New Dyce Medical Practice

Evaluation Report

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NHS Grampian

Table of Contents

EXECUTIVE SUMMARY

Background

In October 2015 a new GP practice was established in Aberdeen that uses a new model of primary care, introducing a wider multidisciplinary team: physician associates (PAs), advanced nurse practitioners (ANPs) and pharmacists working alongside the GPs and practice nurses. The purpose of this evaluation was to understand the effects of this new way of working on patients, staff, and interaction with wider healthcare systems.

Methods

The study was conducted between August and October 2016. A mixed-methods approach was used, that comprised: focus group sessions with the different staff groups and one for patients with long-term conditions; a patient survey; data from the practice IT systems; and secondary care data.

Findings

Patient perceptions of care

Most patients reported they were satisfied with the care they received at New Dyce, with 80% rating it as good or very good. Elements of patient consultations were rated well, including: receiving clear explanations of their condition and treatment (72%); feeling involved in decisions about their care (69%); having sufficient time (60%); confident in the knowledge shown by professionals (75%) and the advice or treatment provided (66%). Moreover, 83% of patients felt that their issue had been dealt with by the right person. While there were reservations about the new model among those who had not received care from ANPs and PAs, those who had consulted these health professionals expressed higher levels of contentment. Some patients felt that continuity of care had diminished as a result of the changes.

How effective is triage and the appointment system?

The current system is problematic, for both patients and staff. The main issues relate to lack of clear guidelines and administrative staff having to make decisions that may be more appropriately made by clinical staff. Most staff groups expressed a strong preference for the introduction of an effective triage system, and the vision of the management team is to create a system where clinicians get involved at an early stage. In addition, many felt there was a need to educate patients about the new roles within the practice team

Staff perspectives

Overall the attitude of staff to the new way of working was very positive with a forward-looking approach and willingness to find opportunities to improve and develop the service. There was a general consensus that patients were becoming more accepting of the new workforce, and increasingly were requesting to see ANPs/PAs.

Staff workload

The monthly number of patient contacts made by GPs, ANPs and PAs has increased from 3,930 in January 2016 to 5,362 in January 2017, despite the full time equivalent (FTE) by clinical groups remaining fairly constant. An increasing proportion of GP activity is now devoted to surgery consultations (35% at the start of 2016 to 60% in 2017). There has been a shift of administrative activities, telephone calls with patients, triage and home visits to the other professionals. ANPs conduct most of the home visits, pharmacists cover all of the medicine management and PAs conduct most of the telephone contact with patients.

Secondary care

The total number of referrals has been increasing steadily from 300 in November 2015 to nearly 400 in January 2017. While there was an increase in the number of emergency admissions to ARI in the months immediately before and after the establishment of New Dyce, these levels appear to have returned to former levels.

Conclusion and recommendations

The response from the evaluation has been generally positive, with high levels of satisfaction from both patients and staff. This suggests that things are moving in the right direction after a very challenging beginning. The main areas for improvement suggested by patients and staff were about having better arrangements for "getting through" to the surgery and having a clear, visible triage system. Sensitive, person-centred communication was a particular issue raised by patients. A full list of recommendations and valuable lessons are made on page 31.

1 INTRODUCTION

New Dyce Medical Practice started as a new entity on 1st October 2015, taking over the GMS contract for 10,000 local patients previously cared for by Brimmond Medical Group and Gilbert Road Medical Group. A few reception staff and 2 senior nurses from the outgoing practices provided some continuity of care for the patients, but otherwise all 10,000 patients and all clinical staff were new to each other - a unique position in British general practice. The need for this new practice was partly due to the recruitment crisis in general practice, and as a result, at the outset the permanent clinical staff included 2 part-time salaried general practitioners (GPs), 3 advanced nurse practitioners (ANPs), 2 physician associates (PAs, a new role in primary care) and 2 pharmacists.

The new practice arrangement was described in the local press, and several public meetings were held to provide information and answer questions. Scotstown Medical Group provided the management expertise and several senior general practitioners to help support the initial working of the practice. The team understood that patients may have concerns about the change after several decades of medical care in two established medical practices.

Acknowledging it would be a 5-year programme to fully establish the practice, the initial aim was to provide timely access to a clinical member of the team for patients presenting with urgent medical problems. It is for this reason reception staff were advised to invite patients to tell them about their problem, the urgency of that problem and then offer an appointment to a suitably qualified member of the clinical team. The patients were informed at public meetings, by newsletter and when requesting appointments that they would see a GP or another member of the clinical team who was directly under the supervision of a GP. The aim of this early model was to provide prompt access for face to face consultations with the clinical team. As the practice matured it was accepted that this model would evolve further with effective, clinician-led triage in the future. Continuity of care for those with longer-term conditions would inevitably take time to develop.

New Dyce was keen to capture staff and patient views of this early innovative work and therefore approached the IJB and Health Intelligence Unit to commission a survey to help understand and reflect on this evolving family practice.

1.1 Aims and Objectives

The purpose of the evaluation is to understand the effects of this new way of working on patients, staff, and interaction with wider healthcare systems. In the short-term, it will provide a description of the process of change and the context in which it is being implemented, highlighting areas requiring attention. With regular long-term follow-up, this work will provide the basis for future impact evaluation and process evaluation that will help to inform and influence the developing nature of primary care practice to increase resilience, sustainability and effectiveness. The main questions of interest from the practice's perspective are:

- What is the patient perception/experience of care?
- How effective is appointment and triage system?
- What is the staffs' perspective? Are they engaged and do they have a vision for the practice?
- What improvements could be made?
- What impact has this new of working had on workload and referrals?

On the basis of this the objectives are to:

1. Describe patient awareness, experience & satisfaction with using the service
2. Describe staff/practitioner experience & satisfaction with providing the service
3. Describe patterns of service use – including practitioner workloads, in and out of hours, referral patterns, consultation/diagnostic changes, A&E attendances, emergency admissions
4. Identify ideas for improvement that can be implemented in an action cycle.

Some of these data will provide indicators that can be measured again in 12 months and used as evidence to demonstrate effectiveness of interventions.

2 METHODS

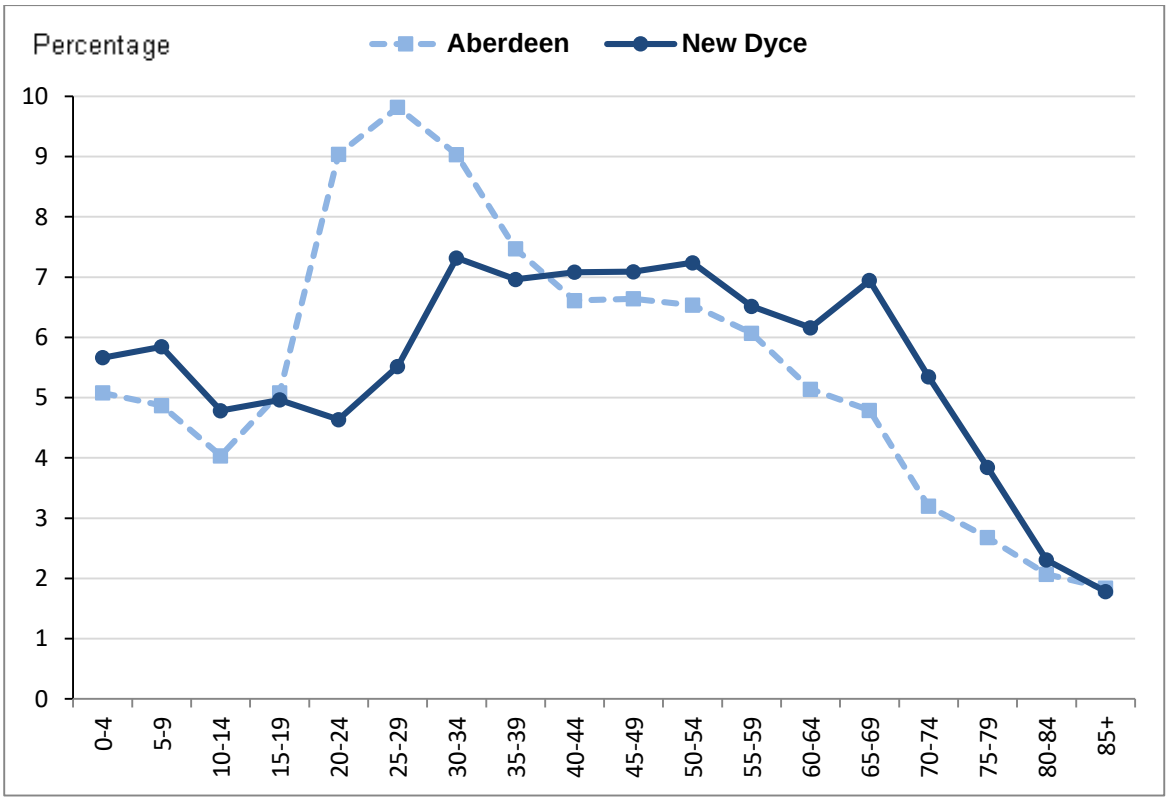
2.1 Profile of practice population

It is important to get an understanding of the Practice population in order to contextualise the findings.

2.1.1 Age

On average, the age profile of the New Dyce Medical Practice population is older than the overall Aberdeen GP registered population (see Figure 2.1 below).

Figure 2.1: New Dyce and Aberdeen City GP registered population by age 2016 (%)



2.1.2 Deprivation

As illustrated in Table 2.1 below, New Dyce patients are more affluent compared to the Aberdeen GP registered population. For example, over three quarters of New Dyce patients were in the two most affluent SIMD quintiles, with none being in the most deprived and second most deprived quintiles.

Table 2.1: SIMD[1] distribution of New Dyce Medical Practice compared to Aberdeen City

	1 (most deprived	2	3	4	5 (least deprived)
New Dyce (10,097)	0.0	0.0	23.1	32.6	44.3
Aberdeen	12.3	17.0	15.2	16.2	39.3

[1]SIMD 2012 quintiles used

2.2 Data collection and analysis

A mixed-methods approach was used to understand this new way of working. The target groups for qualitative work comprised staff members and patients attending services at New Dyce. Staff members and all patients attending the Practice between August and October 2016 had an equal opportunity to participate in this evaluation. Patients were informed about the survey by posters at reception and staff members. Using an opportunistic approach meant that all patients attending the Practice had a chance to complete a questionnaire, either on a Viewpoint machine or on a paper form after their appointment. A decision was taken not to conduct a postal survey in order to obtain information on patients' recent experiences of the service. Data were gathered using a variety of methods:

- Five focus group sessions with different staff groups (administration, PAs/ANPs/pharmacist, GPs, practice nurses, and the management team) and one for patients with long-term conditions.
- A patient survey (see Appendix 1) to understand experiences, satisfaction and to generate suggestions for improvement. The questionnaire focused on the appointment attended that day and asked about their experiences making the appointment and during the consultation.
- Quantitative data were gathered from GP IT systems to review workloads and referral patterns. This was augmented with secondary care data from Trakcare.
- A comparison was made between responses to the patient survey and the most recent Health and Care Experience survey reports available for Brimmond (158 patients in 2013/14) and Gilbert Road Practices (110 patients 2015/16)

Qualitative data from the written responses of the survey and focus groups were transcribed and analysed thematically. Quantitative data were analysed using Excel to produce summaries of patient responses and investigate patterns by demographic/clinical background of respondents. Ethical approval was not required, as this work was for service improvement.

2.2.1 Survey sample

Among the group of respondents, women and older people were over-represented compared to the Practice population as a whole, which is probably a reflection of the sub-groups most likely to attend. Over 95% of respondents came from Brimmond or Gilbert Road Practices.

The professionals seen by the survey respondents are shown in Table 2.2. Very few had seen PAs (10) or the pharmacist (5) at their last appointment, meaning it was not possible to do sub-group analysis in this respect.

