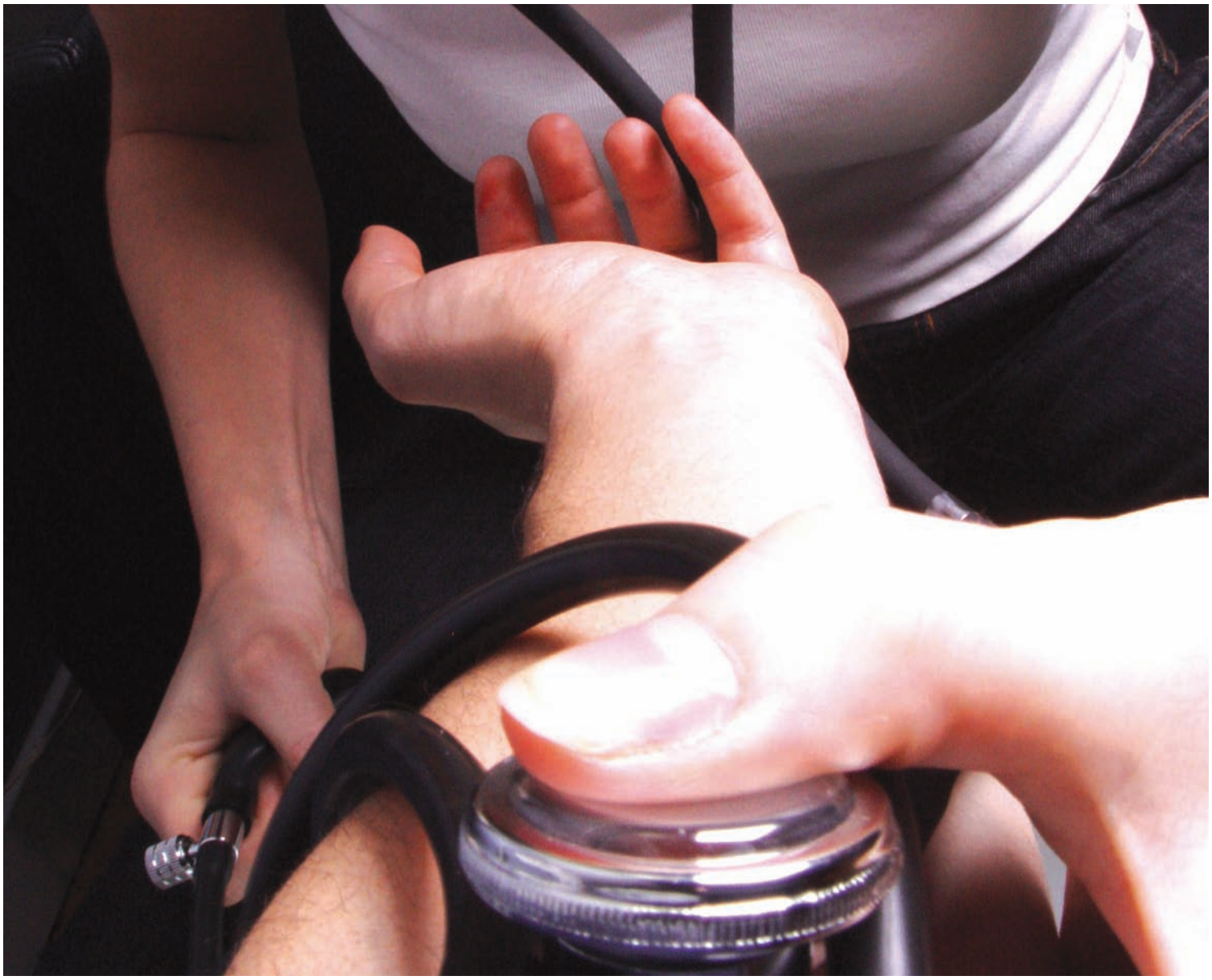

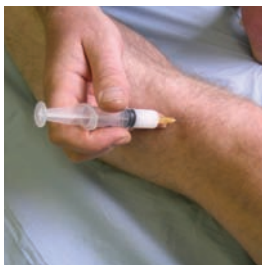

URGENT CARE

a practical guide to transforming same-day care in general practice

Primary Care Foundation

Supported by the Department of Health

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General Practitioners Committee

20 March 2009

Dear Dr Carson, Mr Clay and Mr Stern

Urgent Care - a practical guide to transforming same-day care in general practice

The Royal College of General Practitioners (RCGP) and the British Medical Association's General Practitioners Committee (GPC) support the Primary Care Foundation's report Urgent Care – *a practical guide to transforming same-day care in general practice*. This report throws a spotlight onto an often neglected but very important aspect of general practice. Urgent care can be managed by practices in a wide variety of ways and we welcome this report's acknowledgement that solutions must be locally formulated within the available resources.

The RCGP and GPC support your conclusion that practices should review their access arrangements and their balance of appointment types and staffing. The examples and practical advice contained within your report will help practices to do this. We would certainly encourage all practices to assess their urgent care arrangements and to set themselves achievable goals for improvement where appropriate.

Practice capacity will be critical in determining practices' ability to improve patients' experience of urgent care. All too often practices' desire to improve patient services is frustrated by insufficient capacity, substandard premises and inadequate funding. The ability of practices to implement many of your recommendations depends heavily on Primary Care Organisation (PCO) support and predictable, adequate practice funding. We support your recommendation that PCOs should support practices with resources, expertise and advice.

Yours sincerely

Steve Field
Chairman of Council
Royal College of General Practitioners

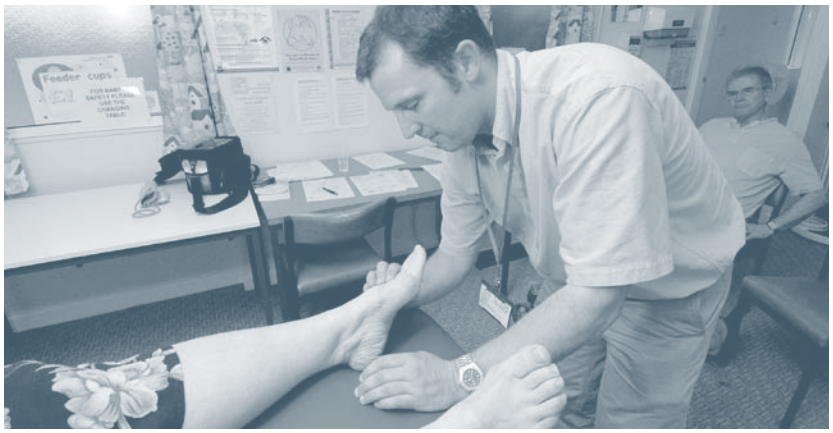
Laurence Buckman
Chairman
General Practitioners Committee

CONTENTS

This report was prepared and written by David Carson, Henry Clay and Rick Stern of the Primary Care Foundation and edited by Kaye McIntosh.

May 2009

EXECUTIVE SUMMARY



Urgent care in general practice matters. It matters to patients, who may be harmed or distressed if diagnosis and treatment is delayed. It matters to the NHS as a whole, because urgent care arrangements which have not kept pace with other operational changes within the NHS place pressure on the rest of the system, driving people towards A&E and avoidable hospital admissions. It matters to practices, where workloads can become unmanageable if urgent care is not handled well. It also affects the reputation of the service - unhappy patients tell their family, friends and colleagues about their experience.

This report shines a spotlight on what actually happens on the ground. It describes our work with practices across five very different PCTs, outlining key lessons for improving urgent care.

The report and recommendations are designed to support all organisations delivering general practice services including GMS, PMS, PCTMS, APMS and the new GP led health centres. Other services, such as walk in centres, that deliver aspects of general practice should look to apply the principles contained in the document within their operating model and framework.

We focused on three simple questions concerning care for patients who contact their practice with an urgent need:

- Will they get through?
- Will they be identified?
- Will they be seen rapidly?

For staff in general practice

This report aims to help practices answer all three questions with an emphatic 'yes'. We outline tried and tested ways to improve patient safety while reducing workload, with real-life case studies showing what can be achieved. In fact many of the practices featured focused on urgent care in order to tackle an intolerable workload.

Our research led to 10 recommendations across a number of areas listed below. These recommendations are aimed at practices because this is not an area where one size, one approach or one answer can fit all.

The different operational processes within each individual practice will dictate the best way for that practice to achieve these goals.

Recommendations

Practices should:

- Address the urgent needs of a patient, whether they choose to access the service by phone or in person.
- Match capacity to demand - both in responding to the initial call or visit from a patient and in recognising the different demand patterns for same day and advance appointments.
- Ensure that the full range of cases that might need urgent attention will reliably be recognised by staff when the patient rings or presents in person and that the process is understood.
- Set deadlines for assessment and intervention and measure performance against these, paying particular attention to the needs of those requesting home visits where the chances are that the case may be more acute or complex.
- Review and audit the processes to refine the way that they operate.

See Recommendations 1 to 10 below, and Chapters 4 to 6, for more details. Practices will also find a useful checklist, 'The four dimensions of care', in Chapter 7.

For Primary Care Organisations and the wider NHS

Offering consistent and ongoing resourced support for practices to improve urgent care can bring major benefits across the system. If surgeries can manage urgent care

EXECUTIVE SUMMARY CONTINUED

as early as possible in the patient's journey, the workload and costs for the rest of the NHS will be reduced. Better management of urgent requests can lead to a substantial reduction in attendance at A&E and emergency hospital admissions, as demonstrated by many of our case studies.

The evidence

Our recommendations are the result of intensive work with primary care professionals, including research into best practice, a survey of GP practices, face-to-face interviews and workshops in five very different PCT areas (see Chapter 1 for more details). We have found a number of ways in which different practices operate to meet the principles of good urgent care within the context of their individual circumstances - patient population, skill mix, geography and other factors.

The case studies we have highlighted often describe only one element of the process, a specific aspect of care, or even just provide an illustrative format for practices to use as a basis for developing their own processes. The named practices would not claim to be exemplars of best practice across the board but do show how it is possible to transform the urgent care offered to patients.

High-quality urgent care depends on four factors:

- Access
- Speed of initial response
- Capacity
- Assessment (by receptionists/call handlers and clinicians).

We have not attempted to draw up any narrow definitions of urgent care, not least because no single description could cover the variety of considerations that need to be taken into account in any individual case. As a result, we have considered any patient that contacts the practice wanting to be seen that day (same-day care) as a potentially urgent case.

Action points for practices:

Recommendation 1 - Access

Ensure patients with urgent conditions will receive timely care however they access the service. Many practices aim to achieve this but a small number have tried to channel patients so rigidly into one process that barriers are created, increasing the risk that urgent needs may be missed. See Chapter 3 for more details.

Recommendation 2 - Matching capacity to demand

Ensure processes minimise avoidable peaks in demand. Practices should assess the pattern of phone demand and make sure that sufficient staff and telephone lines are available so that patients do not find it difficult to contact the practice. See Chapter 3 for further information.

Recommendation 3 - Reviewing capacity

Make sufficient appointments available to meet demand from patients. Practices should review the number of appointments available each week (across all skill groups and including telephone consultations) to ensure that they meet the needs of their patient population. Capacity should be sufficient to meet the predictable demand without resorting to unplanned extra appointments. See Chapter 4 for more details.

Recommendation 4 - Capacity for same-day and advance appointments

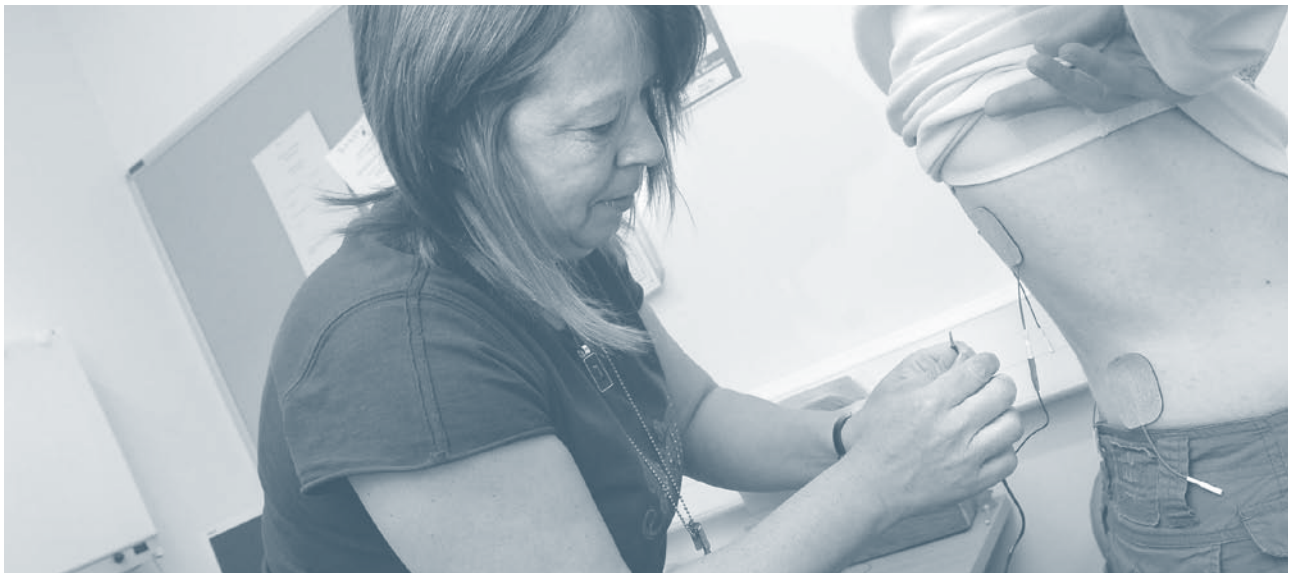
The balance of book ahead to same-day appointments (including other options such as telephone consultation or other responses) should be matched to the pattern of demand. We found two-thirds advance to one-third same-day appointments appears to be the right mix for the normal demand facing many practices as this reflects the character of general practice workload demonstrated in many studies and surveys. See Chapter 4 for further information, which also describes some of the reasons for varying this proportion.

Recommendation 5 - Responding to urgent cases

Review how the practice would identify and respond to a range of urgent cases. Look both at symptoms that might indicate urgency and consider particular groups of patients that may need to be handled differently. See Chapter 5 for more details.

Recommendation 6 - Training

Review receptionist training to ensure these front-line teams understand and use the right processes to identify and handle urgent calls. Where required, practices should run refresher sessions involving both clinical and non-clinical staff. See Chapter 5 for further information.



Recommendation 7 - Deadline for assessment

Define your own practice standard for the length of time from the patient first ringing to assessment by a clinician (telephone or face-to-face). Practices should monitor performance against their standard and review this measure. See Chapter 6 for more details.

Recommendation 8 - Deadline for intervention

Define your own practice standard for the length of time until appropriate clinical intervention or hand-off takes place where a clinician has assessed the case as urgent. Practices should monitor performance against their standard and review this measure. See Chapter 6 for further information.

Recommendation 9 - Quality

Carry out regular audits of the process for urgent care to review the quality and consistency of telephone response, consultations and decision-making. Consider making use of approaches such as those of the Royal College of GP's practice accreditation scheme. See Chapter 5 for more details.

Recommendation 10 - Home visits

Any patient or carer requesting an urgent home visit should be offered a rapid assessment by a clinician. Normally this will be by phone but in some cases the clinician, knowing the patient's condition, may choose to plan an early visit. See Chapter 6 and Case Study 8 for further information.

Action point for Primary Care Organisations:

Recommendation 11 - support from PCOs

Primary Care Organisations should support practices (with recurrent resources, expertise and advice) in reviewing and improving their process for handling requests for same-day urgent care, in line with these recommendations. See Chapter 5 for more details.

Action point for suppliers of phone and IT systems:

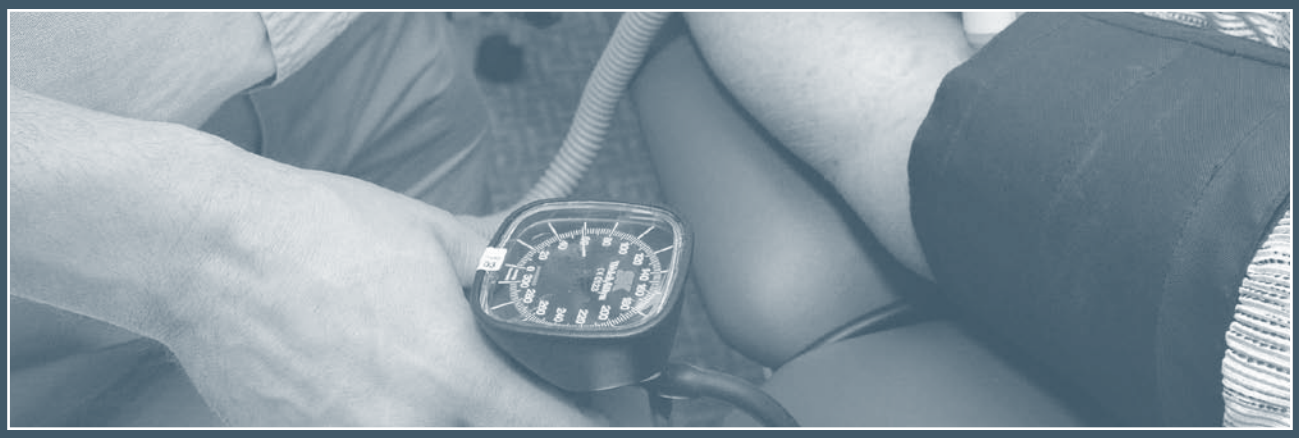
Recommendation 12 - phone and IT systems

Suppliers of both IT and phone systems to general practice should develop reports that support practices:

- In measuring and monitoring capacity and demand.
- In monitoring the timeliness of response.
- In reporting of outcomes at each stage in handling an episode of care from the initial patient contact to appropriate clinical intervention or hand-off.
- In reviewing the quality of telephone response by non-clinical staff as well as the quality of clinical consultations.

Those involved in selecting and specifying systems should consider these needs as they update or renew systems over the coming years. See Chapter 5 for further information.

CHAPTER 1. INTRODUCTION



1.1 Our research

The Primary Care Foundation was commissioned by the Department of Health to undertake a review of urgent care in general practice. The Department's Next Stage Review (known as the Darzi report) in July 2008 pledged: 'Every member of the public should be able to expect integrated local services that provide access to urgent care, 24 hours a day and 365 days a year.'

This project explored the practical steps that GPs and their staff take to improve patient care and reduce pressure on the wider healthcare system.

The terms of reference specified that the review should:

- Identify the different ways in which practices assess and respond to urgent in-hours demand for access to a health professional.
- Examine the standards that are followed, how staff are trained to handle this demand and the extent to which there is any consistency within and between practices in their management of same-day access to urgent care.

There were over 30 expressions of interest from PCTs who wanted to be involved. Five were selected to provide a diverse range of communities and practices across the country.

- Doncaster
- Lambeth
- Plymouth
- Bolton
- Norfolk

1.2 Case studies and examples of current practice

Through this document we have highlighted case studies, showing how individual practices have improved their response to urgent cases. We have also given examples of the kind of analysis that GPs and their teams have found helpful. We have named the specific practices unless they asked us not to, or it seemed unfair to single out any one organisation.

1.2.1 What happens today?

To get a picture of current practice across the five PCTs studied, we developed a web-based questionnaire, exploring all aspects of the management of same-day care. This was based on previous work carried out by the Primary Care Foundation, involving face-to-face interviews with 61 practices in West Kent.

Responses from nearly 150 practices across the five PCTs were reviewed in workshops in each area. They underpin many of the findings in the report. We are grateful for the analysis of this data by Warwick Medical School, University of Warwick.

1.2.2 Best practice

We sought examples of good practice, using sources such as the GP and Practice Managers Bulletin and the NHS Alliance PEC Chairs Network. Over 50 practices emailed, telephoned or completed a web-based survey describing different aspects of their work. Some were followed up with further calls or visited.

1.2.3 New ways of working

Eight pilot practices were established in four of the PCTs involved in the initial questionnaire. Each PCT tried to identify one practice that was performing well and another that was struggling to manage same-day care.

The Primary Care Foundation worked with the practices for between eight and 12 weeks to improve their management of urgent same-day care. Two of the PCTs also offered support to a further two practices.

1.3 What does urgent mean?

The overwhelming majority of interactions that patients have with the NHS take place in primary care. Only a very small proportion of these are clinically urgent by any definition - and even fewer involve potentially life-threatening cases. The challenge posed is to define which cases are included within the category of 'urgent'.

We have avoided describing 'urgent' and 'emergency' in clinical terms, not least because no exhaustive definition could be provided - nor could it cover the wide variety of circumstances that need to be taken into account in considering any individual case. Ultimately, assessment by a clinician in any borderline case is the only way in which those that should be dealt with more immediately can be identified.

As a result, we decided to consider any request for same-day care as potentially urgent, with the agreement of our reference group (see Appendix 1 for membership). This project explores the ways in which a request for a same-day consultation is handled, from the first contact with the practice, through to an appropriate and safe response that meets the needs of the patient. We did not explore in detail the process beyond the clinical assessment (whether face-to-face or telephone consultation) or the process for non-urgent cases seeking a later appointment.

There are three main implications of treating any request for same-day care as potentially urgent:

- **The level of urgency may change**

One of the key roles of any primary care clinician is to identify how urgent a case may be and to advise the patient accordingly.