Table 2.2: Professional seen by respondent prior to completion of the survey

Professional	N	%
GPs	61	26.3
ANPs	58	25.0
PAs	10	4.3
Pharmacists	5	2.2
Practice Nurses	70	30.2
Not sure	9	3.9
Missing	19	8.2
Total	232	100

3 FINDINGS

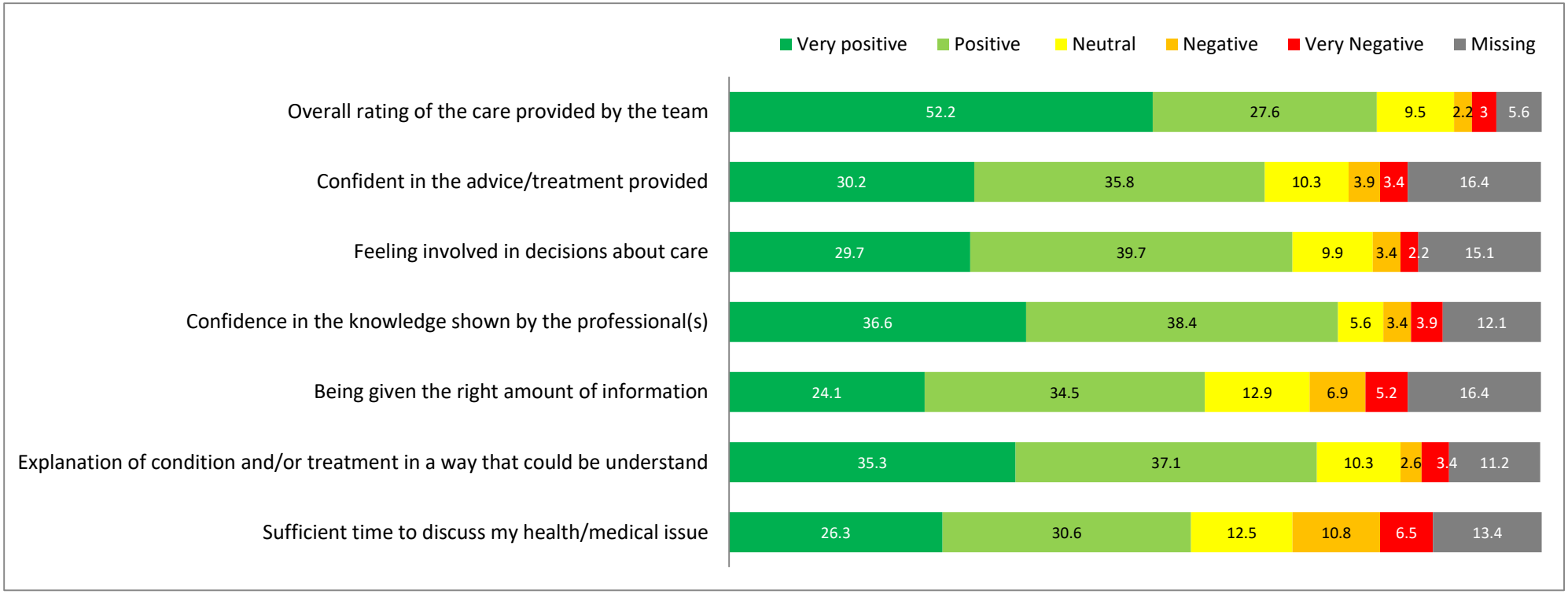
3.1 What was the patient perception/experience of care?

- ❖ The majority of respondents were satisfied with the care they received at New Dyce, 80% rating it as good or very good

3.1.1 Summary of findings

Most patients reported having a good experience in their consultation including: receiving clear explanations of their condition and treatment (72%); feeling involved in decisions about their care (69%); having sufficient time (60%); and confident in the knowledge shown by professionals (75%) and the advice or treatment provided (66%). Moreover, 83% of respondents felt that their issue had been dealt with by the right person, and this was similar across the professional groups seen (GPs, ANP, PAs, pharmacists). Those who were not sure who they had seen were the least likely to respond positively (only 46%). Patients' rating of the care they received is illustrated in Figure 3.1 below.

Figure 3.1: Patients' rating of care provided



3.1.2 Care provided by ANPs and PAs

Fifty-seven percent of respondents felt content with the idea of an ANP providing their care, and 43% were content with a PA providing their care. The approval ratings were higher among patients who had seen either an ANP or PA at their last appointment (81% of those who had seen an ANP were content with ANP care and the corresponding figure for PAs was 60%). This highlights a key issue in that whilst there were reservations amongst those who had never received care from ANPs and PAs, their contentment generally increased once they had experienced care from these health professionals. For some, ANP and PAs were a good addition to the practice because they were able to provide more thorough examinations:

> *"When seen by ANP/PA I find them to be very thorough. They examine you and check your vital signs."*

3.1.3 Perceptions regarding continuity of care

Surprisingly, very few respondents appeared to understand the reasoning behind the practice restructuring, which may explain why a number of patients were asking for their old doctors back. However, it was not purely "mourning" a loss of the doctors who had treated them for many years, but a strong feeling that continuity of care had diminished as a result of the change:

> *"It's not good at all. We've lost all our doctors. No one told us this would happen. Now seem to be all part time staff. No continuity."*

> *"Not great as every time you visit it is with a different doctor, whereas before you more or less could get to see the same doctor who knew all about your illness."*

> *"Feel the service provided is <u>much</u> poorer than the service my family received prior. Wait times/booking-in frequently broken making you 'late' for your appt as you've had to queue for 10 mins to get checked in. 3 wks until you can book an appointment. Rarely can see same doctor twice = poor continuity of care."*

3.1.4 Comparison with previous surveys

Although patients were generally positive about their experience of care, they seem slightly less content than they were in their previous practices. The evidence for this comes from the Health and Social Care (H&SC) survey reports for Brimmond and Gilbert

Road practices (see Appendix 2), where positive ratings on certain aspects of consultations were higher than in the current evaluation. For example in the New Dyce survey 57% responded positively to the statement “Sufficient time to discuss my health/medical issue” while in the H&SC survey over 90% reported having enough time with doctors or nurses. Similarly, the overall care provided was rated positively by 80% in New Dyce compared to the earlier H&SC survey where positive ratings for Brimmond and Gilbert Road were 90% and 92% respectively. It is noteworthy that questions were not worded identically in the two surveys, and that in New Dyce the relationships between respondents and GPs were relatively new, both of which may contribute to the variation in responses.

3.2 How effective is the appointment and triage system?

- The current system is problematic. The main issues relate to lack of clear guidelines and Admin staff making decisions that would be more appropriately made by clinical staff.

3.2.1 Patients' views and experiences

Patients' experiences of making an appointment came through as a significant issue, particularly in relation to the telephone system. Just over half the patients making an appointment got through to the practice on their first attempt whilst 15% had to make 5 or more attempts. This was reflected in the open ended-questions when participants were asked for improvements:

> *"Before the practice changed you just dialled straight through. But now you have to go through all this spiel which is just a waste of time & money"*

> *"To change the phone answering system as when you want an appointment that day - the machine says to call back when less busy - I called 28 times."*

Almost 60% of respondents reported seeing a clinician in less than two days of making an appointment, 37% of these being seen within a day. At the other end of the scale, 12% were seen after more than a week. Over 80% of respondents found the wait until an appointment was available either "acceptable" or "very acceptable". This also came through in the open ended questions where participants were asked how the service compared with that on offer prior to the restructuring:

> *"Improved - quicker to get through by phone, quicker to be seen, time allowed to discuss things not too rushed."*

> *"Up until this point in time it is very much improved. I find appointments don't seem to have a waiting time. Service has been excellent compared to having to wait sometimes more than a week to see someone."*

Unsurprisingly, those who waited for more than a week were most likely to find it "unacceptable" or "very unacceptable". It is noteworthy however that a quicker appointment did not necessarily mean patients got what they wanted. Whilst there was a general appreciation that appointments with ANPs and PAs were more readily available, there was also a sense of frustration amongst patients that they now felt it was more difficult to see a GP.

"More available appointments with doctors. I was initially offered appointment in 2 weeks with doctor and over 1 week for ANP - not great when you have health concerns."

"Poor. Like digging for gold to get past reception to GP appointment"

Importantly, despite 83% of patients stating that their issue had been dealt by the right person, fewer (67%) felt that the decision over who they saw had been made in an appropriate way. Those who were critical (18.7%) were asked for their reasoning. Key themes from their written responses are presented below.

At the heart of it was an underlying "discomfort" discussing medical conditions with reception staff. Some felt that the reason for their appointment was "none of their business" and others questioned how receptionists with no medical training could make such "important" decisions:

"How does a receptionist decide if it is a doctor or NP you see. I would like to know if they are medically knowledgeable to decide."

"Decisions are being made by people who are not medically qualified."

Patients' uneasiness about dealing with receptionists was not limited to them making decisions on which clinicians they should see; some did not understand why they were also involved in giving out test results:

"Let patients know test results - good or bad instead of having to phone up and ask and get the results from receptionist instead of GP."

Another recurring theme was a feeling of not being involved in the decision-making around which health professional they saw. Common assertions were that they had either not been given a choice or they had not understood how the decision was made. Interestingly, as seen in the second account below, this uncertainty was sometimes present amongst those who had experienced a good outcome.

"I was not consulted or given a choice."

"I don't know how the decision was made. Outcome was fine though."

This suggests a breakdown in communication where patients were either not understanding what was being said or the information was not being explained clearly, if at all. A big part of this for patients was about being listened to:

"They didn't take into account what I wanted. I didn't feel they were listening to me. They just cut you off and talk over you when you phone for an appointment."

This highlights an important point, that a number of patients simply did not understand why they could not see a GP if they wanted to. Another emerging theme was a concern by patients that ANPs and PAs were being "passed off" as GPs by receptionists and the practitioners themselves.

"Staff at reception have a tendency to dictate who you need to see based on who they have available, as opposed to who you need to see. They try to pass off [A]NPs and PAs as GPs."

"It should be made clearer which professional you are actually seeing. Only when we asked did she divulge she wasn't a GP."

3.2.2 Staff views and experiences

The **management team** described triage as "currently in its infancy" where it was simply operating as means of signposting patients to an appropriate member of the team. However, it was emphasised that the vision is to create a more robust and detailed triage system where clinicians get involved at an early stage and can, in some instances, deal with patients over the phone to avoid them coming in to see a clinician if it is not necessary. There have been mixed experiences thus far, with patients having positive experiences and other instances of patients seeing the wrong health professional. Management highlighted that one problem is the "out and out refusal" of patients engaging with "just a receptionist" who is asking what they deem to be personal questions. As illustrated below, this can lead to wasted appointments:

"Receptionists just ask for the – "nature of the problem" so they are not delving in anything they shouldn't but some patients do put a barrier and say no which makes it difficult for the Reception Staff to make sure the patient sees an appropriate Clinician. So there has to be some responsibility born by the patient since they take an appointment because time suits them or by not engaging then they may end up with someone who can't deal with the problem presented. This leads to a wasted appointment and a waste of the patients' time."

Amongst the **reception/ administrative team**, there was a general consensus that the most difficult period was in October 2015 during the transition to New Dyce. Those who had been in post during that time recalled how it was "very challenging" fielding questions and angry calls from patients. There was agreement that the situation had

improved immensely and there was a great sense of relief that they got through that initial period.

Reception/administration staff advised that they were learning about the roles of ANPs and PAs (and their different areas of particular expertise) in order to better signpost patients. They also felt that patients are becoming more confident with PAs and ANPs:

> *"We find out what the problem is so we can decide where to put them. For example, if it's contraception they go to an ANP – they all have their own little roles that they do."*

ANPs, PAs and pharmacists asserted that they do not have much involvement in triage and have no control over who they see.

> *"As of yet decision-making as to whether someone needs to come in and be seen is very ad hoc."*

On the whole, they felt having a clinician on the telephone line to triage patients could make a big difference to determine how many patients actually needed to be seen in person because administrative staff could not make this decision.

Practice nurses said the receptionists have to enquire about the nature of the ailment, but some patients get sent to the ANP rather than a prescribing practice nurse. They also felt that there were not enough practice nurse appointments, so patients saw the ANP when it was not really necessary.

There was a dominant view amongst **GPs** that a "proper triage system" could make great improvements in the use of the workforce. If triage was good, they felt the practice could use PAs to confirm the triaging doctor's initial impression and save GPs patient contact time. There was recognition that some patients are more complex and clearly need to be seen by a GP (e.g. those with a complex mental health situation). They also felt that non-clinically trained staff members were not qualified to triage effectively and this was leading to patients being allocated according to availability of appointments rather than clinician ability. Denburn and Danestone practices were given as examples of "triage that works" since everything is triaged by GPs in the morning by phone. It was recognised this would initially mean extra work for the GP team. In addition, they felt there is a need to educate patients about what other roles within the practice team can do. GPs are currently making a note of any appointments for consultation they feel have been inappropriate. It was also felt that admin staff could take on some of the initial sifting and paperwork currently undertaken by PAs if provided with appropriate training.

3.3 Staff Perspectives

- Whilst there was not a written vision, staff members have bought in to the idea that this is a new, and still evolving, way of working in GP Practice. Overall the attitude was very positive with a forward looking approach, finding opportunities to improve and develop the Practice team.

The majority of reception/administrative staff had had come from Brimmond Practice. Most of the practice nurses also had many years of experience with Gilbert Road and Brimmond Practices. ANPs PAs and pharmacists had a range of experience from working in surgical secondary care to decades of experience in various primary care settings. The GPs were all relatively newly qualified and remarked that the ANPs at New Dyce take on a wider range of work than at other practices they had experienced and working with PAs in general practice was a new experience.

3.3.1 Understanding the vision and aspirations

Unsurprisingly, the **management team** had the clearest understanding of the direction for New Dyce. They saw it as a practice that was bringing together a range of clinicians to help support GP services, consequently forming a workforce that can look after the service needs of the Dyce population. They wanted to "develop a Practice that is sustainable for the future given the pressures that primary care is under". They saw the administrative team as being central in this model as they were the first point of contact and would thus help guide patients through that initial triage. The New Dyce model will be dynamic as it will need to evolve over time, but will become the "Go to" model for patient delivery and will be sighted as best practice. They also felt there was a need to share the vision with patients and help them understand that GPs were a finite resource due to increased shortages.

Reception/administrative staff felt they understood the New Dyce Medical Practice would be structured differently and this had been explained to them. How things will evolve over the next few years was less clear in their view and there was an acceptance that "time will tell". Nevertheless, there was agreement amongst the team that things were generally going well with some asserting that it was "quite exciting":

> *"it's going quite well at the moment I think with the PAs and stuff. It's new to people so it's getting them used to it"*

Practice Nurses felt they understood the vision – that it was to be a multi-disciplinary approach, very much patient centred. They felt that patients were coming around to an understanding of the new way of working and not seeing a GP every time. They felt that patients are accepting of this and like the fact that they are seen by a practitioner more quickly, but they need to know there is always a duty doctor around who can be called on if necessary.

> *"This way is easier – you always know there's another nurse you can ask for their opinion or the duty doctor or another colleague. Previously you'd be working on your own. Here there's not the hierarchy there was at my previous practice. This leads to better patient care as they get an answer and don't have to come back to see another person another time."*

The **ANPs, PAs and pharmacists** were less clear regarding the vision, but recognised that they were a central part to this new way of working:

> *"None of us knows what it might mean. Up to July it was fire-fighting, but it feels a bit more settled now."*

> *"Don't feel we'd be got rid of even if there were to be a boundless supply of GPs".*

GPs commented that the GP team is young, with less experience than the practices patients had come from, but it is very forward-looking and ambitious (e.g. one GP expressed a wish for the practice to win an award for "Innovation in General Practice"). Another GP hoped there would be more engagement with neighbouring practices and closer linking with secondary care. As an effectively semi-rural practice, taking in Fintry and Newmachar, it was hoped there might be opportunities to apply for equipment funding on this basis, possibly with neighbouring practices, thus avoiding some referrals into secondary care.

3.3.2 Training and Support Needs

Reception/ administrative team suggested they would benefit from further training in use of the Vision system. Initially they had a little bit of training and had found it very difficult. Some have been peer training among themselves. They felt they work together and support each other well.

PAs, ANPs and pharmacists had not had discussions on training, but said some of the newly arrived GPs have started to look at areas of interest and how the practice all fits

together. They advised that there is no learning programme currently, but some felt they had more on-the-job learning at New Dyce than at their previous practices. They felt they do a lot of clinical admin which probably was not good use of their time, but there had been improvement around work with blood reports. This group also felt the cover for staff absence/ holiday was a problem:

> *"Basically it's all waiting for you when you get back from holiday – no locums or additional help."*

Practice nurses said they have been encouraged to attend training since arriving in the practice and currently have "lunch and learn" sessions with more planned.

GPs plan to set up support meetings e.g. to discuss problematic patients. With more permanent GPs and less reliance on locums now this can progress. Personal training and development is almost entirely self-directed, but management is keen on a group-based learning.

3.3.3 Perception of ANP/PA role

There was a view amongst staff members that the first few months of the transition had been difficult for patients, largely because of poor understanding of the ANP and PA roles. However, there was a general consensus that patients were becoming more accepting of this new workforce. Increasingly, patients (particularly regular attenders) were calling in requesting to see the same ANP/PA that had previously attended to them.

PAs and ANPs acknowledged that, initially, they needed quite a lot of reassurance and this led to them requesting for GP assistance in most cases. However, they advised that the need for help has reduced significantly due to increased confidence and experience in their roles. One ANP felt that having "nurse" in their job title meant they were perceived as more approachable than the GP – some patients now say "So I'll just see you then" in a very positive way.

The fact that ANPs can prescribe was seen as a considerable advantage because it allowed them to work more independently and take on additional responsibilities. One staff member described them as being like "another doctor" because they could just "get on with the work". PAs were seen as being good at what they do (particularly examination skills and history taking) but there was general agreement that they were restricted because they could not prescribe, and consequently almost always have to consult the duty doctor. This was a source of frustration to patients, PAs and other staff members as it often led to delays in consultations.

3.3.4 Continuity of care

Reception/ administrative team thought it was particularly challenging for elderly patients as they previously had the same doctor for years and it is difficult for them to understand that they would not always get a particular doctor. This was also the case for chronic patients who prefer to see the same clinician.

Practice nurses said some patients request them by name, and whilst this is good for continuity of care, if someone else sees one of "your" patients they might pick up something different and suggest an alternative treatment plan. Additionally, when dealing with complicated patients sometimes it is good to "share the pain" so an individual is not always "lumbered" with them.

GPs felt that with lots of locums initially it was difficult to be consistent, but this was improving because now patients were able to ask to see one of the newly appointed GPs by name.

Management team said the patients who find it challenging are those with long term conditions who are looking for continuity of care. With 22 doctors involved since the practice started in October 2015, there has not been a good base to offer good continuity, but that has changed recently with due to an increase in the number of permanent doctors who have joined. Palliative care has generally been good as there has been good continuity with the district nurses.

3.4 What improvements could be made?

3.4.1 Patient views

- The main areas of improvements for patients and staff members included simplifying the telephone system, a better mechanism for allocating patients to appropriate clinicians, the reception area, IT system (including self check-in), continuity of care, training opportunities, and communication between different staff groups. There were some similarities and differences in suggestions for improvements between views of patients and staff members.

When asked what improvements could be made to the Practice, patients identified a number of areas which they felt could be better. The main suggestions included simplifying the telephone system, having a better mechanism for allocating patients to appropriate clinicians, and continuity of care (see discussion above in sections 3.1.3 and 3.2.1). Another important enhancement concerned the reception area as whole. Firstly, there was a recurring view that reception staff needed more training to improve their customer service skills and become more welcoming. The glass barriers seemed to exacerbate this view:

> *"Reception staff require customer service training...Put a bell/buzzer at reception so patients are not routinely ignored by staff..."*

> *"...Feel receptionists quite unhelpful with alternative solutions/ slow to respond at window -leave patients standing."*

> *"Training for receptionists - not as friendly or polite as we previously had at Gilbert Road. Need new phone system."*

Secondly, the waiting area was seen as plain and requiring some light entertainment while patients waited for their appointment

> *"Very happy about all the care. Reading material and tv in reception."*

Lastly, it was also suggested that there should be profiles of staff in the waiting area to make it easier to identify the different health professionals and their different roles (especially in relation to ANPs and PAs)

> *"I would like to see notices on the walls - describing the types of staff you can see and what you would recommend we see them for. This would give me more confidence."*

For others, they did not believe there was much that could be improved as they were receiving a high level of care and took the view that the model adopted by New Dyce Medical Practice would soon become the norm:

> *"Very lucky to have the level of care provided. It is probably the future of GP practice and provision; don't see why other health care providers shouldn't take up other treatments etc."*

Views from the focus group of patients with long-term conditions were consistent with the variety of views that came through the written responses. For example, when asked regarding continuity of care, two of the three participants had not seen any difference to before the change in October 2015 because their appointments were fairly routine. The third participant on the other hand felt that it had become a "flip of the coin" who attended to them which had made it difficult to build a "doctor-patient relationship".

3.4.2 Views from staff members

The main areas of improvements for staff members were the telephone system, reception area, IT system (including self check-in), training opportunities, and communication between different staff groups. There were some similarities with patients in relation to improving the telephone system and reception area. For example, staff members also felt that they telephone system could be simplified, with some suggesting that changing the "03" to a local number may help remove the perception that they were calling a premium number.

They also suggested having some music and/or TV in the reception. This was not only to keep patients occupied but also to reduce the chances of patients listening in to other patients' conversations. There was general agreement amongst staff that the reception area is very exposed and there is some risk to patient confidentiality. As illustrated below, one staff group highlighted how they could hear conversations from a distance:

> *"We can hear what's being said at the window right across the waiting area."*

With regards to IT, even though it was acknowledged that it had improved considerably since the early stages of the transition, it was still seen as an area that could do with significant development. For example, multi-stations were suggested for reception/administrative staff as the best solution to avoid the need to move people around. Furthermore, there was a dominant view that the self check-in service needed a major upgrade or replaced altogether. This was because it hardly worked at all and it was difficult to use. Some staff groups felt that it was poorly set up because the health

professional's name would come up on the screen rather than the patient's name. This was challenging in that patients may not know who they are seeing. That is, they may know that they have come to see "the nurse" without recognising the clinician's name. As a result, it often led to long queues in reception and clinicians having to come in to check if their patient had arrived.

Communication between staff groups and the wider communication between the Practice and patients was another key area of improvement. With respect to the former, suggestions included having weekly meetings to raise issues and discuss ideas that staff members had. Moreover, there was a feeling that communication between clinical and reception/administrative staff was in need of improvement and that both sides had to work together to find suitable solutions. In addition, it was also suggested that PAs and ANPs needed a more dynamic working relationship with GPs in order to make sure they are getting the most out their role and their strengths are being made use of. In relation to communication with patients, a quarterly or biannual newsletter was suggested to keep them informed of developments in the practice (e.g. short articles on self care, new staff members joining the Practice etc).

Improvements relating to training opportunities (see section) and triage have been discussed in detail above (see sections 3.3.2 and 3.2.2 respectively). With regards to the latter is important to highlight that, whilst there was general agreement that triage would be better handled by clinicians (especially GPs), some did emphasise that this should still be through a call back system. Their reasoning was that clinicians undertaking telephone triage at the time the calls came in might not be a good use of their time because they believed that about 80% of the calls the reception staff can deal with perfectly well. GPs/ PAs/ ANPs could do a "call back" for the remaining cases that needed input from clinicians.

Finally, there were some suggestions that recruiting additional practice nurses would be a good use of resources and the Practice could still adapt further to include, for example, physiotherapy alongside the ANPs and PAs as part of the team. Minor surgery was mentioned positively as a future development, along with evening surgeries.