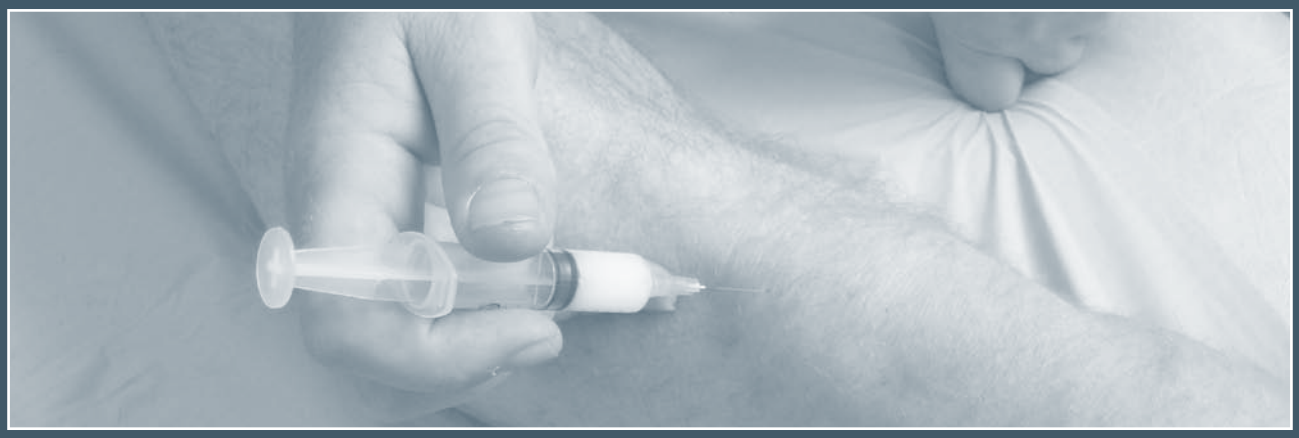
- **Priority can go up as well as down**

In a small number of cases, the patient (or their carer) might not recognise that the problem is urgent or requires a same-day consultation. We are confident that any practice with a well-designed process and properly trained receptionists should be able to identify such cases.

- **Urgency is not restricted to medical emergencies**

In deciding which of the same-day cases are actually urgent we expect the practice to identify both immediately life-threatening cases and also those where there are likely to be benefits from an early intervention. This includes, for instance, elderly patients where a swift response may increase the likelihood that they can continue to stay in their own home.

CHAPTER 2. KEY PRINCIPLES



2.1 One size does not fit all

An estimated 300 million primary care consultations take place in some 9,000 practices throughout England alone each year. Practices vary considerably in their size, staff mix and way of operating. The cities, towns, villages and populations they serve vary too.

Throughout this document we expect the reader to apply the principles we outline to their own practice and system. We recognise that the role of nurses is expanding in many practices and that an appointment is not always the most appropriate response for some patients. We emphasise that the recommendations are not a template but a set of principles with options and suggestions. The decisions on what solution to put in place must rest with the practice and its team and no other organisation.

We did not expect to find consistency in the detailed process by which practices dealt with urgent cases, nor do we feel that it is desirable that there should be standardisation. One of the strengths of general practice is the ability of individual practices to establish ways of working that suit their staff and patients - it is this that makes general practice fleet of foot, able to respond quickly to changes at local or national level.

What we did expect was an absolute commitment to make sure that the services provided were safe for patients and met their healthcare needs. That's exactly what we found when we worked closely with individual practices.

GPs and their staff are driven by the need to provide good care to patients. It is because of this commitment, and because we recognise the value of not just allowing but encouraging local differences to meet local situations, that we are confident that it is right to focus many of our recommendations at the practice level.

2.2 The principles of good urgent care

We thought it important to articulate some key principles. They aim to capture common-sense logic around the process for urgent cases.

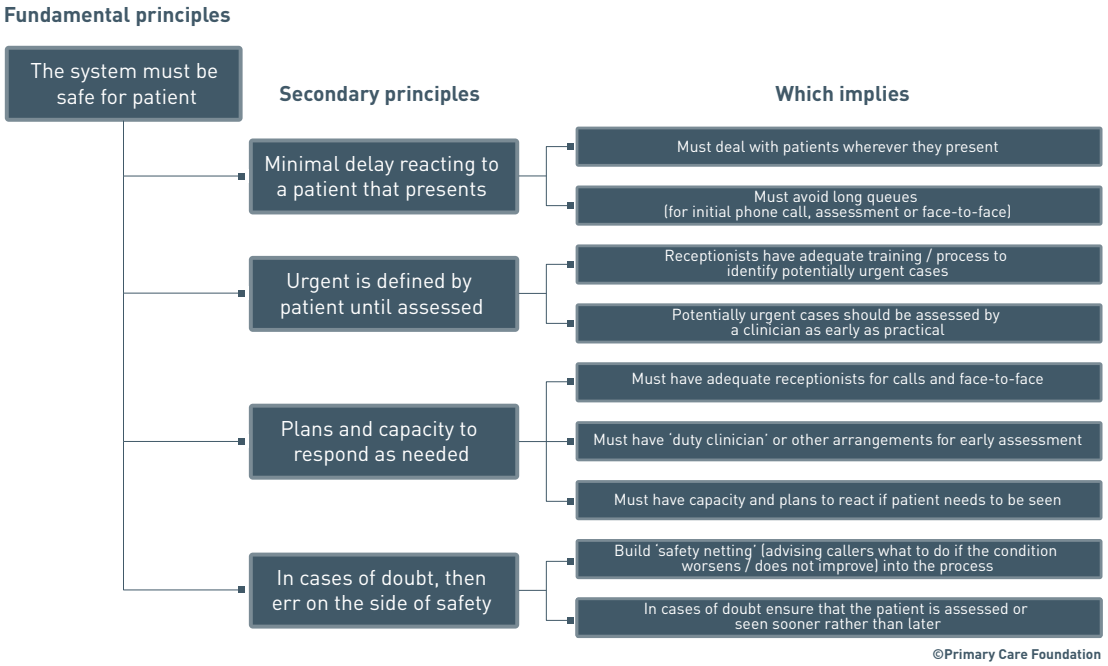
These principles place a high priority on patient safety for all calls or visits to general practice. They assume that in most cases the patient or carer is in the best position to assess the urgency of the case before any clinical assessment, sometimes supported by assistance over the phone from practice staff.

We recognise that:

- Clinically urgent cases are rare
- Practices must follow a process that is rapid and not overly resource-intensive.

Our case studies demonstrate that high-quality care can be achieved without imposing a burdensome process such as asking numerous questions of every caller.

Developing the principles for urgent cases presenting to General Practice



Our approach starts with one key principle:

The system must be safe for the patient.

This leads to four further principles for accessing urgent care:

- **Minimal delay**

The urgent clinical assessment needs of patients should be met wherever and however they present to primary care (or to the wider NHS). The process must be one that avoids delay.

- **Urgency is defined by the patient until assessed**

Urgency is defined by the patient and can only be altered after clinical assessment, either face-to-face or over the telephone. Receptionists must have adequate training to identify potentially urgent cases, supported by an efficient process. These cases must be assessed by a clinician as soon as is practical.

- **Plans and capacity to respond**

Plans, processes and capacity - including the balance of same-day to advance appointments - should be sufficient to respond to demand. There must be adequate numbers of receptionists and clinicians to answer calls and deal with the assessment stage as early as is possible. There must be sufficient clinical resource to see patients as swiftly as necessary (in the surgery or at home) and arrangements in place with other agencies, such as ambulance or community services.

- **In cases of doubt - safety net**

The process should include a safety net. Where a later call-back or appointment is offered, patients should be told what to do if the condition worsens or does not improve. As a final check, receptionists must ask the patient whether they feel a more urgent response is required. In cases where there is any doubt, patients must be assessed as soon as is practical.

2.3 Best practice

We have found a number of different ways in which GPs and their teams operate to meet the principles we have outlined. Our recommendations are mainly targeted at practice level, because they need to be interpreted in the light of individual circumstances. However, two recommendations are aimed at IT system suppliers and Primary Care Trusts respectively, because practices will need support in these areas. See Recommendations 11 and 12, described in Chapter 5.

You should guard against being too quick to assume that your own practice already meets each of these requirements. Many will meet some of them, some of the time, but few will achieve a consistently reliable response to same-day requests.

CHAPTER 3. ACCESS

3.1 Restrictions

We found a small number of practices that restrict the way that patients can access same-day care:

- In one extreme case, patients were made to queue outside the surgery. When the doors were opened, they were given an appointment and told to come back later. Inevitably, those who were further back in the queue found it harder to get a same-day appointment.
- At the other extreme we found a practice which effectively banned patients from attending in person, requiring them to phone in order to book either an appointment or a telephone consultation with a clinician.

We do not accept that either extreme is reasonable. It is clearly better to offer a choice of phone call or turning up in person, rather than insist sick patients attend the surgery and then either endure a lengthy wait or have to go away and return later. Other people, particularly those who need support with language, find it difficult to use the phone.

We found those practices that had a range of access options, coupled with balanced capacity for same-day or advance appointments, were able to respond more rapidly and effectively to patients with urgent medical needs.

Recommendation 1

Practices should ensure patients with urgent conditions will receive timely care however they access the service. Many practices aim to achieve this but a small number have tried to channel patients so rigidly into one process that barriers are created, increasing the risk that urgent needs may be missed.

3.2 Options for improving access

Many practices have made their patients aware of times when they will see anyone who needs a same-day appointment. This approach reduces the number of incoming calls and is a declaration that if a patient wants to be seen, they will be.

While it can be a successful policy, there is a risk of long waits if the hours are too restricted. Equally, practices with walk-in clinics have to ensure the system works for patients, rather than creating lengthy queues.

3.2.1 Walk in clinics

Some have taken the principle of telling patients they will be seen that day further, and set up an open access clinic alongside the normal appointment system.

3.2.2 Integrating urgent care

Offering a comprehensive urgent care service within general practice can reduce emergency admissions and release resources for investment.

CASE STUDY 1: OPEN ACCESS CLINIC

The Waterside practice in Gosport serves 11,000 patients in a mixed urban community. They work out of a purpose built building with an area set aside for a same-day open access clinic. It runs from 8am to 11am (extending for a further hour if needed) and 3pm to 6.30pm.