3.5 What impact has this new of working had on workload and referrals?

- The monthly number of patient contacts[1] made by GPs, ANPs and PAs has increased from 3,930 in January 2016 to 5,362 in January 2017 despite clinical full time equivalent (FTE) remaining fairly constant. An increasing proportion of GP activity is now devoted to surgery consultations (35% at the start of 2016 to 60% in 2017). There has been a shift from administrative activities to the other professionals, including telephone calls with patients and home visits. ANPs carry out most of the home visits, pharmacists cover all of the medicine management and PAs conduct most of the telephone contact with patients.

Since October 2015 the FTE by professional group has remained fairly constant, with about two ANPs, two PAs and two pharmacists. The total FTE for GPs has been about 4.0, with increasing stability as salaried GPs have been employed, and the input from locums and Scotstown partners has been reduced. The workload assessment was based on a listing of activities, with equal weight given to each activity; this means that reported percentages do not necessarily reflect the amount of time spent in each activity.

3.5.1 How do workloads vary by staff group?

The most recent figures from January 2017 (see Figures 3.2 and 3.3 below) show that **GPs** workload is mainly split between surgery consultations (74%) and recording and interpreting results (21%), with the remaining 5% of their activities comprising administration, telephone calls with patients and home visits.

In the same month, **ANPs** workload was split between surgery consultations (68%), recording results (18%) and home visits (11%), with a small amount of administration and telephone calls. The **PAs** workload was split between recording and interpreting results (61%), surgery consultations (16%), telephone calls with patients (12%), administration (11%) and. The amount of results recording completed by PAs was in fact higher than these data suggest, as they often covered the initial interpretation of results for locum GPs. The **pharmacists'** work is predominantly medicine management, over 90% most months. Over 95% of **practices nurses**' workload is surgery consultations every month.

[1] Patient contacts comprise: surgery consultations, home visits, clinics and telephone calls

Figure 3.2: Comparing workload by professional group and activity[1], January 2016 and January 2017 (numbers of activities)

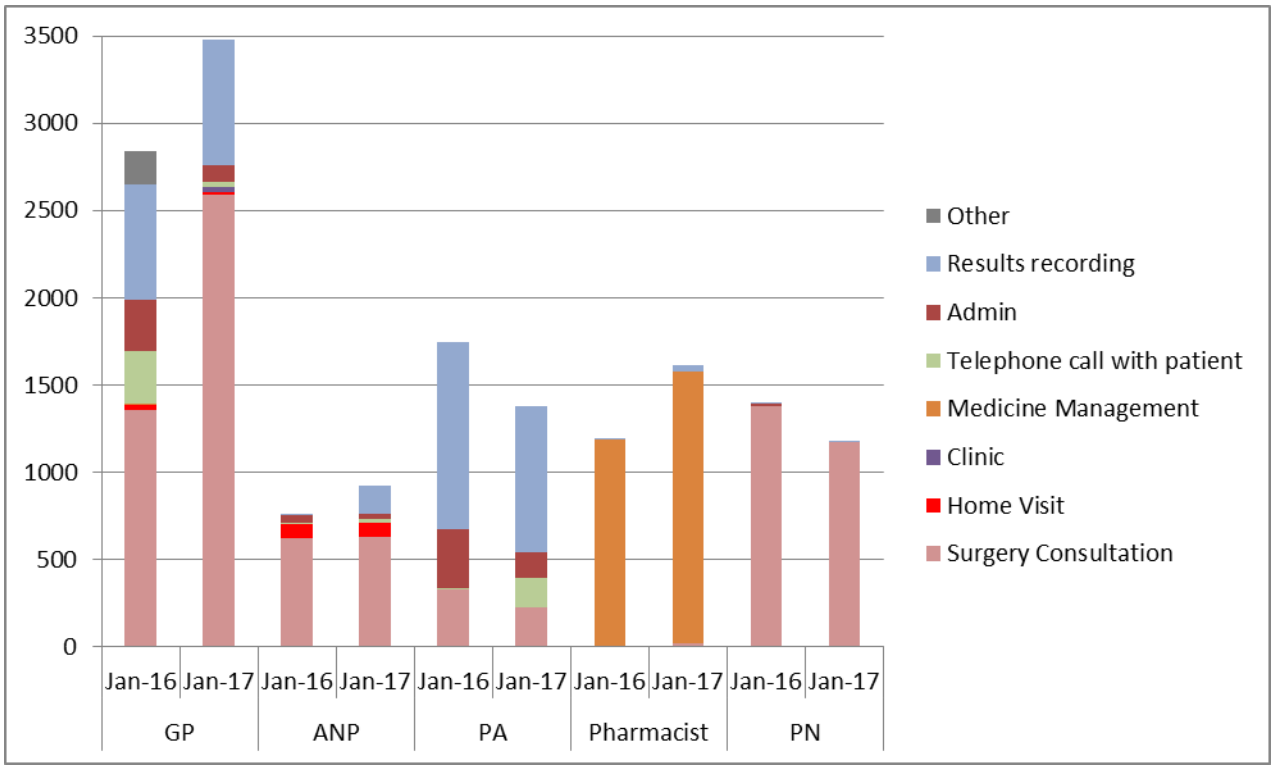
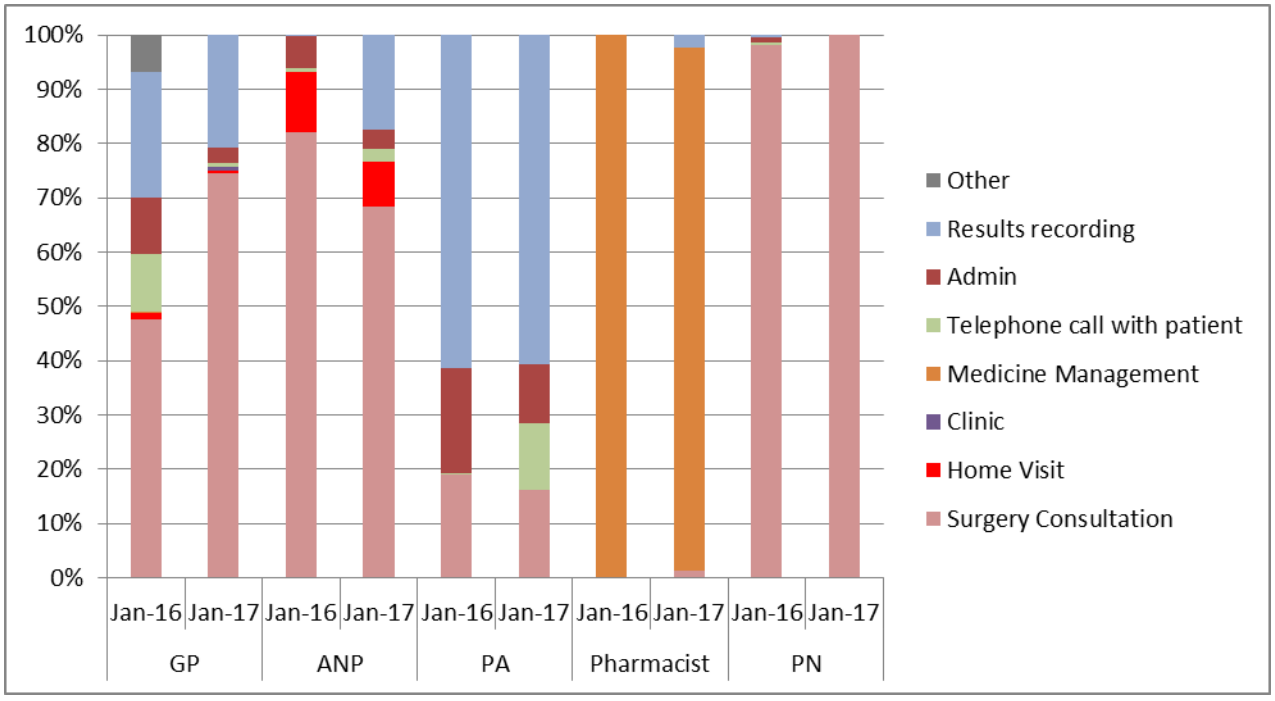


Figure 3.3: Comparing workload by professional group and activity[1], January 2016 and January 2017 (percentages of activities)



[1] Activities given equal weight so the distributions do not necessarily reflect the amount of time spent in each activity

Focussing on differences in the work of GPs, ANPs and PAs, GPs conducted the majority of **surgery consultations** (2,593 in January 2017, which is 74% of the total). In comparison the ANPs did 10% and the PAs, 4%. GPs also shared the **results recording** with PAs. The ANPs did the majority of **home visits**, 76 (84%), with the remainder conducted by GPs. The PAs did more **administration** than the other two groups (55% of the total) and conducted 80% of the **telephone calls with patients**.

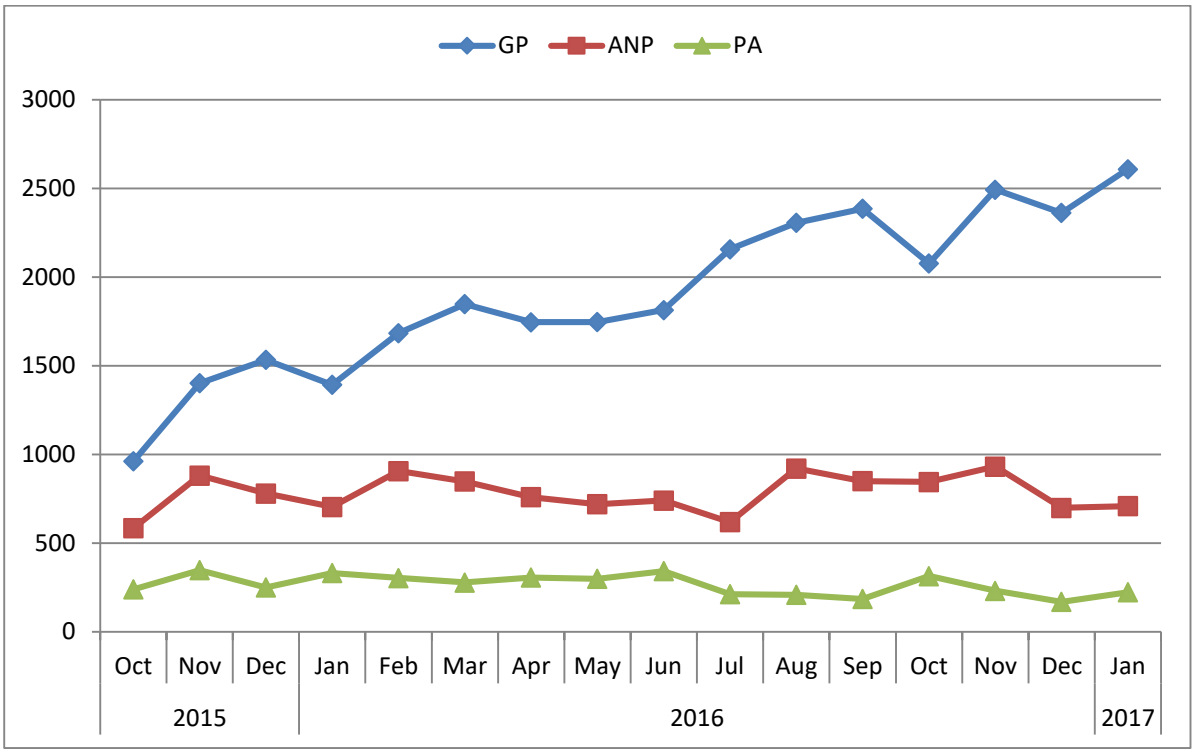
3.5.2 How have workloads changed?

We compared the activity in January 2016 with January 2017. The changes in workload undertaken by clinicians are illustrated in Figure 3.2, 3.3 and Appendices 3 Figures A1-A5. An increasing proportion of the GP workload is devoted to surgery consultations (48% of their activities at the start of 2016 to 74% in 2017) and there has been a fall in their administrative activities, telephone calls with patients, and home visits.

For ANPs the amount of patient contact has remained similar across the year, and they now do results recording, currently about 20% of their activities (this activity was not clearly recorded during the early months). PAs have taken on more patient telephone calls and seen a reduction in the amount of administration and surgery consultations. It's not possible to judge changes in the PA results recording activities as these are often ascribed to the GP who requested the tests. Considering just home visits, the number of patients seen by GPs has fallen to about 10 per month, while ANPs have seen an average of about 70 per month at a consistent level over the period.

As shown in Figure 3.4 below, the number of patients seen each month has been increasing. GP surgery consultations have nearly doubled, from 1,355 in January 2016 to over 2,593 in January 2017. ANPs see about 700 patients and PAs about 250 each month. There are a number of possible reasons that might explain why GPs are now seeing more patients. Firstly, the situation at the practice has stabilised following a rather chaotic period in the first few months of the transition. Secondly, there has been a gradual increase in the number of salaried GPs and a corresponding decrease in locums. Lastly, there has been a shift of administrative activities, telephone calls with patients and home visits to the other professionals.

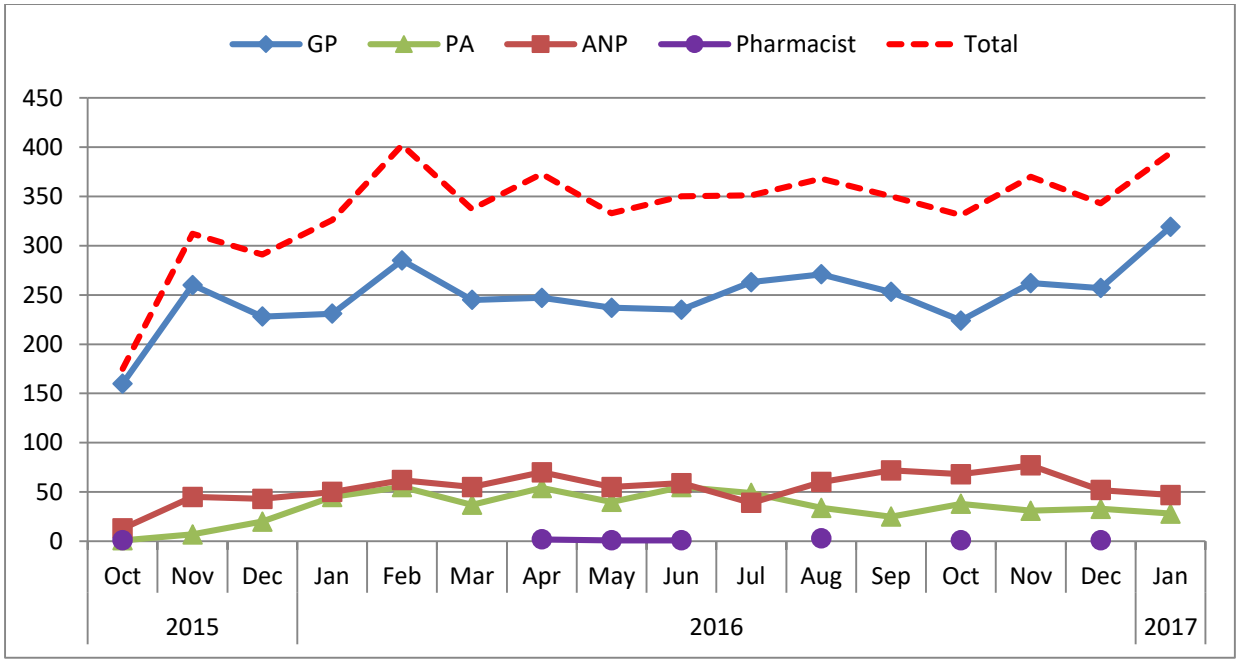
Figure 3.4: Number of patient contacts by professional group (surgery consultations, home visits and medicine management), Oct. 2015 – Jan. 2017



3.5.3 How have referrals changed?

The total number of referrals has been increasing steadily from 300 in November 2015 to nearly 400 in January 2017 (Figure 3.4). GPs make most of the referrals (over 300 in January 2017) with ANPs and PAs making the remainder.

Figure 3.4: Number of referrals made by professional group, October 2015 to January 2017

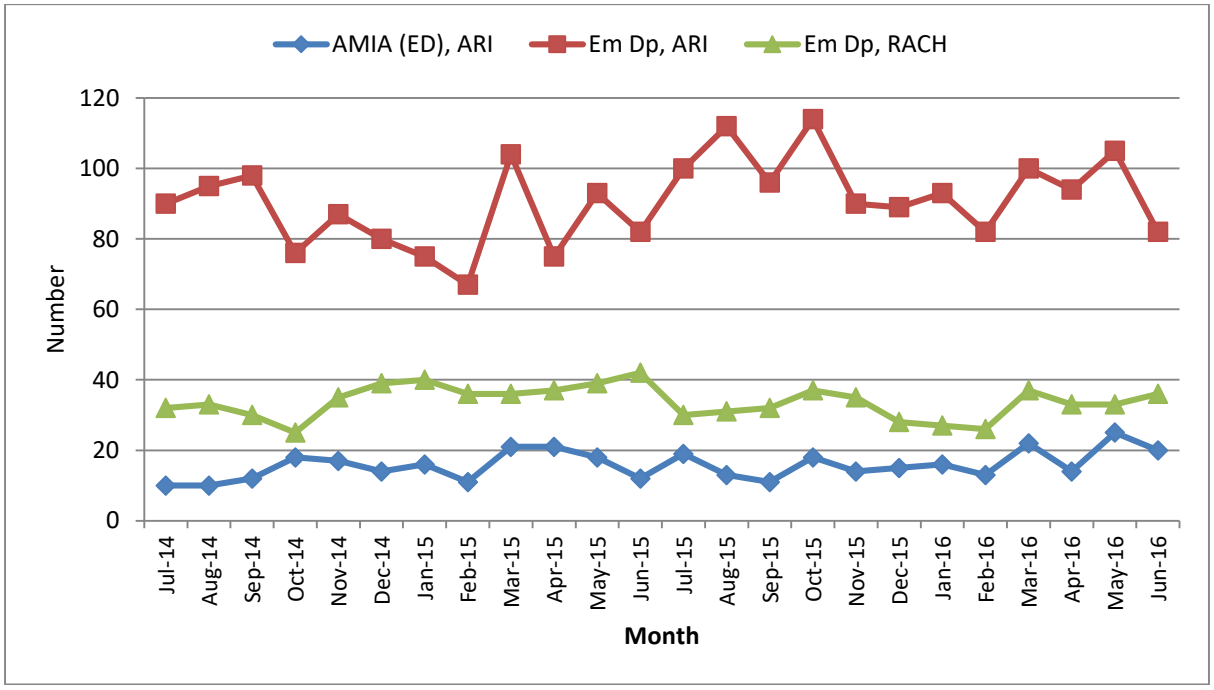


3.5.4 Emergency admissions data

Data were extracted from PMS using the current New Dyce Medical Practice patient CHI list supplied by Practitioner Services. This was used to identify admissions to accident and emergency at ARI or RACH or the AMIA (Acute medical Initial Assessment). AMIA attendances are direct GP referrals that do not require emergency resuscitation. AMIA is an assessment unit, so the patients are assessed, tests requested if required and then decision made to admit or discharge. It is a bedded area, so although they use the TrakED module in PMS, they are not recorded against the four hour standard.

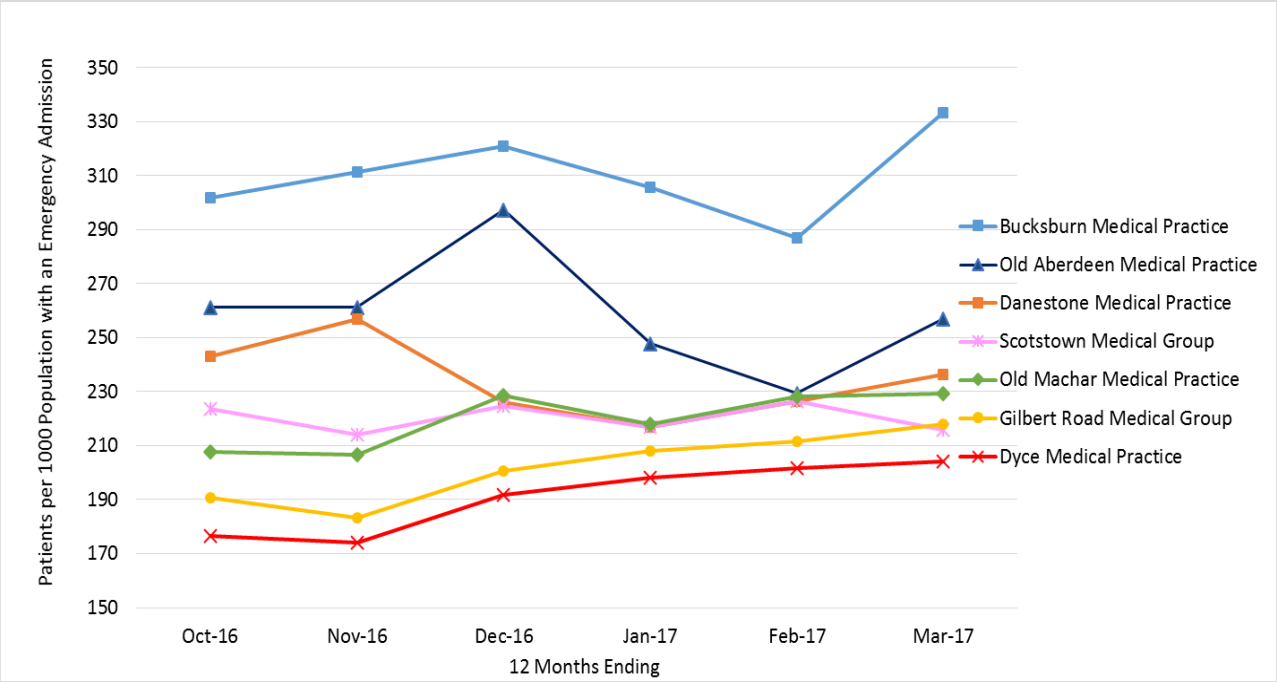
The data originate from the period 1st July 2014 to 30th June 2016, so pre- and post-changeover (Figure 3.5). It was not possible to exclude those patients that had joined New Dyce from practices other than Brimmond and Gilbert Road, but it is thought this would be a very small number of patients. The pattern in the number of admissions each month shows quite a bit of variability and the number recorded during the transition period (October – November 2015) does not seem unusual.

Figure 3.5: Number of New Dyce patient emergency admissions at ARI/RACH, July 2014 to June 2016



Considering emergency admissions to the over-75s (Figure 3.6), New Dyce consistently has the lowest rates among practices in the North Aberdeen cluster.

Figure 3.6: Emergency admissions to over-75s in North cluster Aberdeen, 12-month averages October 2016[1] to March 2017



[1] Data before October 2016 are not shown as 12-month rates may be affected by transfer of patients between Brimmond, Gilbert Road and New Dyce practice lists.