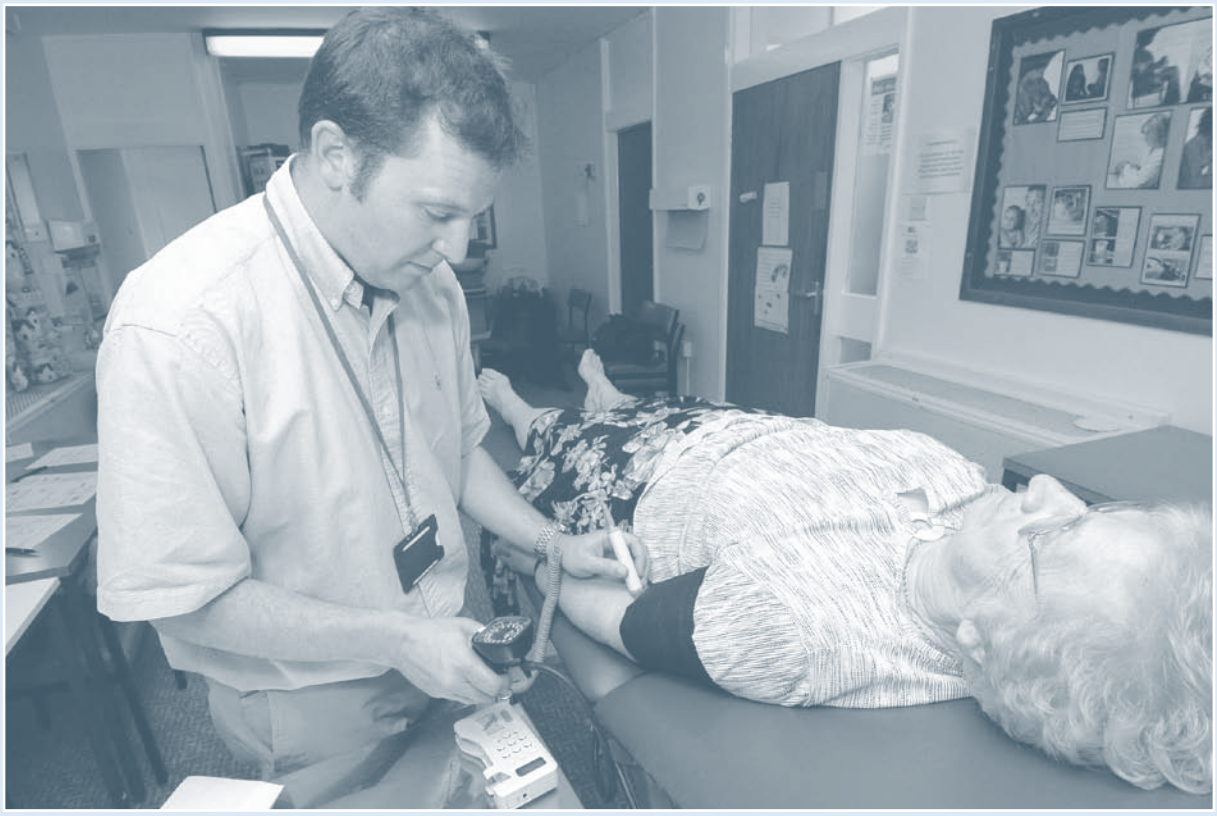
Initially the practice defined a list of a limited range of cases that were suitable for the clinic but this tended to confuse patients and led to confrontation with reception staff. Practice nurses offered triage but this caused duplication as many cases were passed on to doctors.

The solution was to train nurses in medical assessment. Now the clinic has at least one GP, a nurse and a health care support worker on duty, with greater staffing at busy times. Patients with an urgent need are fast-tracked.

People understand this system - up to 90% come to the practice rather than telephoning first. The walk-in sessions are intensive, but patients give good feedback, as they know they will be seen quickly. Outside this process, patients can be given more time and support in a less pressured environment.

The practice reports: 'It now feels we have sorted out the peaks and the troughs so it works well'.

CASE STUDY 2: A COMPREHENSIVE SERVICE



The Birchwood practice, a medium-sized rural practice in Norfolk, is a pioneer in urgent care. GP Paul Everden led a national project to give 'appropriate care at point of need' (ACAPON). Its aim is to take away barriers to care.

The practice has established a genuinely integrated team, working across primary care, based on clear patient pathways. It includes an experienced GP, a nurse practitioner, emergency care practitioner and a health care assistant. The aim is to assess patients as early as possible and to make sure that they are seen by the right person, best able to provide timely care.

When a patient presents with an immediate need a message goes to a team leader who makes an immediate telephone assessment. The patient is directed to the most appropriate clinician, who makes a full assessment, rapidly discusses what to do with the wider team and implements an agreed pathway.

The results have been impressive. Lives have been saved that might well have been lost; there is better use of other services such as ambulances and paramedics; patients are being treated quicker and with better results. This has led to 16% fewer hospital admissions than other local practices, saving money across the system. It offers a good example of how general practice can change the way it manages urgent care.

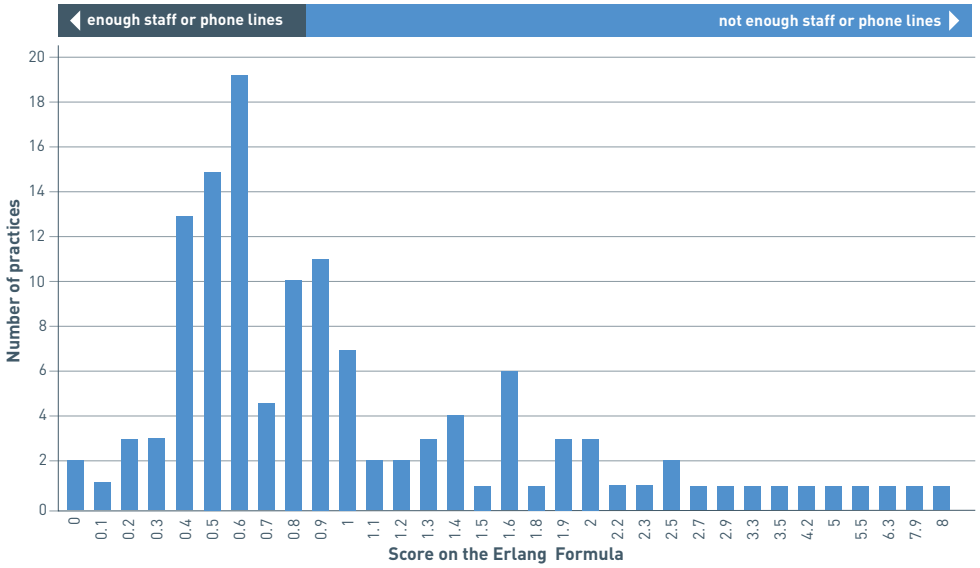
3.3 Speed of initial response

We found room for considerable improvement in the way practices manage phone systems. Very few of the practices studied had measured the typical pattern of calls coming in.

We investigated whether surgeries had sufficient staff handling phone calls to meet peak demand on Monday morning. The results show that more than one-third of practices would be unable to keep up with demand even if the reception staff were to focus exclusively on answering the phone in this period. Since in many practices receptionists have other duties to perform, the proportion where patients have difficulty in getting through is likely to be even higher.

The graph below indicates the number of practices that have sufficient staff to meet peak demand on Monday morning, assuming that the number of calls in one hour is equivalent to 5% of the number of appointments in the week,[1] that calls average 90 seconds and that an acceptable service level is answering 85% of calls in 30 seconds. (See Appendix 3 for more information about the Erlang formula used to calculate the number of staff needed to answer calls.)

Over a third of practices in our survey across five PCTs appear to have insufficient staff to respond reliably and quickly



Some practices have effectively trained patients to ring as early as possible, by making same-day appointments freely available early on and then increasingly more difficult as slots are filled. This results in a very high peak in demand, with patients having to make repeated attempts to get through.

Recommendation 2

Practices should ensure that their processes minimise avoidable peaks in demand. They should assess the pattern of phone demand and make sure that sufficient staff and lines are available so that patients do not find it difficult to contact the practice.

3.4 Intervention - meeting demand

In a number of the pilot practices we carried out some simple analysis to calculate the number of people required to answer the phone, using the Erlang formula (see Appendix 3). The changes were simple and effective, based as they were on making sure that staffing rotas ensured a high probability that the phone will be answered promptly.

In the Collings Park practice, two people focused exclusively on phone calls between 8.30 and 10.00am. Almost immediately, the queue of people who turned up demanding a same-day appointment disappeared.

A key focus in these pilots was ensuring that reception staff concentrated on answering the phones, rather than undertaking other tasks. At busy times, staff in most practices will find that they should focus only on answering the phone, if reasonable targets are to be met. Later in the day, when the demand is lower, multi-tasking does not affect the efficiency of the telephone response significantly, provided the practice and staff recognise the priority that answering the phone has over their other duties.

If practices are to be confident that receptionists are answering the phone within a reasonable timescale, they must handle calls in a consistent way. In Chapter 5, we describe how training can support this and provide examples of methods adopted to ensure a consistent approach.

[1] We are confident that every practice will receive a number of calls in one hour on Monday morning equivalent to at least 5% of the overall number of appointments in the week. Patients ring for many reasons (for example to change or check their appointment time, to see if test results have been received etc.) and there is a well-recognised pattern of calls with 28% typically being received on a Monday, most in the morning. We are sure that this estimate is conservative.

CHAPTER 4. CAPACITY

Our research showed those practices delivering an effective same-day service that was able to respond quickly to urgent cases had achieved two things:

- There was enough capacity overall for both same-day and book-ahead cases.
- The balance of same-day care to appointments bookable in advance was matched to demand.

In contrast, in some places, receptionists would have no same-day slots available within 30 minutes or less of the practice opening. This approach inevitably led to considerable friction with patients, difficulties for reception staff and clinicians and to patients developing techniques to get round the system.

4.1 Number of appointments

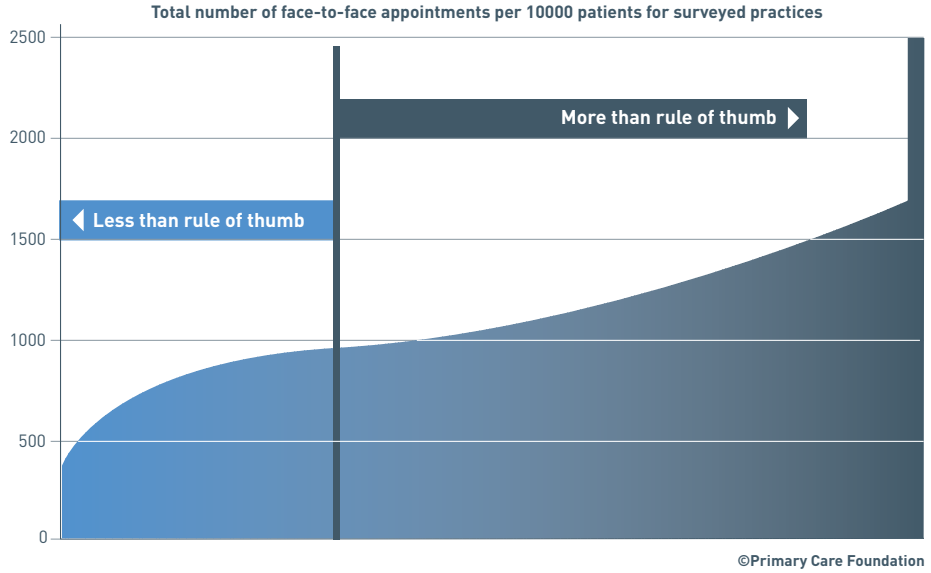
Our survey revealed considerable variation in the number of available appointments per 10,000 patients between practices. Current levels of demand place the national average number of consultations per patient per year at 5.3, with significant local variations. It is important that, as practices plan their capacity and response, they ensure there are adequate appointments (or alternatives such as telephone consultation) across the mix of skills available within the practice to meet their local demand. When planning capacity it is important that annual leave and other staff commitments such as training are taken into account.[2]

Around one-third of practices that answered our survey have less than the expected capacity, while two-thirds had more. The extent of the variation is striking. Many practices apparently offer 125% or more than the national consultation rate and others less than 80%.