4 CONCLUSION AND RECOMMENDATIONS

The response from the evaluation has been generally positive, with high levels of satisfaction from both patients and staff. This suggests that things are moving in the right direction after a very challenging beginning. However, while patients were generally positive about their experience of care, it must be noted that they were slightly less content in their previous practices. As demonstrated using evidence from the Health and Social Care survey reports for Brimmond and Gilbert Road practices, the overall care provided was rated positively by 90% in Brimmond and 92% in Gilbert Road compared to 80% in New Dyce Medical Practice. This highlights the need for further improvement in order to get to similar satisfaction levels. Possible areas for further development have been identified as follows:

- **Triage**: Introduce different triage arrangements, combination of guidelines for reception/administration staff and a GP triage system for patients requiring appointments. Patient allocation is usually conducted by administration staff with no formal guidance, while patient responses show that they prefer to discuss their conditions with clinical staff. One advantage of using GPs for triage would be to increase the confidence of patients in their allocation to other professionals. Ideally triage notes would be passed to the members of staff in consultation so patients would not need to repeat their whole history.
- **Improve patient-facing systems**: Problems with two systems were mentioned by staff and patients, which need to be remedied. The automatic check in should be adapted so the patient's own name is clearly visible and the phone system should be checked regularly to ensure callers can get through in a reasonable length of time.
- **Training for receptionists**: Staff at reception may benefit from further training in dealing with people when under pressure. Customer/patient centred training would help make the front facing as welcoming and professional as possible.
- **Reception area:** Consider introducing a monitor with health information/TV/ music to mask conversations at the front desk.
- **Communication with patients**: To continue to improve patient understanding of the new way of working further information could be given. For example, by using signage in the practice to explain the different clinical roles (including photographs) and/or circulating a newsletter to introduce new staff/explain roles.
- **Review workloads:** it may be useful for all staff to meet regularly to consider workload breakdowns and discuss whether these reflect the optimum use of time.

APPENDICES

Appendix 1: Sample of patient survey

New Dyce Patient Survey

New Dyce Medical Practice want to find out what you think about the care you receive, following the service change in October 2015.

Would you spare a few minutes to answer some questions?
You don't need to give us your name, so your answers will be confidential.

Q1 Gender

Male ☐ Female ☐ Prefer not to say ☐

Q2 Age

Under 16 ☐ 16 - 25 ☐ 26 - 35 ☐ 36 - 45 ☐
46 - 55 ☐ 56 - 65 ☐ 66 - 75 ☐ Over 75 ☐

Q3 Where do you live?

Newmachar ☐ Dyce ☐ Hatton of Fintray ☐ Other ☐
Please specify

Q4 Were you previously registered with:

Brimmond Medical Group ☐ Gilbert Road Medical Group ☐
Other ☐
Please specify

Q5 Approximately how many times have you visited New Dyce Medical Practice since 1st October 2015 to see a healthcare professional?

First visit ☐ Once previously ☐
2 - 4 times ☐ 5 - 10 times ☐
More than 10 times ☐ Cant remember/ Don't Know ☐

We'd like to know more about your experiences related to your **appointment today**

Q6 How many attempts did it take you to get through on the phone?

First time of trying ☐
2-4 attempts ☐
More than 5 attempts ☐
Not applicable (i.e. made appointment in person) ☐

Q7 From the time you requested an appointment, how many days was it until you saw a member of the clinical team?

Less than 1 day ☐ 1 - 2 days ☐
3 - 4 days ☐ 5 - 6 days ☐
1 - 2 weeks ☐ More than 2 weeks ☐

Q8 **How acceptable did you find this wait?**

Very Acceptable ☐ Acceptable ☐
Unacceptable ☐ Very Unacceptable ☐

Q9 **Did the reception team offer you a choice of which type of health professional you saw (e.g. GP, ANP, PA, practice nurse or pharmacist)?**

Yes ☐ No ☐ Not applicable ☐

Q10 **Do you feel the decision over who you saw was made in an appropriate way?**

Yes ☐ No ☐ Don't Know ☐ Not applicable ☐

Q11 **If No/Don't know, why do you think this?**

Q12 **Who did you see today (or at your most recent visit)? (*tick all that apply*)**

Advanced Nurse Practitioner (ANP) ☐ GP ☐
Physician Associate (PA) ☐ Practice Nurse ☐
Pharmacist ☐ Not sure ☐

Q13 **Do you feel your issue was dealt with by the right person?**

Yes ☐ No ☐ Don't know ☐

Q14 **If No, please explain your reasons for this**

Q15 **How do you feel about an Advanced Nurse Practitioner (ANP) providing your care?**

Content ☐ Unsure ☐ Not content ☐ Not applicable ☐

Q16 **How do you feel about a Physician Associate (PA) providing your care?**

Content ☐ Unsure ☐ Not content ☐ Not applicable ☐

Q17 **Thinking about your visit today, how much do you agree or disagree with each of the following statements:**

	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
I did not have enough time to discuss my health/medical issue	☐	☐	☐	☐	☐
My condition and/or treatment was explained in a way I could understand	☐	☐	☐	☐	☐
I was not given the right amount of information	☐	☐	☐	☐	☐
I was confident in the knowledge shown by the professional(s)	☐	☐	☐	☐	☐
I felt I was involved in decisions about my care	☐	☐	☐	☐	☐
I was not confident in the advice/treatment provided	☐	☐	☐	☐	☐

Q18 **Overall, how would you rate the care provided by the team?**

Very good	☐	Good	☐
Fair	☐	Poor	☐
Very poor	☐		

Q19 **How does the service compare with the one you received before October 2015?**

Q20 **If something could be improved about the care you received at New Dyce, what would this be?**

Q21 **Any additional comments on the service provided?**

Q22 **As part of this survey, we would like to hear about patients' experiences of using the New Dyce Medical Practice.**

If you are willing to be contacted to further discuss your views, please write your name and telephone number below : (Please note that not all volunteers will be contacted)

Thank you for taking the time to complete this questionnaire

Appendix 2: Comparative findings from recent Health and Social Care Surveys for Brimmond and Gilbert Road practices

% Positive	Brimmond 2013/14	Gilbert Road 2015/16
It is easy to get through on the phone	85	86
Person answering the phone is helpful	92	97
Overall arrangements for getting to see a doctor	75	72
Overall arrangements for getting to see a nurse	75	85
Can see or speak to a doctor or nurse within 2 working days	84	80
Patients have enough time with doctors	92	95
Patients have enough time with nurses	97	99
Doctors talk in a way that helps patients understand their condition and treatment	93	94
Nurses talk in a way that helps patients understand their condition and treatment	92	89
Patients have confidence in doctors' ability to treat them	93	91
Patients have confidence in nurses' ability to treat them	98	95
Rating of overall care provided by GP practice	90	92

Appendix 3

Figure A1a: GP workload by activity (numbers of activities)

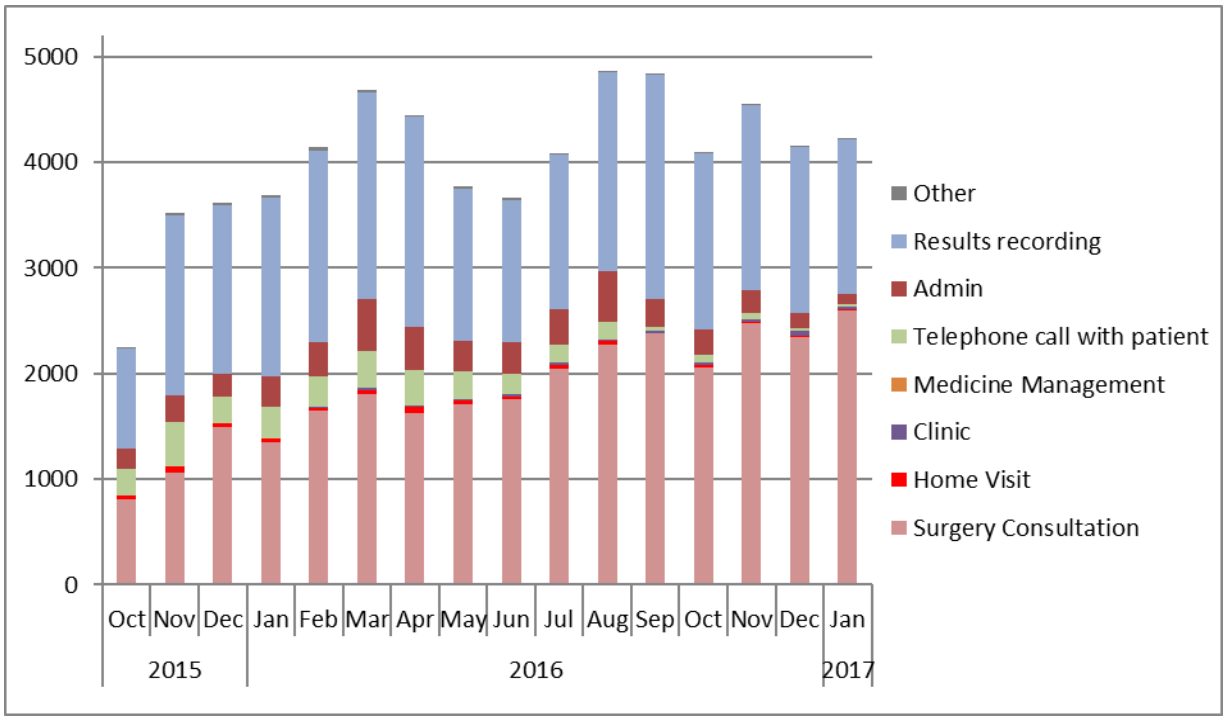


Figure A1b: GP workload by activity (percentages of activities)

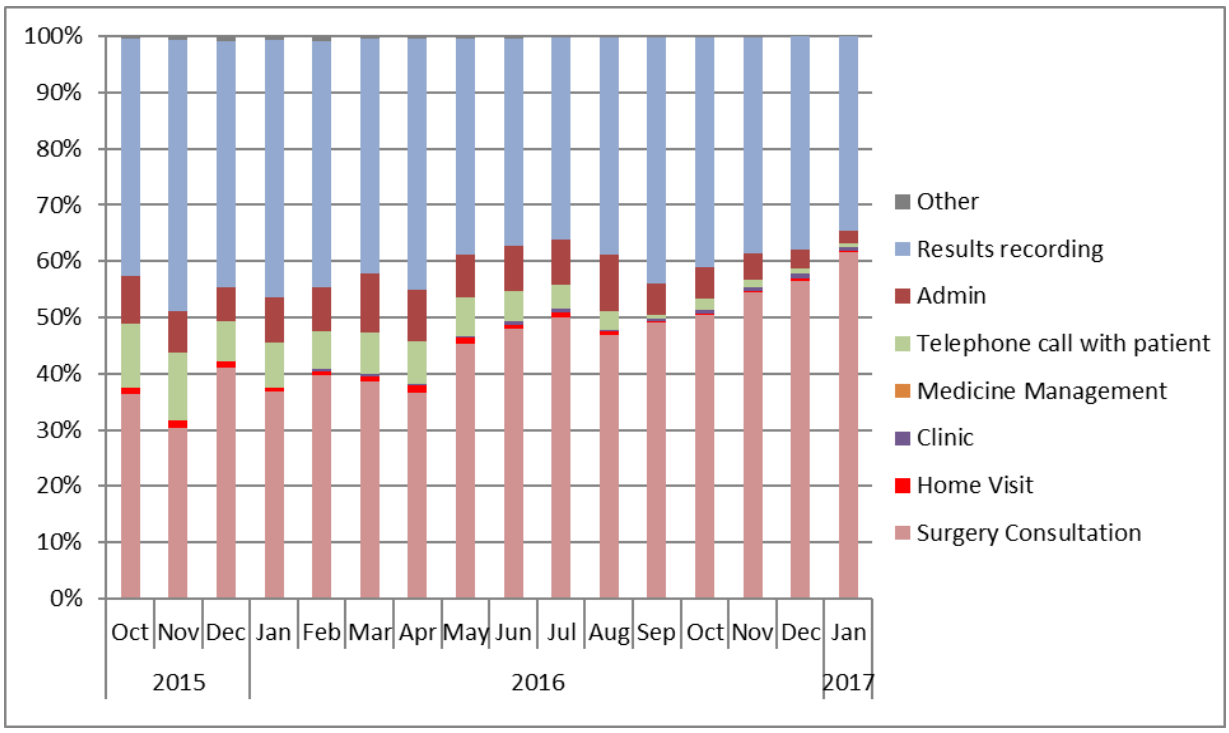


Figure A2a: ANP workload by activity (numbers of activities)