Recommendation 3

Practices should make sufficient appointments available to meet demand from patients. Practices should review the number of appointments available each week (across all skill groups and including telephone consultations) to ensure that they meet the needs of their patient population. Capacity should be sufficient to meet the predictable demand without resorting to unplanned extra appointments.

The variation in the number of appointments per 10000 registered patients is significant



[2] See 'Trends in Consultation Rates in General Practice 1995 to 2007: Analysis of the Research Database. September 2008' for confirmation of this figure expressed as 5.3 visits per person-year. This study also demonstrates that the very wide variation between practices that we found in our survey is typical.

4.2 Balancing same-day and advance appointments

There was also a wide variation in the proportion of appointments only available on the same day. We found some practices had fewer than 10% and others well over 70%.

The recent drive to ensure access to a clinician within two working days has resulted in some PCTs encouraging practices to increase the number of same-day appointments to well in excess of one-third of total capacity. However, it appears that this may have been counter-productive. If the horizon for advance appointments is so short that patients seeking a review of an ongoing condition or episode are forced to make same-day appointments, it actually makes access more difficult and stressful for patients and staff.

The exact balance of book ahead and same-day appointments will vary depending on the way that practices and individual clinicians choose to work. However, we found the most effective same-day access in practices where around two-thirds of the total number of appointments (including nursing capacity and other options such as telephone consultation or minor illness clinics etc.) are available to book in advance so patients can access routine and planned care, leaving one-third for same-day cases.[3] The proportions suggested will need to be varied to take account of the characteristics of the patient population, the pattern of service that the practice has in place and the change in mix of work through the week - for example to reflect the higher demand for same day consultations on a Monday.

Recommendation 4

Practices should ensure that the balance of book ahead to same-day appointments (including telephone and other responses) is matched to the pattern of demand. We found two-thirds advance to one-third on the day appointments appears to be the right mix for the normal demand facing many practices, as this reflects the character of general practice workload demonstrated in many studies and surveys.

CASE STUDY 3: GETTING THE BALANCE RIGHT

Both the Collings Park and Riverside pilot practices increased the overall number of appointments to the national average consultation rate. They also amended the balance of same-day appointments to book ahead to the suggested one-third/two-thirds ratio. The benefit to staff and patients was clear. At Collings Park, the number of 'extras' fell from 165 to 25 over a comparable three-week period.

A receptionist reported: 'It used to be that all appointments had gone within a half hour of the practice opening. Now we usually find that we have a couple of appointments available at the end of the morning and the end of the afternoon.'

4.3 Peaks in demand

Another feature of successful practices was that they had planned the availability of appointments to meet predictable peaks in demand. In general these occur on Mondays, after a bank holiday, or following a half-day closure. Yet our survey found that only a minority of practices had planned more same-day slots for Mondays.

A number of studies have suggested a variety of strategies for ensuring that this need can be met, including building in a greater number of appointments (for example by arranging for part-time clinicians to work on these days) or reducing the number of book-ahead appointments.

4.3.1 Ad hoc responses to increased demand

Many practices simply add slots at the end of morning and afternoon surgeries to deal with same-day requests. This can be a reasonable response as part of range of approaches but it often puts considerable pressure on staff and patients, with surgeries carrying on for an extra hour or even up to 90 minutes. A number of practices cited this problem as one of the key reasons for wanting to change the way they worked.

Practices that delay seeing same-day cases need to be sure that their system is capable of identifying any patients who might need care more urgently.

[3] This assumption may need to be varied if telephone assessment is used to close a significant number of cases, as this will reduce the number of face-to-face appointments needed for same-day cases.

CASE STUDY 4: A DEDICATED TEAM

The College Surgery in Cullompton, Devon, provides a same-day service that is designed specifically to respond to requests for urgent care. There is a dedicated team, including nurse practitioners and emergency care practitioners as well as doctors. The GPs rotate, with all doctors covering one or two shifts a week. Services of this kind tend to be based in larger practices and are often driven by a GP with a special interest in emergency medicine. While working within the urgent care service is demanding, it allows the rest of the practice to run more smoothly, leaving more time for patients with complex, long term conditions.

4.3.2 Did Not Attend rates

It is sometimes suggested that allowing patients to book too far in advance may risk increasing the Did Not Attend (DNA) rate. Our experience, borne out in the pilots, is that this risk can be over-estimated. All practices have a certain proportion of patients that are poorly organised and cause this problem but lengthening the book ahead window did not seem to make a significant difference. Attempting to reduce DNA rates too severely tends to create disproportionate barriers to access for the majority of patients who do attend.

4.4 Approaches to dealing with same-day cases

Practices have found a variety of ways to meet demand for both urgent and scheduled care. The right solution depends on the circumstances of each individual practice.

4.4.1 Urgent treatment services

A number of practices have designed a stand alone, same-day service, often called an urgent treatment service or an on-the-day team.

CASE STUDY 5: A COMPREHENSIVE SERVICE

The Stow practice in Suffolk has 16,000 patients. It created a multi-disciplinary team of doctors, nurses and health care assistants, assisted by a paramedic. The practice acted because staff and patients were ill served by an ad-hoc response. There were a significant number of calls after 4pm, while clinicians were regularly being called out of surgery, or had to deal with extra appointments at the end of the session. Patients were frustrated as it was hard to get a slot and doctors were concerned at not having enough time to provide a quality service.

The on-the-day team has improved the quality of care as people are seen more rapidly. Patients approve and 90% are now happy to be treated by any doctor for same-day care. The practice has freed up time - 40% of same-day calls are given phone advice, while routine appointments have longer slots. The practice is about to develop the system further by routing calls direct to the team, bypassing receptionists.

CASE STUDY 6: NURSE-LED EMERGENCY CLINICS

The Boughton Medical Group in Chester has been conducting morning and afternoon nurse-led emergency clinics, run by a full-time nurse practitioner. Initially, the clinics were greeted with some scepticism from both patients and GPs, but within a few months they were in high demand. It has now reached the point where the practice would fail to function effectively without them. The number of patients referred on to a GP by the nurse has fallen from 55% in 2002 to less than 10% in 2008.

One of the key learning points has been that it is important to ensure that the nurse and GP have a feedback session at the end of each clinic. The process requires highly skilled and dedicated nurses and good team working.

4.4.2 Duty doctor or nurse

All practices should have a duty doctor or nurse. This covers a range of different roles. At its narrowest the clinician will respond to emergencies (including maintaining service continuity in situations such as power loss or telephone failure) but still have a full surgery list. In other cases the clinician is freed from all or most booked appointments and is able to focus on same-day care. Their activities may include: home visits; seeing walk-in patients; telephone assessment; same-day requests from colleagues; evaluating reports from the out of hours service; liaising with other agencies.

CASE STUDY 7: DUTY DOCTOR

In the West Malling practice, any home visits and cases that seem urgent will be passed to the duty doctor for telephone assessment. They will attend home visits immediately if necessary. If the duty doctor is called away, or the slots reserved for routine same-day appointments are full, receptionists will note calls onto a telephone message list, identified by doctor initials. All doctors are expected to review the list carefully throughout their surgery, providing a fallback mechanism.

4.4.3 Smaller practices

There is less flexibility in smaller practices, and we have found a tendency to build in more appointments to cope with fluctuations in demand. But there is plenty of innovation here. Some of the examples of urgent care teams or duty doctors able to focus on urgent care are within practices with lists of only 5,000 to 6,000 patients. It is also possible to apply many of the ideas described in the case studies on a smaller scale.

The Riverside practice has a single doctor site. It introduced telephone consultation for same-day patients in the morning. The outcome has been a more effective use of the doctor's time.

CASE STUDY 8: SMALL PRACTICES COLLABORATE ON HOME VISITS

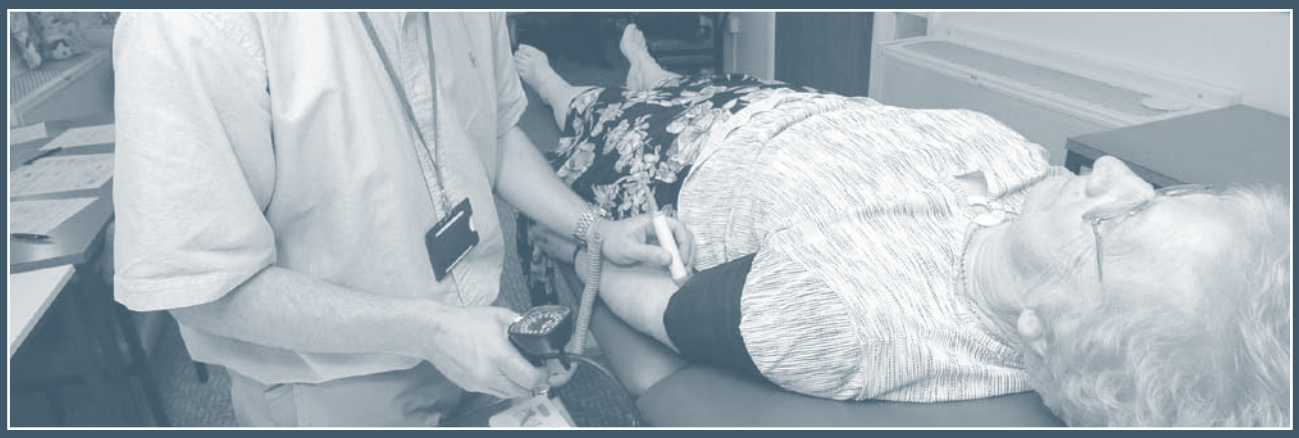
An award-winning scheme in St Helens has cut emergency admissions by 30%, saving £1m. A home visiting doctor service covers nine small practices (four were single-handed initially). Patients ring their regular practice and are called back promptly by their own doctor or practice nurse.

Where the clinician judges the case to be urgent, it is put through to the doctor at the acute visiting service. Three-quarters of patients are seen within an hour and they get a longer consultation, averaging 20 minutes.

The system uses the infrastructure of the local out of hours provider to make sure that relevant patient information is provided to the visiting doctor and that notes are fed back to the practice quickly.

Patients value the early response and longer consultations, while for practices it has freed up clinical time, by about two or three appointments per surgery, without affecting continuity of care. Lead GP Dr Shikha Pitalia explains: 'It prevents that situation when you either call an ambulance "in case" or you delay a visit, only to have a call from a relative later which leads to an admission that might have been avoidable.'

CHAPTER 5. ASSESSMENT - THE INITIAL CALL



Good urgent care depends upon the quality of assessment - both by the person who first answers the phone or meets the patient and by the clinician. Here we consider the first response to the patient and the key role of the receptionist.

The challenge is to respond quickly and appropriately to the small number of urgent cases that will benefit from swift intervention. Our research suggests too few practices have identified an appropriate range of potentially urgent conditions, and then developed a systematic process that enables those conditions to be recognised and treated swiftly.

The practice system must:

- Identify emergency and urgent cases
- Enable a rapid assessment
- Ensure the patient is seen quickly.

The decision about whether and when a patient will be seen by a clinician has clear clinical implications. Yet in the majority of practices we studied, there appears to be little systematic review or feedback around these decisions.

5.1 Recognising urgent cases

Our survey shows that nearly all practices would expect the receptionist to recognise and respond to high profile emergency presentations such as chest pain, breathlessness and haemorrhage.

Yet in both the survey of practices and in discussion at sessions with groups of practices it was clear that for a wider range of potentially urgent symptoms the response was worryingly variable. When confronted by reports of patients with epileptic seizures, babies that had become floppy or drowsy or patients who had an allergic reaction to being stung in the mouth or throat, receptionists might have:

- told the patient to dial 999
- told the patient to go to A&E
- passed them to the doctor immediately
- offered them a later call-back from a doctor.

We were struck by how different the responses were between practices and even amongst receptionists within the same practice. Very few practices had discussed or trained staff in these sorts of examples.

Practices are effectively relying on the common sense of receptionists. We do not feel this is an acceptable or safe approach. Clinically urgent cases are rare so, by definition, experience will be limited.

Worryingly, we identified some practices where receptionists would hesitate before checking with a doctor, often because of past experience of the reaction to such interruptions.

Recommendation 5

Practices should review how receptionists and clinicians would identify and respond to a range of urgent cases. Look both at symptoms that might indicate urgency and consider particular groups of patients that may need to be handled differently.

5.2 Different approaches

We place the onus of defining appropriate targets for responding to urgent cases on practices themselves. This is because the requirements depend on the approach of each practice. For instance:

- A practice that uses a prompt doctor ring-back model may only require receptionists to identify immediately life-threatening conditions and to take brief notes about the reason for the request.
- A practice that routinely offers appointments at the end of the day to patients requesting same-day care may require receptionists to recognise a much wider range of conditions that might require more urgent attention.

5.3 Key questions

Successful practices ensure receptionists ask the right questions, in the right order, to identify urgent cases.

One practice that we visited checked only three things:

- Is this potentially a life-threatening condition? Receptionists were trained to recognise and respond immediately - either calling a clinician or the ambulance service.
- Will an appointment in a day or two be OK?
- Is it important to see the doctor today, in the surgery or at home?

Receptionists were urged to refer anything that they were uncertain about to the doctor.

5.4 The right response

We do not recommend that receptionists be constrained by a rigid protocol with pre-defined algorithms, as this would potentially make the system less safe by introducing delays.

However, the identification of emergencies and urgent presentations can be improved. There are three critical aspects that it is important to get right:

- A framework for identifying urgent cases
- Training for reception teams
- Feedback and analysis.

5.5 A framework for identifying urgent cases

We recommend an approach based on addressing the needs of specific patient groups. Practices should develop a process for receptionists to act or alert the clinical team in the following circumstances:

5.5.1 Life threatening conditions

Receptionists should be aware of a simple list of presentations that are life threatening. They will include symptoms such as chest pain, haemorrhage and severe breathlessness.

CASE STUDY 9: IDENTIFYING EMERGENCIES

The Kingthorne practice developed a simple list for the reception team, identifying potential cases that should be advised either to call 999 or go to A&E. The list itself is not the most important feature of their work - rather it was the discussion and debate at training sessions run by one of the doctors for reception staff that made a difference.

What should automatically be a 999 call and what should go to A&E?

999

- Chest pain in someone over 40 years old
- Severe breathlessness/unusual for patient
- Unconscious/difficulty rousing
- CVA/TIA/Acute loss of vision (CVA/TIA = Stroke)
- Vomiting blood
- Prolonged fit - more than 10 minutes
- Early pregnancy severe abdominal pain

If you advise a patient and they refuse to accept 999 advice, speak to Duty Dr while patient is still on the phone.

A&E

- Head injury
- Sprain/fracture/any acute injury
- Nosebleed for more than 15 minutes
- New/that day injuries
- First fit
- Road traffic accident i.e. car accident

If you are concerned about any patient, please contact the Duty Dr to explain your concerns by phone.

Kingthorne Practice

5.5.2 Potentially life threatening conditions

These patients will present with a set of symptoms which may not be obviously life threatening but do raise concerns. These should be clinically assessed quickly through a process that makes clear that they are a high priority. Examples include a mother worried about a child with non-specific symptoms, or an elderly patient who is known to suffer from potentially serious exacerbations of their condition.

CASE STUDY 10: SPOTTING URGENT CASES

The Downs practice developed two lists to help receptionists identify emergencies and urgent cases:

Emergency: unconscious, chest pain, severe headache, breathing difficulty, fit, serious accident, head injury, diarrhoea/vomiting, persistent nose-bleed, allergic reaction, child floppy or drowsy.

Urgent: accident, bites, serious burn/scald, insect bite/sting, severe pain not responding to painkillers, concern over children, anyone who calls a second time, insulin dependant diabetes.

We do not suggest all practices adopt the same list, but should instead discuss how they respond to different types of patients with different conditions.

5.5.3 Patients who would benefit from early intervention

This includes people with chronic conditions, such as Chronic Obstructive Pulmonary Disease, Coronary Heart Disease or heart failure, as well as those requiring end of life care and the elderly with multiple problems.

These patients are likely to require clinical support or other intervention the same working day. There are significant benefits for them - and the local health economy - of an early intervention that may reduce the risk of avoidable admission to hospital.

5.5.4 Children

Assessing the health needs of children can be problematic. Their condition may change rapidly. It is difficult to assess the severity of their symptoms over the telephone through a description from an adult. Parents may go elsewhere for care if their concerns are not addressed, or there may be child protection issues.

These factors add up to a strong argument for agreeing to see a child in most instances when a parent requests a same-day appointment. As a safety net, the receptionist should ask the parent to ring again if the condition worsens.

5.6 Receptionist training

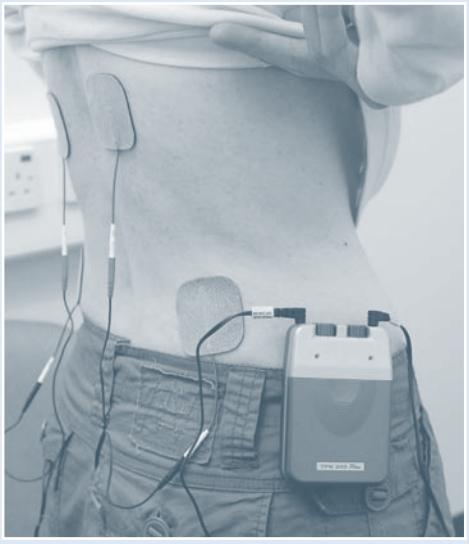
Our survey demonstrated that while most receptionists had received training when first appointed and some subsequent refresher sessions, its frequency and depth varied considerably. This is worrying. Clinically urgent cases are very rare, so recognition of urgency cannot be reliably learned on the job.

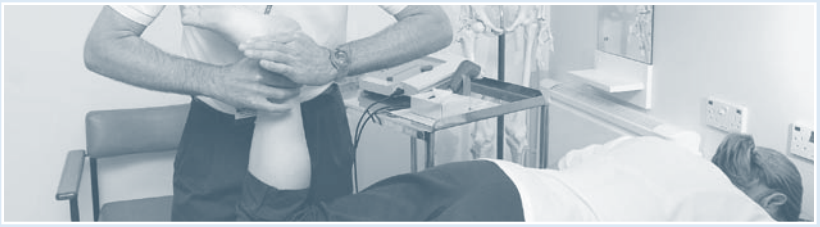
One of the pilot sites in our study held four training sessions with the full reception team over a two-month period. Everyone completed a questionnaire at the start and the end of the project. Overall, nine out of eleven members of the team were more confident after the training, with a 13% improvement over the two months. The three least confident, and newest, members of the team reported a 34% improvement. Crucially, the variation in deciding which clinician to refer patients on to also reduced.

The practice manager said: 'The actual script remains less important than the dialogue that goes into making up the script. We have had quite diverse viewpoints on a few issues which has made the members of staff think quite hard about the impact of what they say.'

One approach that some practices have taken is to develop a standard set of questions for receptionists. This helps to ensure consistency.

CASE STUDY 11: TELEPHONE SCRIPT





In two of our pilots, the practices wanted to make sure their receptionists handled calls consistently and best use was made of the options for face-to-face or telephone consultation.

They developed a model script for the 'ideal' telephone conversation for each of the more common examples that receptionists might come across. The scripts were designed to be as open as possible, allowing the patient to choose the most appropriate option. For example:

Receptionist: Good morning, doctors' surgery. Can I help?

Patient: Can I please book an appointment to see the doctor?

Receptionist: How soon do you feel you need to see the doctor? In a few days' time, or do you need to be seen today?

Patient: Today.

Receptionist: OK, can I please take your name and date of birth?

Patient: Yes, my name is Paul Smith and my date of birth is 5/2/69.

Receptionist: The doctor could call you back in 20 minutes if it's something that could be dealt with over the phone?

Patient: Yes, that's fine.

OR

Patient: I would rather see the doctor.

Receptionist: That's fine, I can give you an appointment at 11.45 today.

CHAPTER 5. ASSESSMENT - THE INITIAL CALL CONTINUED

Recommendation 6*

Practices should review receptionist training to ensure these front-line teams understand and use the right processes to identify and handle urgent calls. Where required, practices should run refresher sessions involving both clinical and non-clinical staff.

5.7 Feedback and analysis

The decisions made about if and when a patient will be seen by a clinician invariably have clinical implications. Yet, in the majority of practices, these decisions appear to be subject to little systematic review or analysis. There seems to be very little feedback to receptionists or others involved in the process.

Yet clinical governance principles demand that decisions that have a clinical implication should be reviewed, so that the organisation can 'endeavour continuously to improve the quality of its services and safeguard high standards of care by creating an environment in which clinical excellence can flourish.'[4]

Recommendation 9**

Practices should carry out regular audits of the process for urgent care to review the quality and consistency of telephone response, consultations and decision-making. They should consider making use of approaches such as those of the Royal College of GP's practice accreditation scheme.

5.7.1 Developing the process for handling same-day requests

The case studies illustrate how some practices have already developed and refined robust processes for identifying and handling requests for same-day care. Many of these examples were found to offer further benefits beyond urgent cases, resulting in a reduction or smoothing out of workload. But reviewing and changing the way that a practice operates requires energy and expertise, and may have knock-on effects. This leads to the only recommendation aimed at Primary Care Organisations.

Recommendation 11 - support from PCOs

Primary Care Organisations should support practices (with recurrent resources, expertise and advice) in reviewing and improving their process for handling requests for same-day urgent care, in line with our recommendations.

[4] From Scally and Donaldson, 1998 and part of the GMS Contract 2004

* for Recommendations 7 and 8 please see Chapter 6, p26
** for Recommendation 10 please see Chapter 6, p28

5.7.2 IT and telephone systems

In the practices we studied in detail, there were noticeable differences between individuals in the percentage of calls identified for urgent attention. Often the least experienced receptionists seemed to have a lower number identified as urgent, raising concerns that cases might be missed.