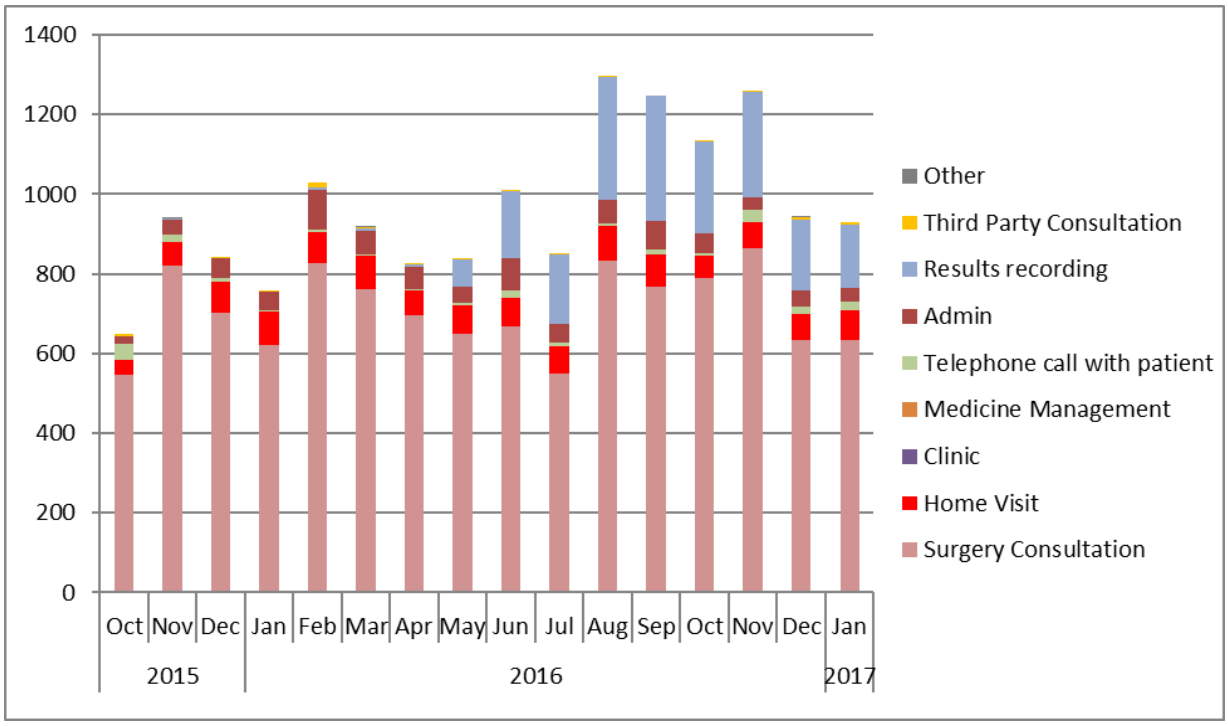


Figure A2b: ANP workload by activity (percentages of activities)

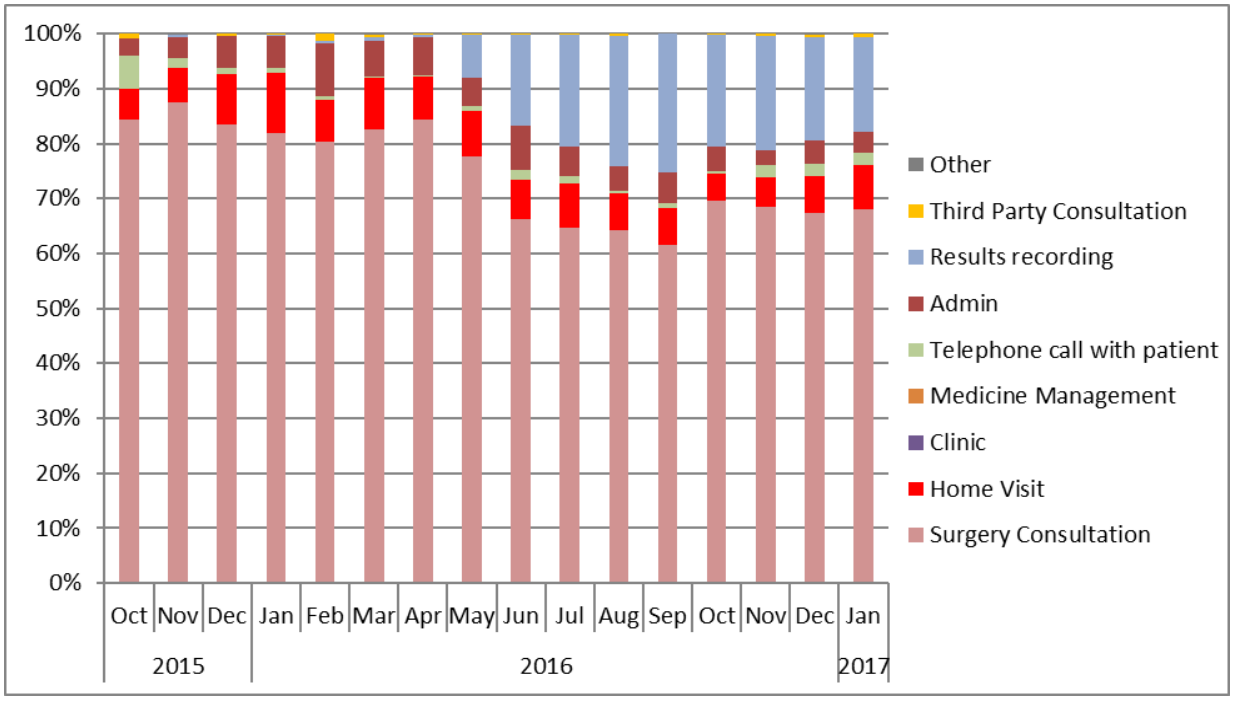


Figure A3a: PA workload by activity (numbers of activities)

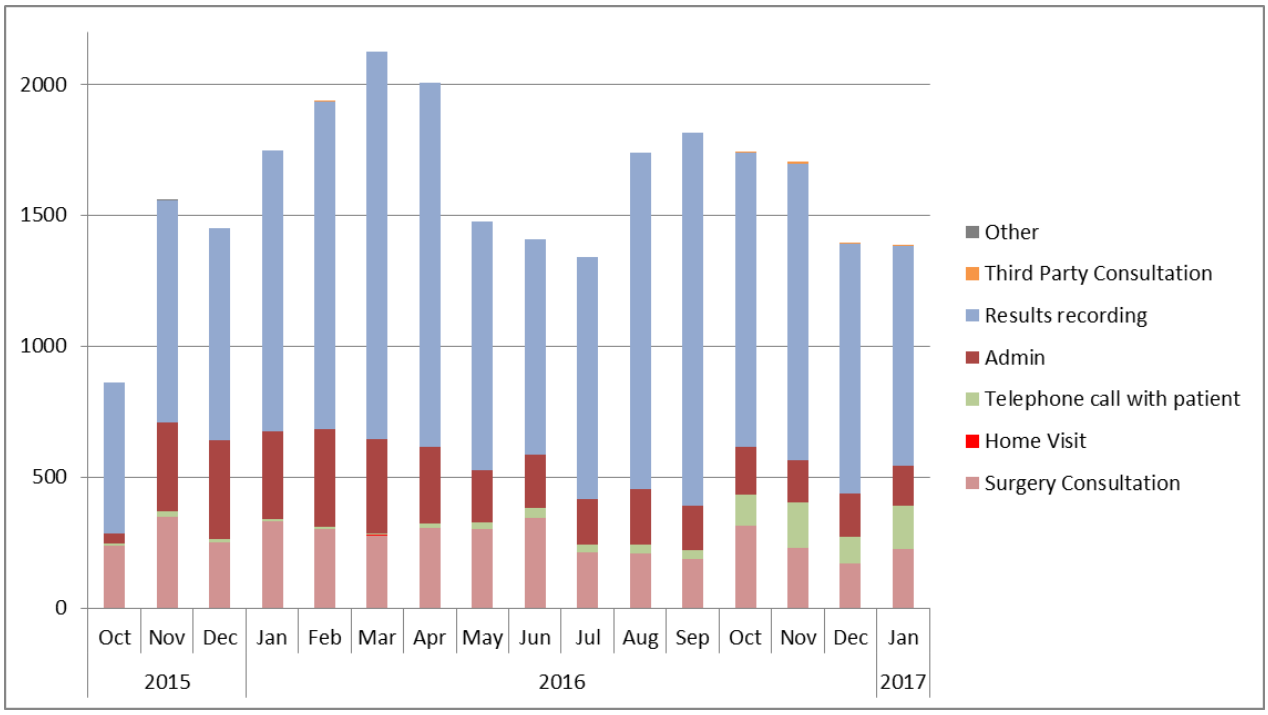


Figure A3b: PA workload by activity (percentages of activities)

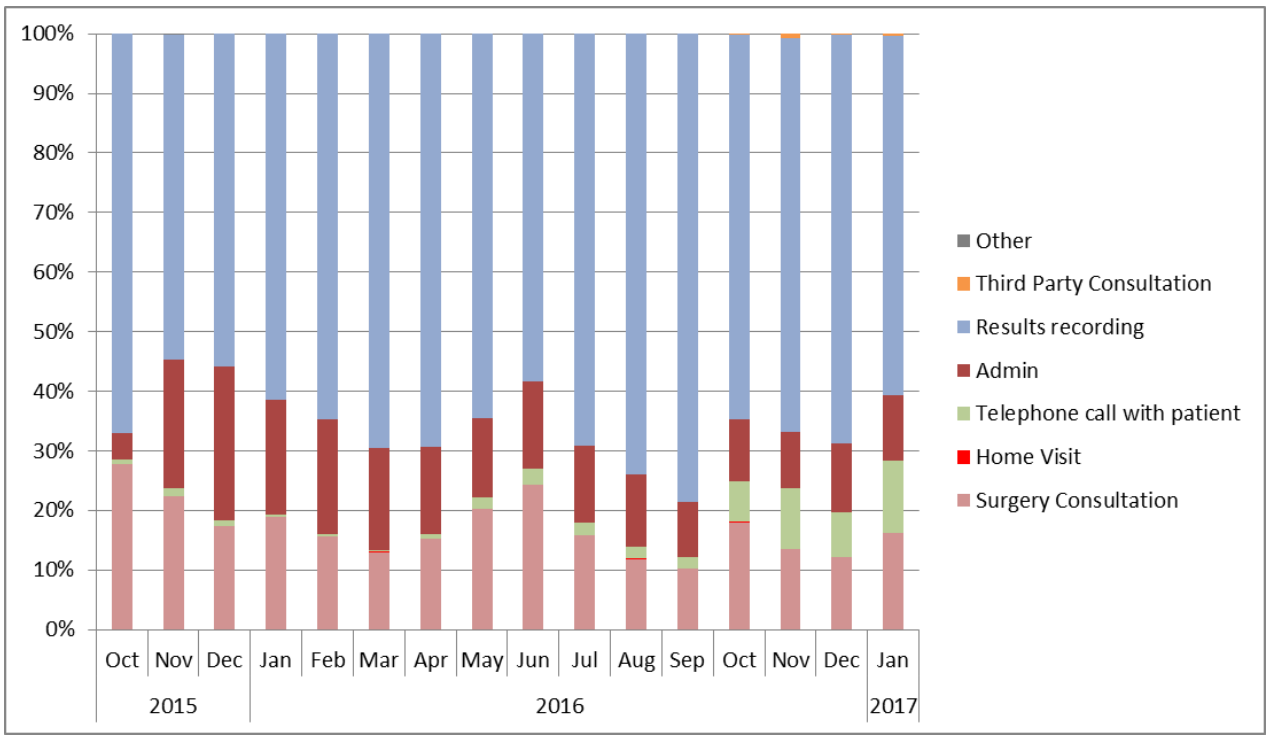


Figure A4a: Pharmacist workload by activity (numbers of activities)