Telephone systems used by general practice increasingly record all in-going and out-going calls. Used intelligently, in a supportive environment and with a structured process and scoring, such a facility makes it practical to give individual feedback and guidance.

However, in working with practices through the pilot stage we found that the IT and phone systems in use did not support measurement. This made it difficult to examine the timeliness and outcomes of cases from the initial contact with the patient through to the point they were seen by a clinician (sometimes including telephone assessment). We see this as a significant gap in current GP software systems.

Recommendation 12

Suppliers of both IT and phone systems to general practice should develop reports that support practices:

- **In measuring and monitoring capacity and demand.**
- **In monitoring the timeliness of response.**
- **In reporting of outcomes at each stage in handling an episode of care, from the initial patient contact to appropriate clinical intervention or hand-off.**
- **In reviewing the quality of telephone response by non-clinical staff as well as the quality of clinical consultations.**

Those involved in selecting and specifying systems should consider these needs as they update or renew systems over the coming years.

CHAPTER 6. CLINICAL ASSESSMENT

In borderline cases, it is only when the patient is assessed by a doctor or nurse that those cases that are clinically urgent can be identified. Clinician assessment is equally important in finding those cases that are not as urgent as they might have seemed initially.

Many practices make such assessment available through one of the range of methods highlighted in our case studies, such as telephone assessment, walk-in clinic or urgent care service. However, there are many practices that routinely offer patients an appointment or opportunity to wait for the doctor at the end of the surgery.

Our concern with this process is that patients who might benefit from early intervention or treatment may not be seen for some hours.

6.1 Risks of delaying assessment

In some cases the risks of asking patients to wait their turn are limited by the receptionist gathering brief details. The doctor keeps an eye on any such cases so that any potentially urgent situations can be picked up. However, we are concerned that this process is insufficiently robust. Clinically urgent cases may be missed.

Similar systems exist in many practices for home visits; requests are written in a book or recorded on the system. While clinicians recognise the need to look at this information from time to time, some told us that often time slipped away and cases might not be reviewed until the end of morning surgery.

A number of practices admitted that some GPs will review the cases regularly and decide whether to intervene earlier by telephoning the patient, while others will hardly look at all. Such variation demonstrates that the process is not reliable. The informal nature of the 'review' makes audit of the process impossible.

Recommendation 7

Practices should define their own standard for the length of time from the patient first ringing to assessment by a clinician (telephone or face-to-face) for urgent cases. Practices should monitor their performance against this standard and review the measure.

However, where practices make use of a duty doctor or duty clinician who focuses on any urgent cases, this often provides a safety net. All practices should have a duty doctor to respond to emergencies and ensure continuity of service in situations such as loss of power, telephone failure or dealing with highly infectious patients but here we are describing the extension of that role in urgent care applied by some practices.

This allows sufficient head-room to review cases and make a decision about whether more urgent action is necessary - if necessary telephoning the patient to gather additional information.

Recommendation 8

Practices should define their own standard for the length of time until appropriate clinical intervention or hand-off takes place where a clinician has assessed a call as urgent. Practices should monitor performance against their standard and review this measure.

6.2 Telephone assessment of same-day requests

We describe telephone assessment (also known as telephone triage or telephone consultation) as a consultation between the caller and a clinician, which may result in advice being given or lead to a face-to-face consultation in the surgery or at home.

It is important to note that we are not recommending the universal adoption of telephone assessment or triage. GPs recognise that some clinicians are far more comfortable dealing with cases over the phone than others, and the evidence from out of hours care is that the extent of variation between practitioners is very large.

Each practice needs to work out its own approach to suit its own circumstances. However, many find that telephone consultation can play a valuable role, offering reassurance and advice to patients.

The advantage of telephone consultation is that an early conversation with a clinician offers a much greater chance that the very small number of potentially urgent cases will be spotted. It is also an effective method of responding to a proportion of less urgent same-day requests for care.

Our research and pilots found that telephone consultation is most effective when offered as an option to patients with the choice of being seen as an alternative. We found triaging of all requests results in around 50% of patients still having to come in to the practice to be seen.

Two of our pilot practices, Riverside and Collings Park, had introduced telephone consultation as a choice for same-day patients. They found that 80% of the patients who choose this option do not need to attend the surgery afterwards. The reception process is outlined below.

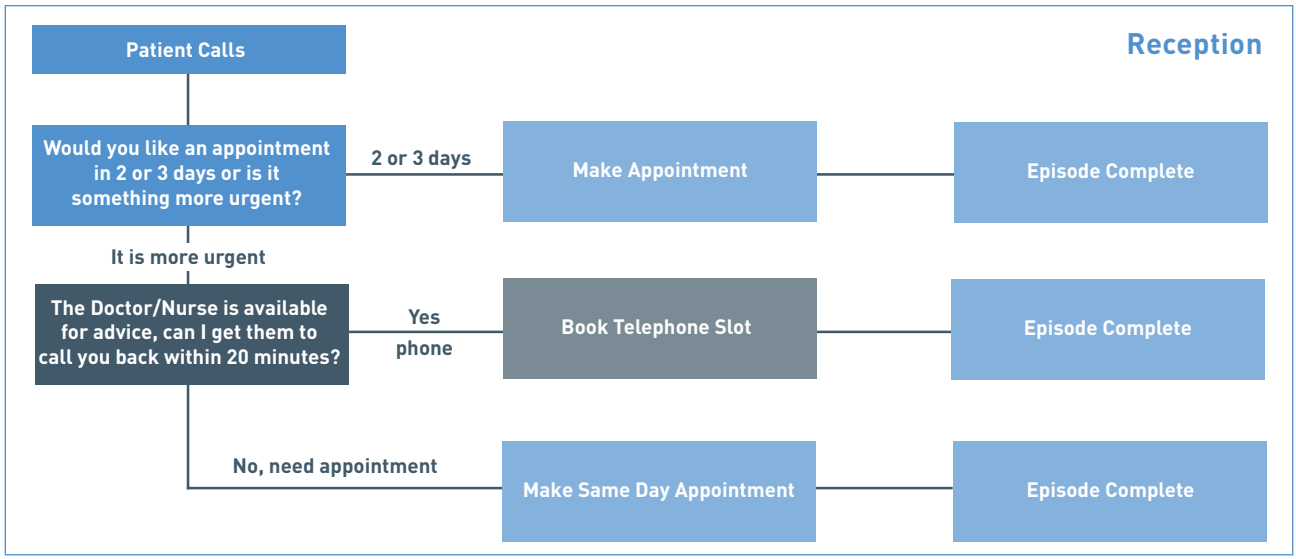
Consideration must be given to patients who find it hard to use the phone, such as speakers of English as a second language. We support the clear guidance of the Institute for Innovation and Improvement that there should be an opportunity for walk in access alongside telephone triage.

The Axminster Medical Practice, in Devon, has addressed this point with a full-time unscheduled care nurse who has alternating 10-minute bookable appointments and open slots for telephone consultations.

6.3 Telephone assessment of home visit requests

There is good evidence to suggest that patients developing an acute illness are more effectively treated if action is taken early in the episode. Yet there is considerable variation in how long it takes before patients requesting a home visit are called back or visited. In Chapter 4 we outlined some examples of rapid assessment of those patients who have a same-day request for care. We believe these principles should be extended to those patients who request a home visit on the day they call.

Some practices ring back all patients who request home visits. But it is more common for the receptionist to add the patient to a list, or book a telephone consultation. There is often variation between GPs in how they deal with such cases and particularly how long it takes to call back these requests. Clearly, practices that routinely call back within 30 minutes to screen requests are significantly improving patient safety and potentially reducing emergency admissions, compared to those where requests wait until the end of the morning surgery.



CHAPTER 6. **CLINICAL ASSESSMENT** CONTINUED

In those cases where a more urgent response is required, some practices have made arrangements for a doctor or nurse to visit the patient quickly, without disruption to normal surgeries. We would recommend this approach to all practices. Practices collaborating may well be an effective method of delivering this aim.

Recommendation 10

Any patient or carer requesting an urgent home visit should be offered a rapid assessment by a clinician. Normally this will be by phone but in some cases the clinician, knowing the patient's condition, may choose to plan an early visit.

6.4 Staffing telephone assessment or consultation

Studies to date have provided no clear evidence that either nurse-led or doctor-led telephone consultations are more effective. Both can work well, or poorly, depending on how:

- Clinical staff are trained
- The reception team explain the option to patients
- Patients are prepared for the change
- It fits into a wider range of options for care within the practice.

In the pilot sites we found that there are doctors who, by virtue of experience or training, are much more comfortable than others with telephone consultation. These practices altered their working arrangements to give these doctors more telephone consultations while the remainder had more face-to-face work.

6.5 Conclusion

There is no simple answer to the question of which process will ensure that urgent cases are reliably identified within a practice, especially bearing in mind the enormous volume of calls received across the 9,000 practices in England alone (several times larger than the estimated 300 million consultations) and the relatively small number that will be urgent.

There are real advantages in choosing an approach that suits the staff and patients of the individual practice, rather than setting generic targets. We are certain that there are several possible solutions. The secret of success will be to define and embed a process that complies with the recommendations we have outlined.

CHAPTER 7. IMPLEMENTATION

GP practices are small organisations that have demonstrated that given adequate resources they can be fleet of foot in adapting the way they operate to provide better care for patients. There are many reputable approaches to planning and making changes that are outside the scope of this report. However we thought it useful to suggest a checklist for practices reviewing their processes around urgent care.

7.1 Pace of change

There are clear advantages in implementing change in manageable ways. The PDSA model (plan, do, study, act), widely promoted by the National Primary Care Collaborative, offers a realistic model for implementing and learning from small changes.

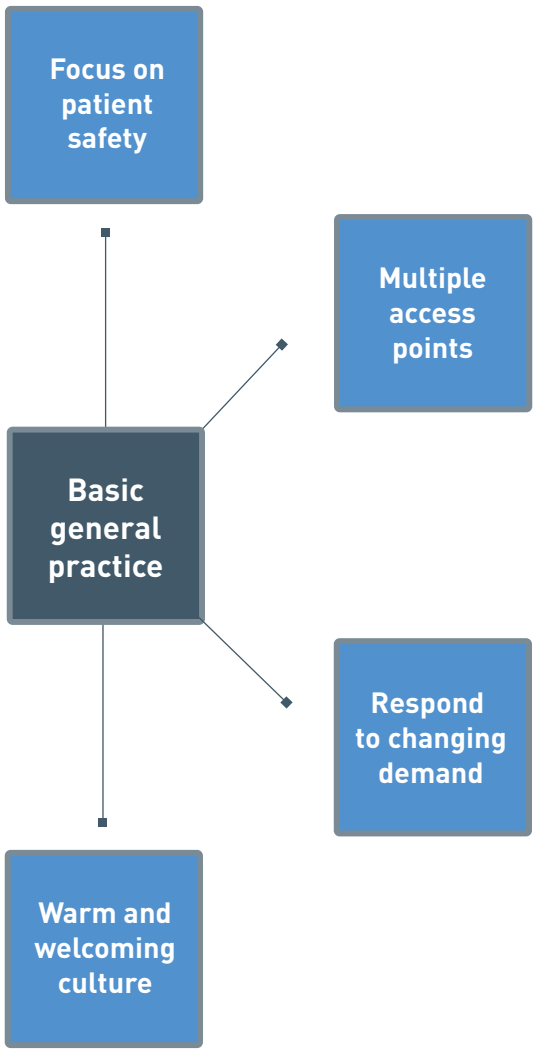
7.1.1 The first step

One of the key principles that practices should adopt is to plan capacity on the basis of existing activity. This requires analysis of numbers of patients contacting and attending the practice each day.

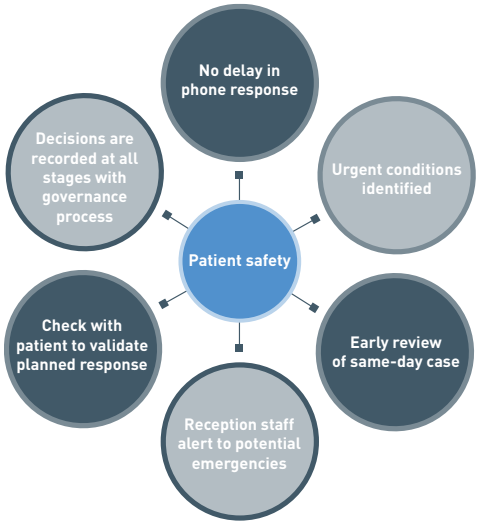
7.2 The four dimensions of care - a process check

During the development of the key principles, we developed a description of four dimensions of care that we felt were important in responding to urgent cases. The features associated with each dimension provide a framework to identify areas for improvement.

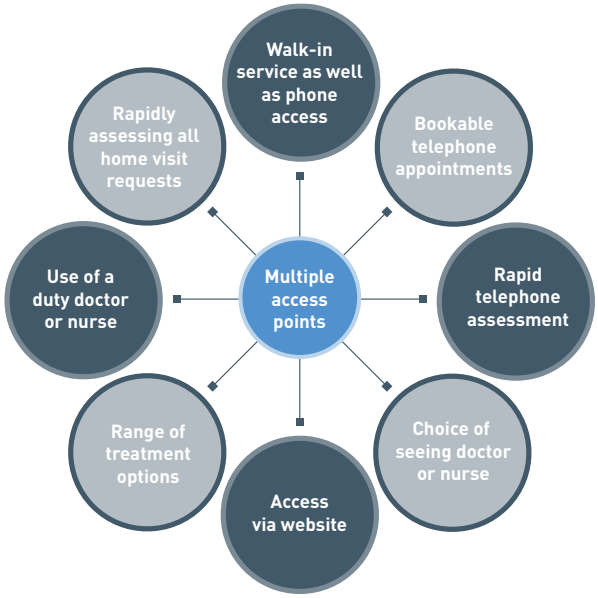
4 dimensions of same-day care



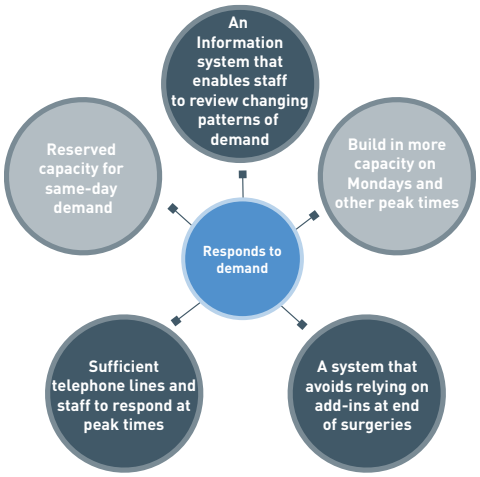
1. Focus on patient safety



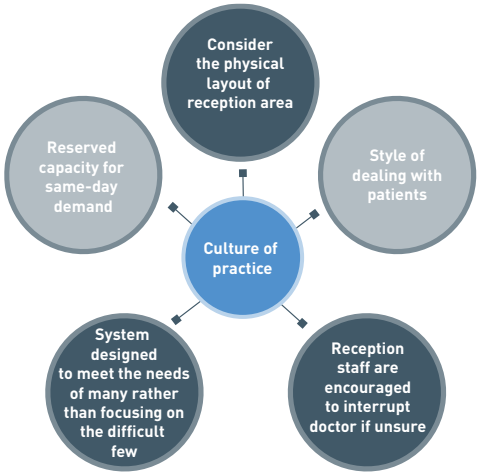
2. Multiple access points: patient able to choose how to access practice



3. Respond to demand



4. Warm and welcoming culture



APPENDIX 1 REFERENCE GROUP

We are grateful to the members of the reference group for their expertise and support. Thanks to Professor Nigel Stallard, University of Warwick, for the analysis of data from the practice questionnaires.

Dr Darren Mansfield	Clinical lead for urgent care, Bolton PCT
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Mike Sobanja	Chief Executive, NHS Alliance
Dr James Kingsland	Chair, National Association for Primary Care
Dr David Carson	Director and Clinical Lead, Primary Care Foundation
Rick Stern	Director and project manager, Primary Care Foundation
Henry Clay	Director, Primary Care Foundation
James Vallance	Urgent Care Policy Manager, Directorate of Commissioning and System Management, Department of Health

APPENDIX 2 PILOT PRACTICES

We are grateful for the support of more than 150 practices across five PCTs that responded to the questionnaire, to the PCT staff that we worked with in these areas and to the pilot practices listed below. In addition, a wide range of PCTs and practices identified areas of good practice that we have drawn upon and included as examples.

Summary details of eight key pilot practices

PCT	Practice	List Size	Focus of pilot
Bolton	Unsworth Group Practice	16,000	Performance in response to telephone demand
Bolton	Great Lever	2,700	Reviewing introduction of GP telephone consultations
Doncaster	Kingthorne	8,900	Streaming of calls from receptionists
Doncaster	Bentley Surgery	6,600	Initial receipt of calls, improving consistency and reliability of process
Lambeth	Riverside Medical Centre	7,500	Offering telephone consultations
Lambeth	Lambeth Walk	2,000	Changes to capacity and reception telephone working
Plymouth	Collings Park	7,500	Redesign of front desk
Plymouth	St Levan's	7,000	Impact of implementing Stour Access system

Note:

Doncaster and Lambeth each have two further practices that they are supporting locally as PCT-run pilots

APPENDIX 3 CALCULATING STAFF NUMBERS TO ANSWER CALLS

Many practices have a poor understanding of how many receptionists are needed to answer a given number of calls per hour. Fortunately a standard formula devised by the Danish mathematician Agner Krarup Erlang - an expert in telephone systems - allows this to be calculated. For simple reference a table is provided below. It indicates the maximum number of calls per hour that can be handled by a given number of receptionists, assuming average call-lengths of 60 seconds and 90 seconds, and a service level of 85%, 90% and 95% of calls answered within 30 seconds. For comparison, the national standard for out-of-hours services is that 95% of calls should be answered within 30 seconds. Go to www.primarycarefoundation.co.uk for links to a calculator and an Excel tool for the Erlang formula.

Look-up table for the number of calls that a given number of agents can handle

	Service level 85% in 30 seconds		Service level 90% in 30 seconds		Service level 95% in 30 seconds	
Length of call (seconds)	**90**	**120**	**90**	**120**	**90**	**120**
Number of agents	7	5	5	3	2	1
2	31	22	25	18	18	12
3	60	43	52	37	41	28
4	92	66	82	59	67	48
5	126	91	114	82	97	69
6	160	116	147	106	128	91

This table allows you to look up the maximum number of calls that a given number of staff can handle whilst meeting a given service level - assuming such 'agents' are working on the phones without interruption or breaks.

Two agents with an average length of call of 120 seconds with a target responding to 90% of calls within thirty seconds can handle up to 18 calls an hour.

Three agents with an average call length of 90 seconds with a target of responding to 95% of calls within 30 seconds can handle up to 41 calls an hour.

APPENDIX 4 ACKNOWLEDGMENTS

We would like to thank all the following individuals, practices and PCTs who offered us examples of good practice, helped pilot the questionnaire, or supported the project in various ways. Responsibility for any errors or omissions in the text is, of course, ours not theirs.

John Hughes, Havant; Paul Ferguson & Michele Davison, North End Medical Centre in Hammersmith & Fulham; Tony Martin, Bethseda Medical Centre in Thanet; Nicholas Plant, Dudley; Richard Brice & John Ribchester, Whitstable in Kent; Mark Shenton, Stow Practice in Suffolk; David Wingfield, Greenbrook Practice in Hammersmith & Fulham; Stefan Morawiec, Crown heights Practice in Basingstoke; Jayne Colebourne, Waterside Practice in Gosport; Pat Phillips, Stockport Managed Care; Gillian Webster at the Galleries Health Centre, Washington, Tyne and Wear; Patrick Craig-McFeely, Pump Court Practice, Tisbury in Wiltshire; Phil Taylor, Axminster in Devon; Shikha Pitalia, St Helen's, Merseyside; Ian Chalmers, Humberside; Lisa Silver; Chris Thomson, The Coastal Viilages Practice in Great Yarmouth; Dianne Moran, Newcastle; John Hodgson, West Cheshire; Patrick Terry, Southampton; Haydn Williams, Luton; Victoria Allen, Sheffield; Sarah Morgan, Hampstead; Julia Bagshaw, Hampshire PCT; Gail Sharp, Watford; Anji Curry, Glenn Medical Group in South Tyneside; Diane Shaw, Whitby; Alison Redhead, North Yorkshire; Lorraine Trim, Christchurch in Dorset; Bernie Naughton, Lea Vale Medical Group in Luton; Steve Bright; Patricia Crates from the Chessel Practice; Phil Smith from Boughton Health Centre; Sue Desmond, Teddington; Sandra Connolly, Beckett House Practice in London SW9; Jackie Hague, Scartho Medical Centre in Grimsby; Sue Bell & Marilyn Plant, Glebe Road Surgery in Barnes; Liz Ekhart, Bedfordshire PCT; Alex Barlow; Dolina Redjimi, Lambeth; Michelle Broutta, Notingham; Chris Simmonds, Doncaster; Mike Watson, Unsworth Group Practice in Bolton; Caroline Djema, Corner Surgery in Lambeth; Stour Surgery, Christchurch, Dorset; Greg Clarke, Thornbury, Bristol; Gale Berriman, Blackbrook Surgery in Taunton; Gavin Bartholomew, White Horse Medical Practice; David Jenner, Wendy Evans & Michael Dixon, Collumpton Practice in Devon; Churchfield Surgery; Pam Jones, Highcliffe Medical Centre in Christchurch, Dorset; Judy Coates, Tricia Busbridge & Peter Dewhurst, Little Common & Old Town Surgeries, Bexhill; Susan Smith and John Rivett, Martin Oaks Surgery, Battle; Renata Dermit and Minesh Patel, Moatfield Surgery, East Grinstead; Liz Coultard and Jonathan Serjeant, Pulborough Medical Practice.

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