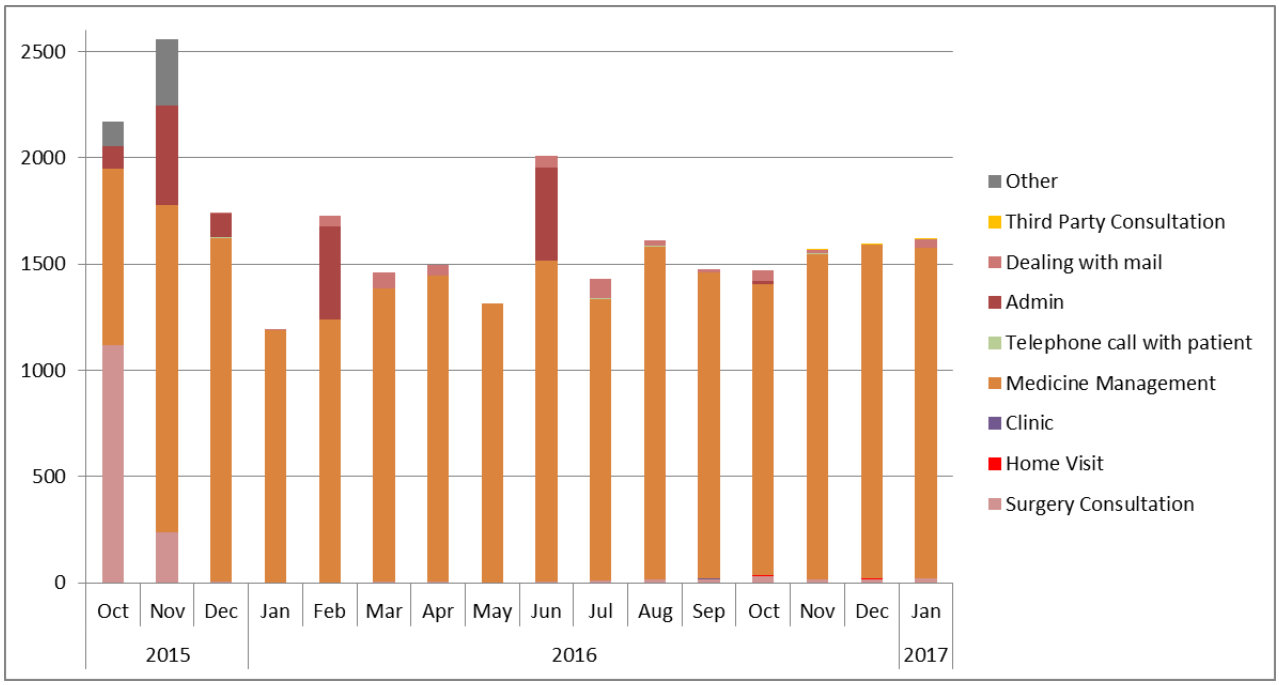


Figure A4b: Pharmacist workload by activity (percentages of activities)

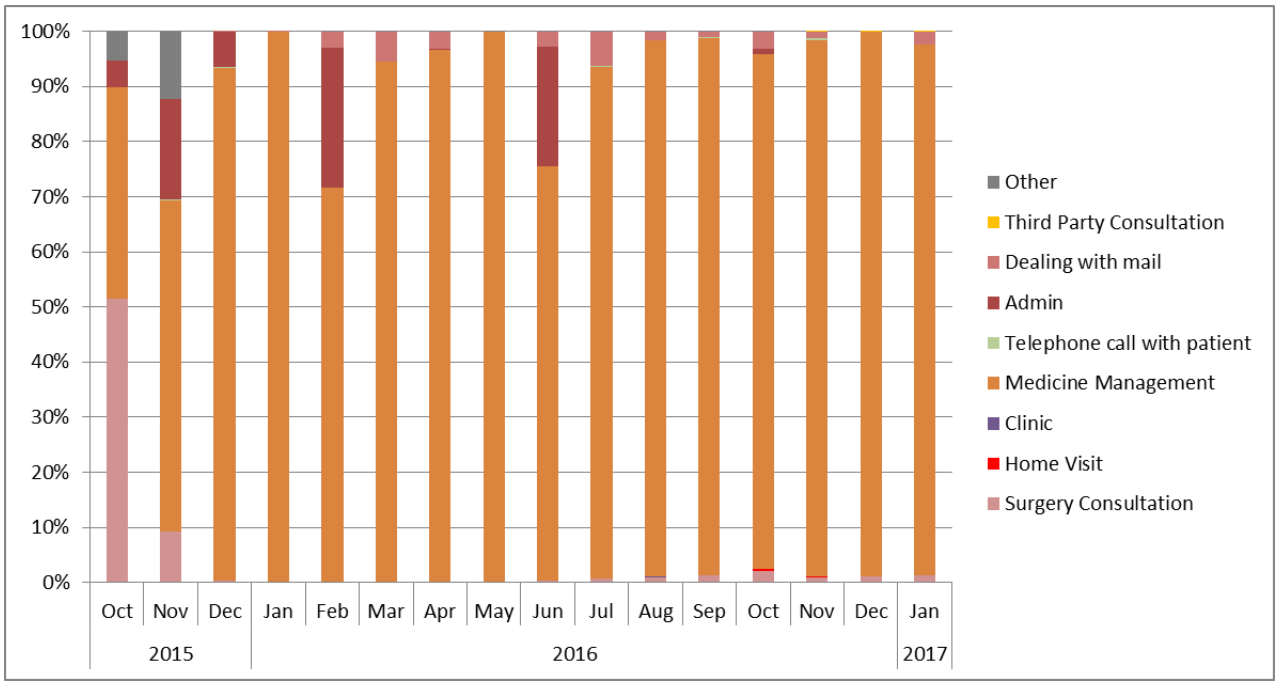


Figure A5a: Practice nurse workload by activity (numbers of activities)

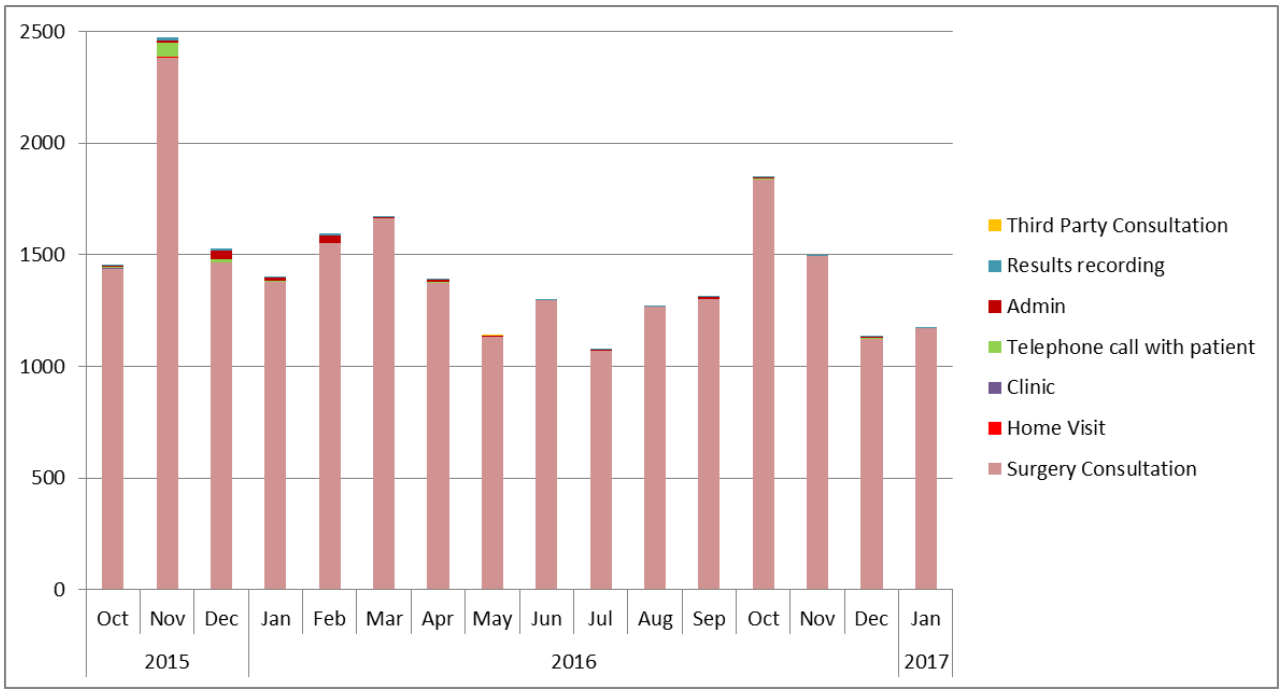
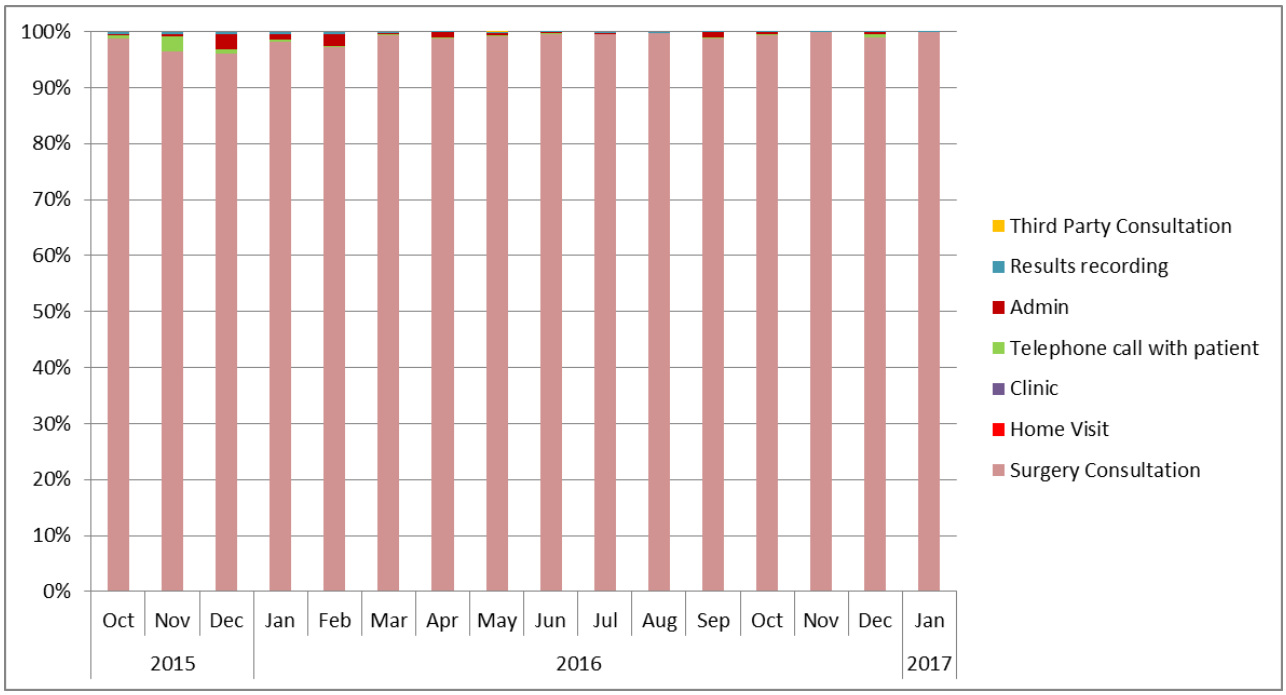


Figure A5b: Practice nurse workload by activity (percentages of activities)



New categories	Original activities included
Home Visit	Home Visit, Acute visit, Hotel Visit, Residential Home Visit
Admin	Administration, Referral Letter, Repeat Issue
Other	Other, Casualty Attendance, GOS18 Report, Hospital Admission
Telephone call with patient	Telephone call from a patient, Telephone call to a patient, Triage
Clinic	
Results recording	
Surgery consultation	
Third Party Consultation	
Medicine Management	